THE BEHAVIORAL WELLNESS CENTER
AT GIRARD
INSPIRING HOPE...TRANSFORMING LIVES
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2022

EMPLOYEE BENEFITS GUIDE

EFFECTIVE JULY 1, 2022 - JUNE 30, 2023

Introduction of 2022 Benefits

Our annual benefits open enrollment period will begin on May 15th and conclude May 31st.

The Behavioral Wellness Center at Girard is committed to consistently providing a strong benefits program to employees and their eligible dependents. We strive to offer benefits that are highly competitive and will continue to serve our employees and their families well into the future.

Please read all of the enrollment communications, study the options, and take advantage of the resources available to you. The decisions you make during your enrollment period will impact you and your family for the next year. **Your enrollment elections will become effective July 1st or the 1st of the month following 60 days of employment.**

All elections you submit for open enrollment will be final and CANNOT BE CHANGED until next year, unless you have a qualifying life event as explained later in this document.

What's New Effective 7/1/2022

- The IBC vision hardware benefit has increased from $35 to $100
- **For 2022, The Behavioral Wellness Center at Girard will offer infertility medical benefits included with the medical plan.** Coverage for Assisted Reproductive Technology (ART) is driven by medical necessity. There is a $10,000 lifetime maximum benefit for infertility services which will be offered effective July 1st, 2022.

2022 Benefits at a Glance

Medical coverage

The ***Keystone Health Plan East HMO*** plan includes a copayment for medical services received in-network. You must select a primary care physician and obtain a referral for specialist visits. There is no coverage for services received out-of-network and the recipient of services will be 100% responsible for those charges. Dependents are eligible for coverage up to age 26.

Prescription coverage

Through RxBenefits, ***Express Scripts*** will provide coverage for covered prescriptions up to 75% of the discounted rates available. The employee is responsible for the remaining 25% of cost. Maintenance medications received through mail order will provide a 90-day supply of medications for a 1-month copay. Therefore, a $10 prescription processed through retail monthly will cost $120 annually. Through mail order, it will cost $40 annually. Dependents are eligible for coverage up to age 26.

Dental coverage

Under ***United Concordia Dental***, the Advantage Network PPO provides enhanced premier and standard dental plan benefits using a network of dentists and facilities. You may see any dentist, but benefits are greater when you receive care from an in-network dentist. Preventive or maintenance service is covered at 100%. Dependents are eligible for coverage up to age 19; FT students to age 23.

Life insurance

Kansas City Life Insurance provides the company paid basic life insurance coverage offered by The Be Well Center to its employees. Excess Risk is the underwriter of these policies. Applications received outside of the initial eligibility enrollment period or in excess of maximum amounts are subject to Evidence of Insurability. Additional supplemental coverage is available for employee, spouse or eligible dependents. Kansas City Life supplemental life insurance is term life insurance coverage that allows you to purchase additional insurance at group discounted rates. Policies are age banded and the premium increases at 5-year increments: 35, 40, 45, 50, etc. Dependents are eligible up to age 19.

Long Term Disability

Unum's Long-Term Disability Insurance pays eligible employees a percentage of their gross monthly earnings (up to the maximum allowed by the plan) if they become ill or injured and can't work for an extended period. This income replacement can be used to pay bills and protect finances at a time when the employee is no longer receiving a paycheck. The amount of benefit received from the plan may be reduced or offset by income from other sources — such as Social Security Disability or other income replacement insurances. The length of time benefits are received is based on the diagnosis and the age at the time of disability. This LTD benefit is NOT available to positions governed by 1199C and UNOP.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary depending on union association. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please contact the Human Resources Department during normal business hours at 215-787-2008.

Voluntary Benefits

Aflac is available to employees who want to supplement their out-of-pocket expenses not covered by the health insurance. (Aflac does not cover short-term or long-term time lost from work.) The BenXtend plan is a 3-in-1 plan that covers, **Accident Insurance** for illnesses or injuries that require emergency room visits, **Hospital Indemnity** where benefits are issued based on inpatient visits and treatment, and **Critical Illness** coverage (including a cancer rider) for major events like heart attacks, bypass surgeries, strokes, major organ transplants, end stage renal failure, and more.

Supplemental long-term disability insurance is available from Kansas City Life (via **Abacus**) to union employees not eligible for the company paid benefit including 1199C and UNOP. This covers extended absences in excess of the 26 weeks of short-term disability coverage received. With enrollment in this benefit, employees can financially afford to be out until physically able to return to work. The options are in your hands to cover yourself!

Enrollment: What You Need to Do

You will need to make choices about which benefits you'd like to elect during "enrollment windows." Enrollment windows are specific times that will require you to take action and select your benefits:

- **When you are first eligible** to participate in benefits, you have 31 calendar days to enroll. Elections you make become effective the first of the month following 60 days of employment. Eligibility due to status changes become effective the 1st of the month following the effective date of the change. For information on what happens if you don't enroll in coverage within the time allotted, refer to the section titled "What Happens If You Don't Enroll or Waive."
- **During the annual Open Enrollment** any changes you make during the Open Enrollment period, which is a two-week period each spring, become effective July 1st.
- **When you experience a Qualifying Life Event (QLE)**, such as marriage or the birth of a child or a HIPAA special enrollment event, you will have an opportunity to make certain benefit elections. You must report the event and submit the application, including supporting documentation, within **30** days of the event date in order to make any allowable changes to your benefits.

What Happens After Enrollment

ID Cards

After you enroll, you will receive ID cards within 10 to 14 business days from Independence Blue Cross for your medical plan, RxBenefits for your prescription plan, and from United Concordia for your dental plan. You will not receive a separate ID card for vision coverage as this benefit is included with your medical plan.

It may take up to 14 business days for your enrollment information to process in all insurance and provider systems (doctors, hospitals, pharmacies, etc.). Although your coverage is in effect, providers

should be able to verify your coverage within 48 hours of your effective date. If you are required to pay out of pocket for any services prior to receiving your cards, please retain all receipts so that you can submit the appropriate claim form to receive reimbursement. (You can access these forms online or via HR.) We recommend that, whenever possible, you wait to schedule provider visits until you receive your ID cards, unless there is an emergency. When you receive your ID card, confirm that all information is accurate. If any information is not correct on your ID card, contact Human Resources.

Selecting Primary Care Physicians (PCP)

When you first enroll in the HMO plan, you'll need to designate your choice of PCP. ***If you do not designate your preferred PCP, you will be enrolled with the DVCH Fairmount Primary Care Center*** which processes pre-employment physicals and clearances for The Be Well Center. To select or change a PCP at a later date, call your plan after you receive your ID card or enroll in IBXpress at http://www.ibx.com/login and make PCP changes online.

Eligibility

Employees

Per the Affordable Care Act (ACA), employees who are scheduled to work 30 hours per week at the time of hire will be eligible for medical and prescription benefits. In addition, variable, part-time employees who average at least 30 hours per week during an initial or standard measurement period will also be eligible. **Eligibility for dental benefits is not covered under the ACA and requires scheduled work up to 35 hours per week.** (See your union benefit summary.)

Dependents

Eligible dependents are:

- Lawful spouses,
- Dependent children are eligible through the end of the month they turn 26 years of age,
- Your mentally or physically disabled child, regardless of age.

When adding a dependent(s) to a health plan, you will be required to provide certain documentation as outlined in the "Required Documents" section.

When Coverage Begins

Coverage for new hires will be effective the first of the month following 60 days of employment – for medical, prescription drug, vision, dental, EAP, and life insurance benefits. Existing employees may elect coverage or changes at the annual open enrollment or within 30 days of a Qualifying Life Event. Changes made during open enrollment will be effective July 1st.

When Coverage Ends

Coverage for the employee and/or dependents will end on the last day of the month during which the employee is terminated or otherwise ceases to meet the eligibility requirements. *See the Summary Plan Description for more details.*

Medical, vision, and prescription drug coverage for dependent children reaching 26 years of age will end at the end of the month following the attainment of 26 years of age.

Making Changes

When you elect coverage under the medical, dental, and vision plans, coverage stays in effect for the entire plan year (through June 30, 2023). You cannot change your coverage, start or stop coverage, or add or drop any family members to or from your coverage during the plan year unless you have a **Qualifying Life Event (QLE)** or a **HIPAA special enrollment event**.

Qualifying Life Events

Qualifying life events include:

- Change in your legal marital status (marriage, legal separation, or divorce or death of a spouse).
- Change in number of tax dependents.
- Birth, adoption, or placement of a child in the associate's home for adoption.
- Death of a dependent.
- Change in employment status of associate or dependents.
- Change in dependent eligibility (e.g., a dependent becoming eligible or ceasing to be eligible for coverage due to age, student status, or obtaining other group coverage).
- A change in residence of the associate or dependents that impacts eligibility.

Changes to your benefits resulting from a qualifying life event must be submitted within 30 days of the qualifying event date.

Medical Coverage

Administered by Keystone Health Plan East (KHPE) 800.626.8144

Please note that the Keystone HMO plan is only available to employees who reside in the Independence Blue Cross service areas and non-contiguous counties.

Keystone HMO

Medical Benefits	In-Network Costs with Referral (You Pay)
Deductible	N/A
Out-of-Pocket Maximum	$3,000 Individual; $6,000 Family
Preventive health Services	$0 per Preventive Care Schedule
PCP/Specialist Visit	$20 Copay PCP, $40 Copay Specialist (referral req'd)
MDLive Telemedicine	$20 copay
MDLive Teledermatology	$20 copay
MDLive Telebehavioral Health	$20 copay
Retail Health Clinic	$20 copay
Urgent Care Visit	$50 copay
Routine Gynecological Care	100% (no referral required)
Obstetrical Care (pre/post-natal)	$40 Copayment for the first visit. Subsequent visits to OB/GYN covered 100%. Inpatient admission covered with $500 Copay per admission.
Routine Mammography (age 40)	100% (no referral required)
Inpatient Hospital Services	$500 Copay per Admission
Outpatient Surgery	$250 Copay per procedure
Emergency Room	$200 Copay (waived if admitted)
Urgent Care	$50 Copay per Visit
Outpatient Lab and Pathology	$0 No Charge
Routine Radiology	$25 Copay
Advanced Imaging (MRI,MRA, CT/CTA Scan, PET Scan)	$25 Copay
Occupational Therapy, Physical Therapy and Speech Therapy	$25 Copay (Up to 60 consecutive visits per condition covered Combined Visit limit)

Durable Medical Equipment	100%
Restorative Services Including Spinal Manipulation (*20 visits/yr)*	$40 copay per visit
Vision care (Including Screening, Eye Exam and Refractions)	$40 Copay once every 24 months at a participating Davis Vision Provider
Mental Health - Outpatient	$25 Copay
Serious Mental Health - Outpatient	$25 Copay
Substance Abuse – Outpatient	$25 Copay

For 2022, The Behavioral Wellness Center at Girard will offer infertility medical benefits included with the medical plan. Coverage for Assisted Reproductive Technology (ART) is driven by medical necessity. There is a $10,000 lifetime maximum benefit for infertility services which will be offered effective July 1st, 2022.

The ART benefit includes the following services:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Zygote intrafallopian transfer (ZIFT).
- Intracytoplasmic sperm injection (ICSI).
- Assisted embryo hatching.
- Frozen embryo transfer (FET).
- Tubal embryo transfer (TET).
- Sperm Retrieval Techniques (SRT).
- Gamete Cryopreservation

The following services are considered standard medical benefits covered under all medical plans with IBC:

- Office visits to diagnose infertility.
- Diagnostic testing (lab, X-ray).
- Artificial insemination (intra-cervical, intra-uterine).
- Tubal ligation.
- Vasectomy.

Please refer to the IBC benefit booklets for more details about these standard medical benefits.

You may also refer to Commercial Medical Policy #07.10.06i:
https://medpolicy.ibx.com/ibc/Commercial/Pages/Policy/a27db102-bd23-420f-a9fd-c5c995a63b0a.aspx

Manage Your Medical Account with Keystone Health Plan East

Get the Most from Your Benefits with ibxpress.com

Get coverage information

ibxpress.com gives you quick, convenient, and secure access to your specific information. You can:

- Review details about the coverage available to you under your plan.
- View processed claims.
- Change your primary care physician (PCP).
- Order an ID card.
- Print a temporary ID card.
- Download forms.
- Email customer service.

IBX App

Manage Your Health on the Go

Get the Free Smartphone App

Download the free IBX app for your **iPhone or Android** to help you make the most of your Independence Blue Cross health coverage. With new and improved features, the IBX app gives you easy access to your health care coverage 24/7, wherever you are.

The new Doctor's Visit Assistant feature allows you to:

- Fax or email a copy of your ID card.
- Check the status of referrals and claims.
- View your health history and prescribed medications.
- Record notes and upload photos of symptoms.

The IBX app also offers expanded provider search capabilities and other ways to manage your health on the go.

- Find doctors, hospitals, pharmacies, urgent care centers, and patient-centered medical homes.
- Access benefit information.
- Track deductibles.

Telemedicine

With telemedicine from **MD**LIVE, you have 24/7 access to a U.S. board-certified and licensed primary care doctor via HIPAA secure video, phone, and mobile app, who can treat non-emergency medical conditions such as:

- Colds and flu
- Allergies / Asthma
- Pink eye / Ear infections / Sinus problems
- Respiratory infections
- Joint aches and pains
- Vomiting and nausea

Using **MD**LIVE is a convenient option when it's not possible to visit your doctor's office, retail clinic, or urgent care center.

The co-pay is the same as a specialist doctor visit (a $40 co-pay) but with a great deal more convenience.

However, to use MDLive, you must register first. Don't wait until you're sick!

You have several ways to register:
• Visit mdlive.com/ibx
• Download the MDLIVE app on your smartphone
• Call 1-877-764-6605

Your Urgent Care Needs Are Covered

Getting quick medical care shouldn't be a headache. Life is unpredictable. One minute, you have a sniffle, and the next it's a painful sinus infection, but your doctor's office is closed. What now? If it's not a true emergency, the hours you'll spend waiting in the ER will make an uncomfortable situation even worse. Now you can eliminate the wait. When a sudden illness or injury requires prompt medical attention, your choices for care include participating urgent care centers and retail health clinics.
Just walk in, present your Keystone Health Plan East member ID card, and get treated by a trusted health care professional. You don't need an appointment or referral.

Remember:

If you have a life-threatening medical situation, such as uncontrolled bleeding or chest pain with shortness of breath, you should always seek treatment at the nearest hospital emergency room. Locate a participating urgent care center near you TODAY. Don't wait until there is an emergency.

Prescription Drug

Prescription — Rx Benefits backed by Express Scripts* 800.334.8134

Prescription Drug Benefits	
Retail pharmacy (up to a 30-day supply)	**Generic-** 25% copay, minimum $5 copay **Preferred Brand** 25% copay, minimum $5 copay **Non-Preferred drugs** 25% copay, minimum copay
Mail order (or Walgreens) (up to a 90-day supply)	**Generic-** 8% copay, minimum $5 copay **Preferred Brand** 8% copay, minimum $5 copay **Non-Preferred drugs** 8% copay, minimum copay
***Rx Benefits utilizes the ESI formulary and mail order. Please call the number on your RxBenefits card for any prescription inquiry.**	

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*This plan includes a **Mandatory Generic** provision. When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and you will be responsible for the member cost sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If you choose to purchase a brand drug, you will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate member cost sharing for a brand drug.*

Dental Plans (United Concordia - UCCI) 866.851.7568

Dental Benefits Summary

Deductible	N/A
Annual Calendar Maximum (per covered person)	$2,500
Lifetime Orthodontics (dependents under age 19) Maximum per covered person	$2,500
Class I- Diagnostic and Preventive Services	
Exams	100%
Cleanings & Fluoride Treatments	100%
X-rays	100%
Sealants	100%
Spacers	100%
Palliative treatment (Emergency)	100%
Class II- Basic Services	
Basic Restorative (fillings, etc.)	100%
Simple Extractions	100%
Endodontics	100%
Oral Surgery	100%
General Anesthesia	100%
Class III- Major Services	
Surgical & Non-surgical Periodontics	50%
Inlays, Onlays, Crowns	50%
Prosthetics (bridges, dentures)	
Repairs to Inlays', Onlays and Crowns and Prosthetics	50%
Orthodontics (dependents to age 19)	
Diagnostic, Active, Retention Treatment	50%

Other Benefits

Rosemont Momentum

Earn your degree for less with, our partnership program with Rosemont College, ***Rosemont Momentum***. As a Momentum partner student, you are eligible for special tuition rates for Rosemont's accredited online degrees and certificates. But that's not all. The Momentum advisors will support you every step of the way-guiding you through an expedited admission process, optimizing transfer credits, advising on Financial Aid eligibility, and making sure you receive the technical and emotional support you need on your journey as an online adult learner. Momentum is available to you and ANY family members! Yes, all in-laws, aunts, uncles, nieces, nephews, and cousins too! ANY family member!

Additional Information can be found at bewell.rosemont.edu

Tuition Reimbursement

Tuition Reimbursement is available to full-time employees seeking to further their education. Up to a maximum of $1,500 per semester/$3,000 per year, The Be Well Center will reimburse you for each class you pass with a C or better. (*Members of 1199C should contact their Training & Upgrading Fund for tuition assistance.)* What better way to use your tuition reimbursement benefit than with **Rosemont College**! **The Momentum Program** is available to advance the education of all employees and their family members. **ANY** family members!

Employee Assistance Program

In addition to the counseling services the Employee Assistance Program (EAP) is normally used for, our program has been improved and now includes Work/Life services for parenting, childcare or eldercare, education, assisted living, and so much more. We've also added financial and legal services to help with reviewing legal documents, drawing up simple wills, and support for your parents or parent-in-laws. You and any household member can call a trained professional for assistance or consultation. To view available services or for more information, go to www.firstcalleap.org, click on the "Member Portal" briefcase and use: **Login: bewell Password: firstcall** or call 800.382.2377.

BIRE Financial Services

Through its long-term relationship with BIRE Financial Services, The Be Well Center is able to introduce employees to certified agents dedicated to comprehensive support in achieving the employee's financial goals. BIRE designs, plans and implements strategies to address investments, insurance, education, and retirement goals. BIRE agents are also able to refer employees with financial or legal issues to law firms, accounting firms, property and casualty firms, mortgage companies, and banks or credit unions for assistance. They are a 'one stop shop' dedicated to serving the financial needs of The Be Well Center employees.

Through payroll deduction, employees are able to enroll in 403b tax sheltered annuities (TSA), whole life insurance policies that build a cash value, and 529 college savings plans.

Working Advantage Employee Discount Program

Receive access to exclusive deals, limited-time offers, and members-only perks on the products, services, concerts, and experiences you need, want, and love. To view available savings or for more information, go to www.workingadvantage.com click Become a Member, and use company code **BEWELLPERKS**

Contacts

For questions concerning the information contained in this guide, please contact Human Resources or the plan carrier. Use this chart to help guide you to the right resource.

Plan Carriers

Plan	Vendor	Phone	Website	Plan #
Medical-KHPE	Independence Blue Cross	800-626-8144	www.ibx.com	10053840
Prescription Drugs	RX Benefits	800-334-8134	www.rxbenefits.com	RXBNOPH
Vision	Davis Vision	800-999-5431	www.davisvision.com	10053840
Employee Assistance Program	FirstCall	800-382-2377	www.firstcalleap.org	
Dental-Flex PPO	United Concordia	866-851-7568	www.unitedconcordia.com	260155
Employee Discount Program	Working Advantage	800-565-3712	www.workingadvantage.com	BEWELLPERKS
Rosemont Momentum	Rosemont College	610-273-8686	bewell.rosemont.edu	
Financial Services-403b, whole life, 529 savings plan, TSA	BIRE Financial	800-838-2473	www.bireswan.com	

Required Disclosure Notices
Table of Contents

If you have any questions regarding any of these notices, please contact:

The Behavioral Wellness Center at Girard
Attn: Human Resources Department
801 Girard Avenue
Philadelphia, PA 19122
215.787.2008

I. NOTICE OF PRIVACY PRACTICES

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you on behalf of: The Be Well Center Group Benefits Plan

General Information Individually identifiable information about your past, present, or future health or condition (including genetic information), the provision of health care to you, or payment for the health care is considered "Protected Health Information" or "PHI". The Plan is required by the Health Insurance Portability and Accountability Act of 1996 and its regulations (the "Law") to maintain the privacy of your PHI and to provide you with notice of its legal duties and privacy practices with respect to PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan will abide by the terms of the Notice currently in effect, but it reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that it maintains. You will be notified about the changes and the availability of a revised Notice, or a revised Notice will be delivered to you, at least 60 days prior to the date that it will become effective.

The Plan is required by law to tell you:

- The Plan's uses and disclosures of your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services; and
- The person to contact for further information about the Plan's privacy practices.

Notice of PHI Uses and Disclosures

The Plan will use and disclose your PHI as follows:

- Upon your request, the Plan will give you access to your PHI so that you can look at or copy it.
- The Plan may be required by the Secretary of the Department of Health and Human Services to disclose your PHI in connection with an investigation to determine the Plan's compliance with the privacy regulations.
- The Plan and any business associates may use or disclose your PHI to carry out claim payment activities and healthcare operations. The Plan will also disclose your PHI to the Plan Sponsor related to claims payment activities and healthcare operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by law. For example, the Plan or a business associate may tell your doctor whether you are eligible for coverage and the limits on your coverage.
- The Plan may disclose your PHI to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Plan. The Plan may disclose only summary information. Summary information does not include any information that has been determined under the Law to be capable of identifying you in any way. Genetic information includes information about your genetic tests, the genetic tests of your family

members, the manifestation of a disease or disorder in your family or any request for or receipt of genetic services or participation in clinical research by you or a family member.

THE PLAN IS PROHIBITED FROM USING PHI THAT IS GENETIC INFORMATION FOR UNDERWRITING PURPOSES.

- The Plan may disclose your PHI as required by law, including disclosures about victims of abuse, neglect or domestic violence (but then must inform you (with certain exceptions) that the disclosure has been made), disclosures for law enforcement purposes, and disclosures for judicial or administrative proceedings.
- The Plan may disclose your PHI for public health activities for the purpose of preventing or controlling disease, injury or disability.
- The Plan may disclose your PHI to a coroner, medical examiner, or a funeral director for the purpose of performing their duties as authorized by law.
- The Plan may use or disclose your PHI when it believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, but only to someone who can prevent or lessen the threat.
- The Plan may disclose your PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- Except as otherwise indicated in this Notice, the Plan will disclose your PHI only with your written authorization and subject to your right to revoke that authorization.

The Plan's Duties with Respect to Use and Disclosure of your PHI. The Plan will use and disclose (and will request disclosure of) only the minimum amount of PHI about you as needed under the circumstances, taking into consideration any practical and technological limitations. This requirement does not apply when disclosing information to a provider for treatment, when disclosing information to you or at your request, when disclosing information to the Secretary of the Department of Health and Human Services, or when disclosing information that is required by law or regulations.

The Plan's Duty to Notify you in the Event of Breach In the event that the Plan's PHI is unsecured based on standards set by the DHHS, the Plan will notify you within 60 days of the date of discovery of any breach of your PHI or the date that there is reason to believe that there has been a breach of your PHI. A breach does not include a disclosure where there is a low probability that the PHI has been compromised. The Plan will determine this based on the following factors: (1) the nature and extent of the PHI involved including the possibility of re-identification; (2) the unauthorized person who used the PHI or to whom the disclosure was made; (3) whether the PHI was actually acquired or viewed; and (4) the extent to which the risk to the PHI was mitigated. The notice will include the circumstances of the breach, the date of the breach, the date of discovery of the breach, the type of information involved, steps you should take to protect yourself, steps that the Plan is taking to mitigate the harm and protect against future breaches.

Your Rights the Law provides you with the following rights with respect to your PHI that the Plan and its business associates or subcontractors maintain:

Right to Request Restrictions. You have the right to request restrictions on our uses and disclosures of PHI. You may request that we limit disclosures of your PHI only for our payment or healthcare operations and to certain individuals. However, we are not required to agree to your request. We will accommodate reasonable requests to receive communications by alternative means or at alternative locations.

Right to Inspect and Copy. You have the right to inspect and copy the PHI that the Plan maintains or to receive an electronic copy. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if it is maintained off site. We may request a 30-day extension of this time frame but will notify

you if we elect the extension and will provide you with the reason. If we deny you access to your PHI, we will provide you with a written denial, which will include the reason for the denial along with other relevant information.

Right to Request Amendment. You have the right to request that we amend your PHI. Within 60 days of receiving your request we will respond. We may request an additional 30-day extension, but if we do this, we will explain our reasons. If we deny your request, we will provide you with a written denial that clearly explains why we denied it. You will then be given the opportunity to give us a statement of disagreement. We will include your statement with the PHI that is the subject of your request.

Right to Receive an Accounting. You have the right to receive a list of our disclosures of your PHI, except for those disclosures that are made in connection with claims payment or our health care operations. We will also not include any disclosures we have made to you or at your request, or any disclosures made prior to April 14, 2004. We will provide you with the list within 60-days after we receive your request, except that we may request a 30-day extension. If you request more than one accounting within a 12-month period, we will charge you a reasonable fee for each subsequent request.

Copy of Notice. You have the right to receive a copy of this Notice upon request.

In order to exercise any of these rights, you will be required to complete a form that we will provide to you upon request. All requests should be made to the individual contact shown at the end of this Notice.

Complaints. If you feel that your privacy rights as described in this Notice have been violated, you may complain to the Plan as described under Contact Information, below. You may also file a complaint with the Department of Health and Human Services at the Office for Civil Rights, Region III, 150 S. Independence Mall West, Suite 372, Philadelphia PA 19106-9111. Phone: (800) 368-1019. The Plan will not retaliate or discriminate against you for filing a complaint.

II. GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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

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

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

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

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

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

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

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

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

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

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both)

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

The Be Well Center
801 Girard Avenue, Philadelphia, PA
Attn: Human Resources Department

Included in your written notification should be the necessary supporting documentation (court order, birth or death certificate, etc.) to substantiate the qualifying event.

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. In order to be considered for this you must provide documentation from the Social Security Administration that validates the timing of the disability in support of your claim by the end of the 17th month of COBRA coverage. This information will need to be provided to The Be Well Center, Attn: Human Resources.

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

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

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

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

III. CREDIBLE COVERAGE NOTICE-IMPORTANT NOTICE 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 The Behavioral Wellness Center at Girard and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. The Behavioral Wellness Center at Girard has determined that the prescription drug coverage offered by the 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 The Behavioral Wellness Center at Girard coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current The Be Well Center coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

NOTE: You'll get this notice each year.

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).

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).

Name of Entity/Sender:	The Behavioral Wellness Center at Girard
Contact:	Human Resources Department
Address:	Philadelphia, PA

IV. WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

As required by the Women's Health and Cancer Rights Act of 1998, this plan provides coverage for all stages of reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance and prostheses and physical complications of mastectomy, including lymph edemas. For more information, contact your medical plan provider or The Be Well Center HR department in writing.

V. GINA-THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

Also referred as GINA, is a federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The President signed the act into federal law on May 21, 2008. The law prevents discrimination from both health insurers and employers. Health insurers are prohibited from restricting enrollment or adjusting premiums on the basis of genetic information. Employers are prohibited from failing or refusing to hire or discharge an employee because of genetic information of the employee or their family members.

VI. SPECIAL ENROLLMENT/NOTICE OF EMPLOYEE RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you are declining enrollment for yourself or your Dependents (including your spouse and eligible children) because of other group health insurance coverage, you may in the future be able to enroll yourself or your Dependents in the Plan. You must request enrollment within 31 days after you or an eligible Dependent lose coverage under another group health plan either because:

- Eligibility ends;
- COBRA benefits are exhausted;
- You return to work after serving active military/reserve duty; or
- Employer contributions end.

In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. An otherwise eligible employee and Dependent(s) who did not apply for coverage when initially eligible because of other group coverage at another place of employment, but who later lost their coverage due to a change in employment status, may apply within 31 days if the loss of coverage is due to loss of employment/change in job status, or death of a spouse, or divorce from a spouse. This provision also applies to employees who return to work after serving active military/reserve duty. Please remember you must contact The Be Well Center within 31 days of the event to make any changes. You will be asked to provide documentation of your life event. All life events are effective the first of the month following the date of the event, except for birth and adoption which are effective the date of the event.

NOTICE OF OPPORTUNITY TO ENROLL DEPENDENTS TO AGE 26: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before the attainment age of 26 are eligible to enroll in the Health Plan. Individuals may request enrollment for their children by contacting Human Resources. Documentation will need to be provided to finalize the addition of the overage dependent to the plan.

VII. EMPLOYEE RETIREMENT INCOME SECURY ACT (ERISA)

Federal law imposes certain requirements on employee benefits plans voluntarily established and maintained by employers (29 USC §1001 et seq.; 29 CFR 2509 et. Seq.) ERISA covers two general types of plans: retirement plans, and welfare benefit plans designated to provide health benefits, scholarship funds, and other employee benefits. ERISA facilitates portability and continuity of health insurance coverage as a result of added provisions under the Health Insurance Portability and Accountability Act (HIPAA). It also covers continued health care coverage rules mandated under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

VIII. HIPAA INFORMATION NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Be Well Center recognizes your right to privacy in certain matters related to the disclosure of health-related information. The Notice of Privacy Practices (provided to you upon your enrollment in the health plan) details steps that The Be Well Center has taken to assure your privacy are protected. The Notice also explains your rights under HIPAA. A copy of this Notice is available to you at any time, free of charge by contacting The Be Well Center HR department in writing.

IX. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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 (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-related injuries or illness.

X. NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital 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 insurance 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).

XI. NEW HEALTH INSURANCE MARKETPLACE OPTIONS & YOUR HEALTH INSURANCE COVERAGE (expires 6.30.2023)

Part A: General Information

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

What Is the Health Insurance Marketplace?

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

Can I Save Money on My Health Insurance Premiums in The Marketplace?

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you will lose the company's contribution (if any) toward the cost of health coverage. Also, your employer's contribution - as well as your contributions toward the cost of coverage— is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace will be made on an after-tax basis.

How Can I Get More Information?

For more information about your health coverage offered by **The Behavioral Center at Girard**., please contact **Human Resources.**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov or the state website shown on the attached State Marketplace List for more information or for an online application for health insurance coverage.

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

PART B: Information About Health Coverage Offered by Your Employer

1.	Employer Name	**The Behavioral Wellness Center at Girard**	
2.	Employer Identification Number (EIN)	**23-2610538**	
3.	Employer Address	**801 W Girard Avenue**	
4.	Employer Phone Number	**215.787.2000**	
5.	City	**Philadelphia**	
6.	State	**PA**	
7.	Zip Code	**19122**	
8.	Who can we contact about health coverage at this job?		**HR**
9.	Phone Number (if different from above)	**215.787.2565**	
10.	Email Address	**Kfisher@BeWellCtr.org**	

You are receiving this notice as an employee of the company and as such you fall into one of three categories:

If You Are Currently Eligible: You are eligible for coverage under the company's group health plan as you have met the plan's eligibility requirements and the waiting period, or

- **If You Are Currently in the Waiting Period**: You are not yet eligible for coverage under the company's group health plan as you are currently in the waiting period

- **If You Are Currently Not Eligible**: You are not eligible for coverage under the employer's group health plan as you have not met the plan's eligibility requirements.

- **The Cost of Our Plan**: The employer intends that at least one health plan option that it offers provides the "minimum value standard" as established by the Affordable Care Act and that the cost of the plan for "employee only" coverage is, based on the employee's income, affordable under the Act.

What This Means to You: In general, employees who are offered health insurance from an employer are not eligible for a tax credit that lowers monthly premium, or a reduction in cost-sharing, as long as at least one option offered meets specified requirements for affordability and the minimum value standard. A plan is affordable if your cost to cover yourself (and not any other members of your family) is not more than 9.5% of your household income for the year. If you are eligible for Medicare or Medicaid, you will not be eligible for a tax credit or cost-sharing subsidy if you purchase coverage from the Marketplace.

State Marketplace List: This list was last updated: November 2021

If you live in a state that is listed below, please go to the website shown in order to find more information about the Marketplace in your state and to apply for coverage. Otherwise, go to healthcare.gov for information about the Federal Marketplace.

State	Marketplace Name	State Marketplace Website
California	Covered California	http://www.coveredca.com/
Colorado	Connect for Health Colorado	http://www.connectforhealthco.com/
Connecticut	Access Health CT	http://www.accesshealthct.com/
District of Columbia	DC Health Link	http://dchealthlink.com/
Idaho	Your Health Idaho	http://www.yourhealthidaho.org/
Kentucky	Kynect	https://kynect.ky.gov/s/?language=en_US
Maine	CoverME	https://www.coverme.gov/
Maryland	Maryland Health Connection	http://www.marylandhealthconnection.gov/
Massachusetts	Health Connector	https://mahealthconnector.optum.com/individual/
Minnesota	MNsure	http://mn.gov/hix/
Nevada	Health Link	https://www.nevadahealthlink.com/
New Jersey	Get Covered NJ	https://nj.gov/getcoverednj/
New York	New York State of Health	http://healthbenefitexchange.ny.gov/
Pennsylvania	Pennie	https://pennie.com/
Rhode Island	Healthsource RI	http://www.healthsourceri.com/
Vermont	Vermont Health Connect	http://healthconnect.vermont.gov/
Washington	Washington Healthplanfinder	http://www.wahealthplanfinder.org/

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840

IOWA-Medicaid and CHIP (Hawki)	MINNESOTA-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493

NEW YORK-Medicaid	UTAH-Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U.S. Dept of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

XIII. Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)