The enclosed Model Notices are supplements to the Compliance Checklist tool, and have been provided by various governmental entities and regulatory agencies, or as part of statutes and regulations pertaining to employer sponsored group health plans.
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General Notice of COBRA Continuation Coverage Rights

**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.”
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 NOTICE B

COBRA Continuation Coverage Election Notice

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [enter date] due to [check appropriate box]:

☐ End of employment
☐ Death of employee
☐ Entitlement to Medicare
☐ Reduction in hours of employment
☐ Divorce or legal separation
☐ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [enter 18 or 36, as appropriate and check appropriate box or boxes; names may be added]:

☐ Employee or former employee
☐ Spouse or former spouse
☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on [enter date] and can last until [enter date].

[Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options].]

COBRA continuation coverage will cost: [enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.] You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].
COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [Enter Name and Address]

This Election Form must be completed and returned by mail [or describe other means of submission and due date]. If mailed, it must be post-marked no later than [enter date].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the [enter name of plan] (the Plan) as indicated below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Relationship to Employee</th>
<th>SSN (or other identifier)</th>
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<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>[Add if appropriate: Coverage option elected: _____________________________]</td>
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<tr>
<td>b.</td>
<td></td>
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<tr>
<td></td>
<td>[Add if appropriate: Coverage option elected: _____________________________]</td>
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<tr>
<td>c.</td>
<td></td>
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<td></td>
<td>[Add if appropriate: Coverage option elected: _____________________________]</td>
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<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Print Name</th>
<th>Relationship to individual(s) listed above</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Print Address</th>
<th>Telephone number</th>
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</table>
Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [add if applicable: open enrollment and special enrollment rights].

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued 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. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:]

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify [enter name of party responsible for COBRA administration] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.
Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has 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. [Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.] Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA’s determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee’s spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee’s spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant.
or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

[If employees might be eligible for trade adjustment assistance, the following information may be added:] The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

**When and how must payment for COBRA continuation coverage be made?**

**First payment for continuation coverage**

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact [enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan] to confirm the correct amount of your first payment.

**Periodic payments for continuation coverage**

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the [enter due day for each monthly payment] for that coverage period. [If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [select one: will or will not] send periodic notices of payments due for these coverage periods.

**Grace periods for periodic payments**

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period [or enter longer period permitted by Plan] to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. [If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:] However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]
If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[enter appropriate payment address]

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].

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 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 and your family’s rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
MODEL NOTICE C

ERISA Rights Statement

As a participant in (name of plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Securities Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age ***) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. In any case, plans and issuers 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).

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(u)(1) For a group health plan, as defined in section 733(a)(1) of the Act, that provides maternity or newborn infant coverage, 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 hospital length of stay in connection with childbirth for the mother or newborn child. If federal law applies in some areas in which the plan operates and state law applies in other areas, the statement should describe the different areas and the federal or state law requirements applicable in each.

(2) In the case of a group health plan subject to section 711 of the Act, the summary plan description will be deemed to have complied with paragraph (u)(1) of this section relating to the required description of federal law requirements if it includes the following statement in the summary plan description:

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).
SUMMARY ANNUAL REPORT

Summary Annual Report for (name of plan)

This is a summary of the annual report of the (name of plan, EIN and type of welfare plan) for (period covered by this report). The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

[If any benefits under the plan are provided on an uninsured basis:]

(Name of sponsor) has committed itself to pay (all, certain) (state type of) claims incurred under the terms of the plan.

[If any of the funds are used to purchase insurance contracts:]

Insurance Information

The plan has (a) contract(s) with (name of insurance carrier(s)) to pay (all, certain) (state type of) claims incurred under the terms of the plan. The total premiums paid for the plan year ending (date) were ($ ----).

[If applicable add:]

Because (it is a) (they are) so called “experience-rated” contract(s), the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending (date), the premiums paid under such “experience-rated” contract(s) were ($) and the total of all benefit claims paid under the(se) experience-rated contract(s) during the plan year was ($ ).

[If any funds of the plan are held in trust or in a separately maintained fund:]

Basic financial statement

The value of plan assets, after subtracting liabilities of the plan, was ($ ) as of (the end of plan year), compared to ($ ) as of (the beginning of the plan year). During the plan year the plan experienced an (increase) (decrease) in its net assets of ($ ). This (increase) (decrease) includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of ($ ) including employer contributions of ($ ), employee contributions of ($ ), realized (gains) (losses) of ($ ) from the sale of assets, and earnings from investments of ($ ). Plan expenses were ($ ). These expenses included ($ ) in administrative expenses, ($ ) in benefits paid to participants and beneficiaries, and ($ ) in other expenses.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report: [Note--list only those items which are actually included in the latest annual report].

1. an accountant's report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan);
5. loans or other obligations in default or classified as uncollectible;
6. leases in default or classified as uncollectible;
7. transactions in excess of 5 percent of the plan assets;
8. insurance information including sales commissions paid by insurance carriers; and
9. Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of (name), who is (state title: e.g., the plan administrator), (business address and telephone number). The charge to cover copying costs will be ($ ) for the full annual report, or ($ ) per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (address), (at any other location where the report is available for examination), and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

• For incapacity due to pregnancy, prenatal medical care or child birth;

• To care for the employee’s child after birth, or placement for adoption or foster care;

• To care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or

• For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.
MODEL NOTICE E (continued)

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer’s normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

• Interfere with, restrain, or deny the exercise of any right provided under FMLA;

• Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Employment Standards Administration | Wage and Hour Division WHD Publication 1420 Revised January 2009
Notice of Eligibility and Rights & Responsibilities
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration Wage and Hour Division

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]
TO: ________________________________________

Employee

FROM: ________________________________________

Employer Representative

DATE: ________________________________________

On _____________________, you informed us that you needed leave beginning on _____________________ for:

____ The birth of a child, or placement of a child with you for adoption or foster care;

____ Your own serious health condition;

____ Because you are needed to care for your ____ spouse; _____ child; _____ parent due to his/her serious health condition.

____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____ son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

____ Because you are the ____ spouse; _____ son or daughter; ______ parent; ______ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

____ Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

____ You have not met the FMLA’s 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ____ months towards this requirement.

____ You have not met the FMLA’s 1,250-hours-worked requirement.

____ You do not work and/or report to a site with 50 or more employees within 75-miles.
MODEL NOTICE F (continued)

If you have any questions, contact ________________________________ or view the FMLA poster located in ________________________________.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _________________________________. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ___is/___ is not enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed:

________________________________________________________________________

________________________________________________________________________

____

____ No additional information requested

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

____ Contact ________________________ at _____________________________ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid ______ sick, ______ vacation, and/or ________other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a “key employee” as defined in the FMLA. As a “key employee,” restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___have/___ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _______________________. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:
MODEL NOTICE F (continued)

• You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  ____ the calendar year (January – December).
  ____ a fixed leave year based on
  ________________________________.
  ____ the 12-month period measured forward from the date of your first FMLA leave usage.
  ____ a “rolling” 12-month period measured backward from the date of any FMLA leave usage.

• You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a
  covered servicemember with a serious injury or illness. This single 12-month period commenced on
  ______________________________________________.

• Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you
  continued to work.
• You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of
  employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA
  entitlement, you do not have return rights under FMLA.)
• If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset
  of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a
  covered servicemember’s serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances
  beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your
  behalf during your FMLA leave.
• If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave
  entitlement, you have the right to have _____ sick, _____ vacation, and/or _____ other leave run concurrently with
  your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions
  related to the substitution of paid leave are referenced or set forth below. • If you do not meet the requirements for
  taking paid leave, you remain entitled to take unpaid FMLA leave.
  ____ For a copy of conditions applicable to sick/vacation/other leave usage please refer to __________ available
  at: ______________________________________.
  ____ Applicable conditions for use of paid
  leave: ______________________________________
  ______________________________________

 Once we obtain the information from you as specified above, we will inform you, within 5 business days,
 whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you
 have any questions, please do not hesitate to contact:
 ________________________________ at ________________________________.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2618; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

WH-381 Revised January 2009
Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee’s FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form H-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____________________________

Date: _____________________________

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.

We received your most recent information on ________________________ and decided:

____ Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement:

____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

____ We are requiring you to substitute or use paid leave during your FMLA leave.

____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position __________ is __________ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.
MODEL NOTICE G (continued)

Additional information is needed to determine if your FMLA leave request can be approved:

The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than [Provide at least seven calendar days] unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

(Specify information needed to make the certification complete and sufficient)

We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

Your FMLA Leave request is Not Approved.

The FMLA does not apply to your leave request.

You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

Form WH-382 January 2009
MODEL NOTICE H

PPACA: Grandfathered Health Plans

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

The following model language can be used to satisfy this disclosure requirement:

```
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.]
```
According to HHS, the following model language, which shall be prominently displayed in clear, conspicuous 14-point bold type on the front of the materials, shall be used to satisfy the notice requirement, for all applicable plans except Health Reimbursement Arrangements (HRA). For those plans, use Version 2:

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least [$750,000/$1.25 million/$2 million, as applicable].

Your health insurance coverage, offered by [name of group health plan or health insurance issuer], does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

[dollar amount] on [all covered benefits]

and/or

[dollar amount(s)] on [which covered benefits — notice should describe all annual limits that apply].

This means that your health coverage might not pay for all the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay for [insert amount] days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least [$750,000/$1.25 million/$2 million, as applicable] this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until [the
If you are concerned about your plan’s lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact [provide contact information for plan administrator or health insurance issuer]. [For plans offered in States with a Consumer Assistance Program] In addition, you can contact [contact information for consumer assistance program].
According to HHS, the following model language, which shall be prominently displayed in clear, conspicuous 14-point bold type on the front of the materials, shall be used to satisfy the notice requirement for Health Reimbursement Arrangements (HRA) only. For all other plans, use Version 1:

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least [[$750,000/$1.25 million/$2 million as applicable]].

Your health coverage offered by [name of group health plan/applicant], does not meet the minimum standards required by the Affordable Care Act described above. Your employer makes an annual contribution of:

[Dollar amount] to your Health Reimbursement Arrangement (HRA). This means your health coverage may not pay for all the health care expenses you may incur.

The U.S. Department of Health and Human Services has granted your HRA a waiver from the requirement that it provide [$750,000/$1.25 million/$2 million] in benefits until [the end date of the last plan or policy year beginning before January 1, 2014] because it would cause a significant decrease in your access to this benefit.

If you are concerned about your plan’s lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact [provide contact information for plan administrator]. [For plans offered in States with a Consumer Assistance Program] Additionally, you can contact [contact information for Consumer Assistance Program].
MODEL NOTICE M

PPACA: Patient Protections

When applicable, it is important that individuals enrolled in a plan or health insurance coverage
know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer
requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care
without prior authorization. Accordingly, the interim final regulations regarding patient
protections under section 2719A of the Affordable Care Act require plans and issuers to provide
notice to participants of these rights when applicable. The notice must be provided whenever the
plan or issuer provides a participant with a summary plan description or other similar description
of benefits under the plan or health insurance coverage. This notice must be provided no later
than the first day of the first plan year beginning on or after September 23, 2010.

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/allow] 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].
This document contains important information that you should retain for your records. This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>ID Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: (street, county, state, zip)</td>
<td></td>
</tr>
<tr>
<td>Claim #:</td>
<td>Date of Service:</td>
</tr>
<tr>
<td>Provider:</td>
<td></td>
</tr>
</tbody>
</table>

Reason for Denial (in whole or in part):

|--------------|-------------|-----------------|------------|--------|-------------|------------------------|----------|

YTD Credit toward Deductible:  
YTD Credit toward Out-of-Pocket Maximum:

Description of service:  
Denial Codes:

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Explanation of Basis for Determination:

If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.

[Insert language assistance disclosure here, if applicable.]  
SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].  
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].  
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].  
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]
Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don’t agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

How do I file an appeal? [Complete the bottom of this page, make a copy, and send this document to {insert address}.] [or] [insert alternative instructions] See also the “Other resources to help you” section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also [insert instructions for filing request for simultaneous external review].

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, you may supply additional information. [Insert any applicable procedures for submission of additional information.]

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at [insert contact information].

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact: [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact [insert contact information]]

---

**Appeal Filing Form**

**NAME OF PERSON FILING APPEAL:**

Circle one: ☐ Covered person ☐ Patient ☐ Authorized Representative

Contact information of person filing appeal (if different from patient)

Address: ___________________ Daytime phone: _______________ Email: _______________

If person filing appeal is other than patient, patient must indicate authorization by signing here:

___________________________________________________________________________

Are you requesting an urgent appeal? ☐ Yes ☐ No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician’s letter, bills, medical records, or other documents to support your claim):

___________________________________________________________________________

Send this form and your denial notice to: [Insert name and contact information]

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.

29
MODEL NOTICE K
MODEL NOTICE OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

Date of Notice
Name of Plan
Address

Telephone/Fax
Website/Email Address

This document contains important information that you should retain for your records.
This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal (see the back of this page for information about your appeal rights).

Internal Appeal Case Details:

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>ID Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: (street, county, state, zip)</td>
<td></td>
</tr>
<tr>
<td>Claim #:</td>
<td>Date of Service:</td>
</tr>
<tr>
<td>Provider:</td>
<td></td>
</tr>
</tbody>
</table>

Reason for Upholding Denial (in whole or in part):

|--------------|-------------|----------------|------------|--------|-------------|------------------------|-----------|

YTD Credit toward Deductible: YTD Credit toward Out-of-Pocket Maximum:

Description of Service: Denial Codes:

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: Describe facts of the case including type of appeal and date appeal filed.

Final Internal Adverse Benefit Determination: State that adverse benefit determination has been upheld. List all documents and statements that were reviewed to make this final internal adverse benefit determination.

Findings: Discuss the reason or reasons for the final internal adverse benefit determination.

[Insert language assistance disclosure here, if applicable.]
SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]
Important Information about Your Rights to External Review

What if I need help understanding this denial? Contact us [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don’t agree with this decision? For certain types of claims, you are entitled to request an independent, external review of our decision. Contact [insert external review contact information] with any questions on your rights to external review. [For insured coverage, insert: If your claim is not eligible for independent external review but you still disagree with the denial, your state insurance regulator may be able to help to resolve the dispute.] See the “Other resources section” of this form for help filing a request for external review.

How do I file a request for external review? Complete the bottom of this page, make a copy, and send this document to {insert address}. See also the “Other resources to help you” section of this form for assistance filing a request for external review.

What if my situation is urgent? If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by [insert instructions to begin the process (such as by phone, fax, electronic submission, etc.)].

Who may file a request for external review? You or someone you name to act for you (your authorized representative) may file a request for external review. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, once your external review is initiated, you will receive instructions on how to supply additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at [insert contact information].

What happens next? If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact: [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact:[insert contact information].]

NAME OF PERSON FILING REQUEST FOR EXTERNAL REVIEW:

Circle one: □ Covered person □ Patient □ Authorized Representative

Contact information of person filing request for external review (if different from patient)
Address: __________________ Daytime phone: ________________ Email: ________________

If person filing request for external review is other than patient, patient must indicate authorization by signing here: __________________________________________

Are you requesting an urgent review? □ Yes □ No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician’s letter, bills, medical records, or other documents to support your claim): __________________________________________

Send this form and your denial notice to: [Insert name and contact information]
Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.
MODEL NOTICE L
MODEL NOTICE OF FINAL EXTERNAL REVIEW DECISION

Date of Notice
Name of Plan
Address

Telephone/Fax
Website/Email Address

This document contains important information that you should retain for your records.

This document serves as notice of a final external review decision. We have [upheld/overturned/modified] the denial of your request for the provision of, or payment for, a health care service or course of treatment.

<table>
<thead>
<tr>
<th>Historical Case Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>Address: (street, county, state, zip)</td>
</tr>
<tr>
<td>Claim #:</td>
</tr>
<tr>
<td>Provider:</td>
</tr>
<tr>
<td>Reason for Denial (in whole or in part):</td>
</tr>
<tr>
<td>YTD Credit toward Deductible:</td>
</tr>
<tr>
<td>Description of Service:</td>
</tr>
<tr>
<td>Denial Codes:</td>
</tr>
</tbody>
</table>

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: Describe facts of the case including type of appeal, date appeal filed, date appeal was received by IRO and date IRO decision was made.

Final External Review Decision: State decision. List all documents and statements that were reviewed to make this final external review decision.

Findings: Discuss the principal reason or reasons for IRO decision, including the rationale and any evidence-based standards or coverage provisions that were relied on in making this decision.
Important Information about Your Appeal Rights

What if I need help understanding this decision? Contact us [insert IRO contact information] if you need assistance understanding this notice.

What happens now? If we have overturned the denial, your plan or health insurance issuer will now provide service or payment.

If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, you can contact your consumer assistance program at [insert contact information].]
HIPAA Certificate of Creditable Coverage

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

* IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate:

2. Name of group health plan:

3. Name of participant:

4. Identification number of participant:

5. Name of any dependents to whom this certificate applies:

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

7. For further information, call:

8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ____ and skip lines 9 and 10.

9. Date waiting period or affiliation period (if any) began:

10. Date coverage began:

11. Date coverage ended:_______(or check if coverage is continuing as of the date of this certificate: _______).

*Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.
HIPAA 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 towards 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).

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 decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].
This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to (Individual’s Name) at (Address) or (Telephone Number).
MODEL NOTICE Q
Employer CHIP Notice

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 –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Medicaid and CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a></td>
<td>Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a></td>
</tr>
<tr>
<td>Phone: 1-800-362-1504</td>
<td>Medicaid Phone (In state): 1-800-866-3513</td>
</tr>
<tr>
<td>Medicaid Phone (Out of state): 1-800-221-3943</td>
<td></td>
</tr>
<tr>
<td>ALASKA – Medicaid</td>
<td>CHIP Website: <a href="http://www.CHPplus.org">http://www.CHPplus.org</a></td>
</tr>
<tr>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
<td>CHIP Phone: 303-866-3243</td>
</tr>
<tr>
<td>Phone (Outside of Anchorage): 1-888-318-8890</td>
<td></td>
</tr>
<tr>
<td>Phone (Anchorage): 907-269-6529</td>
<td></td>
</tr>
<tr>
<td>ARIZONA – CHIP</td>
<td>FLORIDA – Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.azahcccs.gov/applicants/default.aspx">http://www.azahcccs.gov/applicants/default.aspx</a></td>
<td>Website: <a href="https://www.flmedicaidtplrecovery.com/">https://www.flmedicaidtplrecovery.com/</a></td>
</tr>
<tr>
<td>Phone (Outside of Maricopa County): 1-877-764-5437</td>
<td>Phone: 1-877-357-3268</td>
</tr>
<tr>
<td>Phone (Maricopa County): 602-417-5437</td>
<td></td>
</tr>
<tr>
<td>CALIFORNIA – Medicaid</td>
<td>GEORGIA – Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a></td>
<td>Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a></td>
</tr>
<tr>
<td>Website: <a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a></td>
<td>Click on Programs, then Medicaid</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid and CHIP/DHSS Information</th>
</tr>
</thead>
</table>
| **IDAHO** – Medicaid and CHIP | Medicaid Website: [www.accesstohealthinsurance.idaho.gov](http://www.accesstohealthinsurance.idaho.gov)  
Medicaid Phone: 1-800-926-2588  
CHIP Website: [www.medicaid.idaho.gov](http://www.medicaid.idaho.gov)  
CHIP Phone: 1-800-926-2588 |
| **MONTANA** – Medicaid | Website: [http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml](http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml)  
Phone: 1-800-694-3084 |
| **INDIANA** – Medicaid | Website: [http://www.in.gov/fssa](http://www.in.gov/fssa)  
Phone: 1-800-889-9948 |
| **NEBRASKA** – Medicaid | Medicaid Website: [http://www.dhhs.ne.gov/med/medindex.htm](http://www.dhhs.ne.gov/med/medindex.htm)  
Phone: 1-877-255-3092 |
| **IOWA** – Medicaid | Website: [http://www.dhs.state.ia.us/hipp/](http://www.dhs.state.ia.us/hipp/)  
Phone: 1-888-346-9562 |
| **NEVADA** – Medicaid | Medicaid Website: [http://www.dhss.nv.gov](http://www.dhss.nv.gov)  
Phone: 1-800-992-0900 |
| **KANSAS** – Medicaid | Website: [http://www.kdheks.gov/hcf/](http://www.kdheks.gov/hcf/)  
Phone: 1-800-792-4884 |
| **NEW HAMPSHIRE** – Medicaid | Medicaid Website: [http://www.dhhs.nh.gov/ombp/index.htm](http://www.dhhs.nh.gov/ombp/index.htm)  
Phone: 603-271-8183 |
| **LOUISIANA** – Medicaid | Medicaid Website: [http://www.lahipp.dhh.louisiana.gov](http://www.lahipp.dhh.louisiana.gov)  
Phone: 1-888-695-2447 |
| **NEW JERSEY** – Medicaid and CHIP | Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid](http://www.state.nj.us/humanservices/dmahs/clients/medicaid)  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710 |
Phone: 1-800-572-3839 |
| **Massachusetts** – Medicaid and CHIP | Website: [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Phone: 1-800-462-1120 |
| **MINNESOTA** – Medicaid | Website: [http://www.dhs.state.mn.us/](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 |
| **MISSOURI** – Medicaid | Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005 |
| **NEW YORK** – Medicaid | Website: [http://www.nyhealth.gov/health_care/medicaid/](http://www.nyhealth.gov/health_care/medicaid/)  
Phone: 1-800-541-2831 |
| **NORTH CAROLINA** – Medicaid | Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 1-800-635-2570 |
| **NORTH DAKOTA** – Medicaid | Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005 |
| **KENTUCKY** – Medicaid | Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 1-800-635-2570 |
| **NEW JERSEY** – Medicaid and CHIP | Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid](http://www.state.nj.us/humanservices/dmahs/clients/medicaid)  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710 |
Phone: 1-800-572-3839 |
| **Massachusetts** – Medicaid and CHIP | Website: [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Phone: 1-800-462-1120 |
| **MINNESOTA** – Medicaid | Website: [http://www.dhs.state.mn.us/](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 |
| **MISSOURI** – Medicaid | Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005 |
| **NEW YORK** – Medicaid | Website: [http://www.nyhealth.gov/health_care/medicaid/](http://www.nyhealth.gov/health_care/medicaid/)  
Phone: 1-800-541-2831 |
| **NORTH CAROLINA** – Medicaid | Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 1-800-635-2570 |
| **KENTUCKY** – Medicaid | Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 1-800-635-2570 |
| **NEW JERSEY** – Medicaid and CHIP | Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid](http://www.state.nj.us/humanservices/dmahs/clients/medicaid)  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710 |
Phone: 1-800-572-3839 |
| **Massachusetts** – Medicaid and CHIP | Website: [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Phone: 1-800-462-1120 |
| **MINNESOTA** – Medicaid | Website: [http://www.dhs.state.mn.us/](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 |
| **MISSOURI** – Medicaid | Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005 |
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid and CHIP</th>
<th>State</th>
<th>Medicaid and CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>OKLAHOMA</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>VERMONT</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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<tr>
<td></td>
<td>Phone: 1-888-365-3742</td>
<td></td>
<td>Phone: 1-800-250-8427</td>
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<td></td>
<td>Phone: 1-888-564-9669</td>
<td></td>
<td>Medicaid Phone: 1-800-432-5924</td>
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<td></td>
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<td>CHIP Phone: 1-866-873-2647</td>
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<tr>
<td>PENNSYLVANIA</td>
<td>Website: <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a></td>
<td>WEST VIRGINIA</td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-692-7462</td>
<td></td>
<td>Phone: 304-558-1700</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Website: <a href="http://www.dhs.ri.gov">www.dhs.ri.gov</a></td>
<td>SOUTH CAROLINA</td>
<td>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 401-462-5300</td>
<td></td>
<td>Phone: 1-888-549-0820</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td></td>
<td>WISCONSIN</td>
<td>Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a></td>
</tr>
<tr>
<td>TEXAS</td>
<td>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
<td></td>
<td>Phone: 1-800-362-3002</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-440-0493</td>
<td>WYOMING</td>
<td>Website: <a href="http://www.health.wyo.gov/healthcarefin/index.html">http://www.health.wyo.gov/healthcarefin/index.html</a></td>
</tr>
<tr>
<td>UTAH</td>
<td>Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a></td>
<td></td>
<td>Phone: 307-777-7531</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-866-435-7414</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)
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 through 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 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
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]

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]
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. 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 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 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 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?
[INSERT IF EMPLOYER/UNION SPONSORED GROUP PLAN]: However, if you decide to drop your current coverage with [Insert Name of Entity], since it is employer/union sponsored 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 Plan].

[INSERT IF PREVIOUS COVERAGE PROVIDED BY THE ENTITY WAS CREDITABLE COVERAGE]: Since you are losing creditable prescription drug coverage under the [Insert Name of 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 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 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 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 will [or will not] [Medigap issuers must insert “will not”] be able to get this coverage back.
MODEL NOTICE S (continued)

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.

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).

[Optional Insert – If a beneficiary has had creditable coverage under the entities plan for any period of time since May 15, 2006, entities can 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]
MODEL NOTICE T

GINA: EEOC POSTER

Equal Employment Opportunity is

THE LAW

Private Employers, State and Local Governments, Educational Institutions, Employment Agencies and Labor Organizations

GO TO THE FOLLOWING LINK TO DOWNLOAD A COPY OF THE FULL EEOC POSTER:

Notice to Employees Regarding Employer Contributions to HSAs

This notice explains how you may be eligible to receive contributions from [employer] if you are covered by a High Deductible Health Plan (HDHP). [Employer] provides contributions to the Health Savings Account (HSA) of each employee who is [insert employer’s eligibility requirements for HSA contributions] ("eligible employee"). If you are an eligible employee, you must do the following in order to receive an employer contribution:

(1) establish an HSA on or before the last day in February of [insert year after the year for which the contribution is being made] and;

(2) notify [insert name and contact information for appropriate person to be contacted] of your HSA account information on or before the last day in February of [insert year after year for which the contribution is being made]. [Specify the HSA account information that the employee must provide (e.g., account number, name and address of trustee or custodian, etc.) and the method by which the employee must provide this account information (e.g., in writing, on a certain form, etc.).]

If you establish your HSA on or before the last day of February in [insert year after year for which the contribution is being made] and notify [employer] of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for [insert year for which contribution is being made] by April 15 of [insert year after year for which contribution is being made].

If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then we are not required to make any contributions to your HSA for [insert applicable year]. You may notify us that you have established an HSA by sending an [e-mail or] a written notice to [insert name, title and, if applicable, e-mail address]. If you have any questions about this notice, you can contact [insert name and title] at [insert telephone number or other contact information].
MODEL NOTICE V

Newborns’ and Mothers’ Health Protection Act Model Language

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).
MODEL NOTICE W

Notice of Your Rights Under USERRA


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.

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.

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.

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 don't 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.

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 for representation.
• You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.
MODEL NOTICE X

Women’s Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. 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].