Instructions for Group Health Plans and Health Insurance Issuers
(For use for plan years beginning on or after January 1, 2022)

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

(1) the restrictions on balance billing in certain circumstances,
(2) any applicable state law protections against balance billing,
(3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
(4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

No Surprise Bill Law intends to protect patients from unanticipated medical expense after receiving care from an out-of-network physician, other health professional, hospital, or other provider.

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

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

You are protected from balance billing for:

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

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

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

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

- Call the No Surprises Help Desk at 1-800-985-3059.
- Get help in a language other than English through the No Surprises Help Desk.
- Call the No Surprises Help Desk to get this information in large print, Braille, or audio.

Submit A Complaint: *nsa-idr.cms.gov/consumercomplaints/s/?language=en_US*
For More Information: NJ DOBI: *www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html*
For More Information: NJ Department of Labor: *www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act*

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If a state develops model language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

Language access

Use of Plain Language
Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:
- Plainlanguage.gov/guidelines
- Section508.gov
- LEP.gov

Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services

If you are someone who is trying to figure out how to use your health coverage provided by your employer to pay for your mental health or substance use services – this sheet is for you. Your health plan or health coverage is sometimes called *health insurance*.

Parity of mental health and substance use benefits

There is now a United States law stating that certain health plans must cover mental health and substance use (MH/SU) services comparably (in a similar way) to medical and surgical care, or what most people refer to as physical health.[1] Many simply refer to the requirement of the law as parity, as we do here.

Parity: requires that certain health plans apply certain comparable (similar) rules to MH/SU benefits as they do for physical health.

In this document, we explain MH/SU parity, answer questions about the parity law, and provide ways to learn more. We hope you use this information to get the mental health and substance use services you and your family need paid for (either fully or partially) by your health plan. You may want to talk about this information with your doctor, therapist, your family members, or others who help you with your MH/SU care.

Here you will learn about:

- Laws about parity of MH/SU benefits with other physical health benefits
- Reasons why some MH/SU benefit claims are denied
- How to file an internal or external appeal if your claim is denied
- Ways to learn more about parity, your MH/SU benefits, and appeals of denied claims.

[1] Specifically, the law (the Mental Health Parity and Addiction Equity Act or MHPAEA) requires that plans and issuers that provide mental health or substance use benefits do not impose financial requirements or treatment limitations that are more restrictive than those that apply to medical or surgical benefits. See the Mental Health Parity home page on the U.S. Department of Labor website.

Does my health plan offer parity for MH/SU benefits?

Most employer-based health plans, but not all, must offer parity for MH/SU benefits.[2] These are health plans that people get from where they work.

- Not all health plans are required to provide MH/SU benefits. Parity only applies to health plans that provide MH/SU benefits.
- Parity applies to private employer plans with 51 or more workers.
- Parity also applies to smaller employers that started offering benefits or made major changes to their health benefits after the Affordable Care Act came into effect in 2010. This includes most small plans.
- Parity also applies to most health insurance coverage sold to individuals. This includes coverage sold through the health insurance marketplace.[3]
- Health plans that are only for retirees do not need to comply with MH/SU parity.

What does parity mean in terms of MH/SU benefits?

Health Benefits: This means physical health, mental health, and substance use services paid for by health plans.

Parity means that financial requirements (such as copayments, deductibles, coinsurance or out-of-pocket maximums)[4] and treatment limitations used by health plans must be comparable for physical and MH/SU services. There are two different sets of parity rules.

[2] MHPAEA applies to plans with 51 or more employees of private companies or governmental employers. MHPAEA also applies to plan of smaller groups that started offering or made major changes to their plan after March 23, 2010. (Plans that made major changes are sometimes referred to as non-grandfathered plans). For more information related to determining if the parity rules apply to a plan, see Health Insurance Rights & Protections, Grandfathered Health Insurance Plans on the HealthCare.gov website. For more information on other types of plans that do not have to follow parity, see the Mental Health Parity and Addiction Equity Act home page on the Centers for Medicare & Medicaid Services website.

[3] For more information about the health insurance exchange see the healthcare.gov website.

[4] A plan's lifetime and annual dollar limits are subject to different rules under the earlier Mental Health Parity Act (MHPA) which was supplemented by MHPAEA and the Affordable Care Act (ACA). For information on MHPA, see The Mental Health Parity Act. For information on the ACA's ban on lifetime and annual limits for essential health benefits, go to Affordable Care Act—About the Law on and select Benefit Limits on the US Health and Human Services homepage.

The first set of rules is for financial requirements (such as rules for copayments) and for treatment limits that you can count (such as number of visits).[5,6] The other set of rules deals with how treatment is accessed and under what conditions (such as obtaining permission from your health plan before going to MH/SU treatment).[7]

Here are some ways in which MH/SU and physical health benefits must be comparable:

- **Co-payment** (or simply co-pay). A co-pay is a fixed amount you pay for each covered service such as an outpatient doctor's visit. For example, generally if your co-pay for all outpatient physical health benefits is $20, then your co-pay for outpatient mental health or substance use benefits must be $20 or less.
- **Yearly visit limits**. If there are no yearly limits on all outpatient office visits to medical providers, there should generally be no yearly limit for outpatient office visits to an MH provider.
- **Prior authorization**. Prior authorization (sometimes called preauthorization, prior approval, or precertification) means that a doctor from your plan must confirm that you need a service before it begins. Generally speaking, if your health plan does not require prior authorization for any medical/surgical visits, a plan will not be able to require it for MH/SU related visits. Once your treatment begins, rules for continuing your care should be based on a comparable process for both mental health and physical health benefits.
- **Proof of medical necessity**. Medical necessity standards are used to determine appropriate care for different medical conditions. The standards are based on research showing that a treatment is effective. A health plan must use a similar process to create medical necessity standards for MH/SU services, compared to the process used for physical health services.

[5] These usually are called *quantitative treatment limitations* or QTLs. They include the number of visits or days covered or frequency of treatment.

[6] A plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health or substance use benefits in any classification that is more restrictive than the *predominant* financial requirement or quantitative limitation of that type applied to *substantially all* medical/surgical benefits in the same classification.

[7] These are usually called non-quantitative treatment limitations or NQTLs. NQTLs deal with how treatment is given and under what conditions (such as medical necessity or prior authorization requirements). A plan may not impose an NQTL with respect to MH/SU benefits unless *any processes, strategies, evidentiary standards, or other factors used in applying the limitation to MH/SU benefits are comparable* to and applied no more stringently than those used in applying the limitation with respect to medical/surgical benefits.

To learn more about financial requirements, treatment limits, and other MH/SU parity issues go to the Frequently Asked Questions for Employees about the Mental Health Parity and Addiction Equity Act on the U.S. Department of Labor website.

How can I find out about my health plan's MH/SU benefits?

You have the right to call your plan and request information about your benefits. Sometimes a different company manages your MH/SU benefits than the one that manages your physical health benefits. For example, this may be another insurance company. You are entitled to information about your plan regardless of who manages it. There are many ways to learn about your MH/SU benefits:

- Read your health plan's *Summary Plan Description* and/or *Summary of Benefits and Coverage*. If you do not have these documents, you may request them from your health plan or employer. These documents should include information about your MH/SU benefits. However, they may not contain all of the information you need about how to access these benefits. You may also request rules for accessing your MH/SU benefits in writing from your plan. These documents also should have facts about your rights under the Employee Retirement Income Security Act (ERISA, a law that protects your health benefits and gives your certain rights).[8]
- Ask your health plan about its requirements for prior authorization or medical necessity for MH/SU benefits. The law requires that health plans make their medical necessity criteria available to you for MH/SU and physical health services for comparison. This includes telling you how those criteria were developed. Speak up if you question whether these requirements for MH/SU services are determined in a comparable manner to those for physical health services.
- You may request copies from your health plan of all information it uses to decide about co-payments, yearly limits, lifetime limits, medical necessity and prior authorization.[9] ERISA states that your health plan must give you copies of all these materials within 30 days of your request.

[8] For more information about ERISA, see the Health Plans and Benefits ERISA home page on the U.S. Department of Labor website.

[9] You also can request other medical management criteria such as how a plan determines what prescriptions are covered, how a plan decides who is in its network of providers, the plan exclusions based on requirements that individuals do certain things (like complete a specific treatment) before a benefit will be covered, and limits related to where (what geographic area) a benefit will be covered.

For more information about your benefits, call your health plan directly at their customer service phone number.

- The customer service number usually is listed on the back of your health plan's card.
- Have your health plan card nearby when you call so you can quickly find your plan number, group number, and name of your employer.
- Locate your health plan's website in advance. Additional information about your plan usually can be found online by going to the websites listed in the *Summary of Benefits and Coverage*.

Why some MH/SU benefit claims are denied

Claim: This term refers to a request for payment for MH/SU services from your health plan.

Deny a claim, or a denied claim: This means that your health plan refuses to pay for some or all of the MH/SU services you received as stated in the claim.

Sometimes health plans deny claims for certain services. If they deny your claim for MH/SU services, ERISA and other laws require them to send you a letter explaining the reason they denied the claim. The letter also will have information about your right to file an appeal, with details about how and when to do so. The denial letter should be specifically about the reason why your claim for services is being denied.

Sometimes claims are denied because a health plan is not complying with the law. However, there are many reasons that health plans deny a claim that may not violate parity:

- Your health plan does not offer this service as part of your benefits.
- MH/SU services were not considered medically necessary, and the medical necessity criteria used for physical health services are comparable.
- MH/SU services are no longer appropriate in a specific health care setting or level of care. For example, you were receiving residential treatment, but based on your current symptoms residential treatment will no longer be medically necessary. So now, your health plan will only pay for outpatient visits unless your symptoms change. Physical health services are being treated in a comparable way.
- The MH/SU service was considered experimental or investigational. This means the plan thinks the service is too new and has not yet been studied enough to show that it is effective. The process for determining that a service is experimental or investigational must be applied similarly for MH/SU and physical health services.

What can I do if my health plan denies my MH/SU claim, and I suspect it is because the plan is not complying with the parity law?

Begin by calling your health plan to get more information. You can find this number on the back of your health plan's card. Have the following information when you call:

- Your bill for the MH/SU services that were not paid by your health plan.
- The Explanation of Benefits (EOB). This is a summary of which services were paid by your health plan and which services were not paid. Your health plan should send this to you. It should include a denial code and a statement that explains why a service was denied or not covered.
- Your health plan's *Summary Plan Description* or *Summary of Benefits and Coverage*. It helps to mark the pages that refer to MH/SU benefits before calling your health plan.

You have the right to request information about the treatment limitations the plan used to deny your claim. You can also request the treatment limitations for your physical health benefits to check if comparable treatment limitations apply to your MH/SU benefits. You also have the right to request information about how treatment is accessed under your plan, although it can be harder to identify when plans break rules related to how treatment is accessed.[10] To find this out, you can ask how your plan developed the rules for any treatment limitations. You can also ask your MH/SU provider to request information about these rules on your behalf.

Appeal: This means that you ask your health insurer or plan to review its decision. You try to get your health plan to reverse their decision.

How to file an internal or external appeal if your claim is denied

How can I appeal if I think my health plan should not have denied this claim?

You have the right to appeal a denied claim. You will need to file an *internal appeal* with your health plan. Start by calling your health plan and asking them what to include in your internal appeal request. You should include all information related to your claim in your appeal. This includes any additional information or evidence, that you want the plan to consider. Your EOB should have information about how to file this request. The request must be submitted in writing.

[10] This means that it is usually easier to identify when plans break rules related to treatment limitations that you can count (QTLs) than treatment limitations that are related to processes under which treatment is accessed (NQTLs). See the section of this document titled: *What does parity mean in terms of MH/SU benefits?*

Conducting an internal appeal means that people who work at your health plan carefully review your denied claim. There may be two or more levels of internal appeals. Many appealed claims are reversed, or changed in the patient's favor. You must get a response from your health plan within 60 days of filing an internal appeal.

You can get help with an appeal:

- Your doctor or therapist, a family member, or someone you have chosen to represent you can help you. They can find out about your claim and your appeal. They can write a letter to support payment of your claim. You may need to sign a form giving them permission to help.
- In some states, a consumer assistance program may be able to help you file an appeal. You can find information for your state through the Consumer Assistance Program home page on the Centers for Medicare & Medicaid Services website.

If your health plan still denies the claim after all levels of internal appeal, you may have a right to request an *external review*. This means that an organization outside the health plan will review your case and give an unbiased opinion. This review may be conducted by an independent review organization (IRO), through the federal Office of Personnel Management's external review process, or through your state's external review process.[11] Your final internal appeal determination should have information on how to request an external review, if one is available to you.

You must request an external review no later than four months after getting the final denial from your health plan. Here are some reasons to request an external review:

- Your health plan says this treatment was not medically necessary. You disagree, and suspect the plan used medical necessity criteria that were not developed in a comparable way to what they used for physical health.
- Your health plan said that it cancelled your coverage retroactively, to before you received the MH/SU services. You want to challenge this decision.

The external review either will **overturn** the denial (say that the health plan needs to pay your claim) or **agree** with the health plan's denial. This decision must be made within 45 days. It is your right to take your health plan to court.

You can learn more about how to file a claim or request an external review by going to the U.S. Department of Labor web page titled Filing a Claim for Your Health or Disability Benefits.

[11] The party that conducts the review will depend upon the type of coverage in which you are enrolled.

Parity provides important protections related to MH/SU benefits. Make sure you receive the benefits to which you are entitled!

More ways to learn:

To learn more about the Mental Health Parity and Addiction Equity Act (MHPAEA) and your health plan's compliance with parity, call or go to the following:

- U.S. Department of Labor Employee Benefits Security Administration (EBSA) web page that has consumer information on health plans. Or contact EBSA toll-free at: 1-866-444-3272 or through their website.
- U.S. Department of Health and Human Services: 1-877-267-2323 ext. 61565
- Your state's department of insurance website and contact information, which can be found on the National Association of Insurance Commissioners website.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) page.

To learn more about benefits and the appeals process, go to:

- The National Conference of State Legislatures page titled Mental Health Benefits: State Laws Mandating or Regulating.
- The HealthCare.gov page on health insurance rights and protections.

ACKNOWLEDGMENTS

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Truven Health Analytics Inc. under SAMHSA IDIQ Prime Contract #HHSS283200700029I, Task Order #HHSS28342002T with SAMHSA, U.S. Department of Health and Human Services (HHS). Elizabeth Siegel McNamee served as the Contracting Office Representative.

DISCLAIMER

This document is not meant to be considered legal advice and is not representative of the official position of the U.S. Departments of Labor, Health and Human Services, and the Treasury. This document is intended to give a basic understanding of certain requirements related to MHPAEA and claims and appeals under the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (the Code). The statute, recent regulations, and other guidance issued by the Departments should be consulted.

RECOMMENDED CITATION

Substance Abuse and Mental Health Services Administration. *Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services*. HHS Publication No. SMA-16-4937. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

U.S. Department of Labor
Employee Benefits Security Administration

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.

The required coverage includes:

- 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.

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

Additional consumer information on WHCRA is available in the publication **Your Rights After A Mastectomy**.

Information for group health plans and employers on WHCRA and other health benefit law requirements is available in the publication **Compliance Assistance Guide – Health Benefits Coverage Under Federal Law**.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

U.S. Department of Labor
Employee Benefits Security Administration

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the **Frequently Asked Questions** (FAQs) About the Newborns' and Mothers' Health Protection Act.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

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 https://nj.gov/getcoverednj/

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, 2023. Contact your State for more information on eligibility.

NEW JERSEY – Medicaid and CHIP
Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

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

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

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

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

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

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

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

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

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

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

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

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

Notices of Nondiscrimination and Taglines

Under Section 1557 of the Affordable Care Act (ACA), covered entities[1] are required to post notices of nondiscrimination and taglines that alert individuals with limited English proficiency (LEP) to the availability of language assistance services. While some recipients may not be covered entities under the ACA, all recipients should inform LEP individuals of what language services are available and that they are free of charge

Notices of Nondiscrimination

Each covered entity must take appropriate steps to notify beneficiaries, enrollees, applicants, and members of the public of the following:

(1) The entity does not discriminate on the basis of race, color, national origin, sex, age, or disability;
(2) The entity provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities;
(3) The entity provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to LEP individuals;
(4) How to obtain the aids and services;
(5) An identification of, and contact information for, the compliance coordinator (if applicable); [2]
(6) The availability of the grievance procedure and how to file a grievance, if applicable; and
(7) How to file a discrimination complaint with the HHS Office for Civil Rights.

Taglines

Covered entities must also post taglines in at least the top 15 non-English languages spoken in the State in which the entity is located or does business advising consumers of the availability of free language assistance services.

Posting Requirement

Covered Entities must post Notices of Nondiscrimination and Taglines in a conspicuously-visible font size:

(i) In significant publications and significant communications targeted to beneficiaries, enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures;
(ii) In conspicuous physical locations where the entity interacts with the public; and
(iii) In a conspicuous location on the covered entity's Web site that is accessible from the homepage.

Translated Resources

Translated notices of nondiscrimination, statements of nondiscrimination, and taglines in 64 languages can be found at https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

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[1] Covered entity means: (1) An entity that operates a health program or activity, any part of which receives FFA; (2) An entity established under Title I of the ACA that administers a health program or activity; and (3) HHS.

[2] Covered entities that employ 15 or more persons shall designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under Section 1557, including the investigation of any grievance alleging noncompliance with Section 1557.

GROUP PLANS HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

You are eligible to participate in a group health plan. To participate, you must enroll and pay the costs if required by your employer. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions for workers and dependents that allow you to have special enrollment rights should you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

HIPAA allows you special enrollment rights in a group health plan according to the following guidelines:

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program)
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage 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 (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of coverage for Medicaid or a State Children's Health Insurance Program
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.

New dependent by marriage, birth, adoption or placement for adoption
If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

Eligibility for 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.

Notice

If you decline enrollment for yourself or for an eligible dependent, your employer may require that you complete the *Waiver of Medical Coverage* form. If you do not complete the form, you and your dependents may not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption or placement for adoption or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a State Children's Health Insurance Program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period unless special enrollment rights apply because of a new dependent by marriage, birth, adoption or placement for adoption or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a State Children's Health Insurance Program with respect to coverage under this plan.

To request special enrollment or to obtain more information about the plan's special enrollment provision, contact your employer's authorized representative or call Christopher S Kudryk at **1-732-333-1976.**

2025 Medicare Part D Notice of Creditable Coverage

Important Notice from Your Employer 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 your employer 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. Your employer has determined that the prescription drug coverage offered by our employer-sponsored group health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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 employer-sponsored group health plan coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current employer-sponsored group health plan coverage, be aware that you and your dependents will not be able to get this coverage back until the plan's next open enrollment period.

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 your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the number listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

For more information, contact People Operations.