IVY TECH COMMUNITY COLLEGE

2023 Compliance Bundle

Contact Name	Benefits and Leaves Hub
Mailing Address	statewide-benefitsleaves@ivytech.edu

You may request paper copies of all notices, free of charge, upon request to the Plan Administrator.

Presented by:
LHD

team IVY
IVY TECH COMMUNITY COLLEGE

Legal Notices for 2023

The Employee Retirement Income Security Act (ERISA), Department of Labor (DOL), Department of Health and Human Services (HHS) and Internal Revenue Service require plan administrators to provide certain information related to their health and welfare benefits plan to plan participants in writing. To satisfy this requirement, please review the compliance notifications included in this package. These notices explain your rights and obligations in relation to the health and welfare plan provided by **Ivy Tech Community College**.

Please read these notices carefully and retain a copy for your records:

- Women's Health and Cancer Rights Act
- Newborns' and Mothers' Health Protection Act
- Patient Protection Notice
- Notice of Privacy Practices
- HIPAA Special Enrollment Notice
- Notice Regarding Wellbeing Program
- Premium Assistance under Medicare and Children's Health Insurance Program (CHIP)
- Paperwork Reduction Act Statement
- Genetic Information Nondiscrimination Act (GINA)
- Mental Health Parity and Addiction Equity Act (MHPAE)
- No Surprises Act
- USERRA
- Family Medical Leave Act (FMLA)
- Medicare Part D Creditable Notice
- Market Exchange Notice
- Notice Regarding Wellness Program

Legal Notices for 2023

WOMEN'S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE

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

- All stages of reconstruction of the breast on which mastectomy was performed.;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.;

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

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

PATIENT PROTECTION NOTICE

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact the customer service phone number on the back of your medical ID card.

For children, you may designate a pediatrician as the primary care provider, but it is not required.

You do not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact the customer service phone number on your medical ID card.

LEGAL NOTICES FOR 2023

NOTICE OF PRIVACY PRACTICES:

This notice described how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Certain employer-sponsored health plans are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of your health information that the plan creates, requests, or is created on the Plan's behalf, called Protected Health Information ("PHI") and to provide you, as the participant, covered dependent, or qualified beneficiary, with notice of the plan's legal duties and privacy practices concerning Protected Health Information.

The terms of this Notice of Privacy Practices ("Notice") apply to the following plans (collective and individually referenced in this Notice as the "Ivy Tech Community College Health Plans"): Group Medical and Prescription Drug Plans, Voluntary Dental Plans, and Voluntary Vision Plans

This Notice describes how the Ivy Tech Community College Health Plans may use and disclose your PHI to carry-out payment and health care operations, and for other purposes that are permitted or required by law.

The Ivy Tech Community College Health Plans are required to abide by the terms of this Notice so long as the Ivy Tech Community College Health Plans remain in effect. The Ivy Tech Community College Health Plans reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all PHI maintained by the Ivy Tech Community College Health Plans. Copies of revised Notices with which there has been a material changes will be mailed to all participants then covered by the Ivy Tech Community College Health Plans. Copies of our current Notice may be obtained by calling the Privacy Officer at the telephone number or address below.

DEFINITIONS

Plan Sponsor means Ivy Tech Community College and any other employer that maintains the Ivy Tech Community College Health Plans for the benefits of its associates.

Protected health Information ("PHI") means individually identifiable health information, which is defined under the law as information that is a subset of health information, including demographic information, that is created or received by the Ivy Tech Community College Health Plans and that relates to your past, present or future physical mental health or condition; the health care services you receive, or the past, present, or future payment for health care services you receive; and that identifies you, or which there is a reasonable basis to believe the information can be used to identify you.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that the Ivy Tech Community College Health Plans may use and disclose your PHI. For each category of uses and disclosures we will explain what we mean and, when appropriate, provides examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below or otherwise permitted by law, the Ivy Tech Community College Health Plans will not use or disclose your PHI unless you have signed a form authorizing the Ivy Tech Community College Health Plans to use or disclose specific PHI for an explicit purpose to a specific person or group of persons. Uses and disclosures of your PHI for marketing purposes and/or for the sale of your PHI require your authorization. You have the right to revoke any authorization in writing except to the extent that the Ivy Tech Community College Health Plans have taken action in reliance upon the authorizations.

Uses and Disclosures for Payment – The Ivy Tech Community College Health Plans may use and disclose your PHI as necessary for benefit payment purposes without obtaining an authorization from you. The persons to whom the Ivy Tech Community College Health Plans may disclose your PHI for payment purposes include your health care providers that are billing for or requesting a prior authorization for their services and treatments of you, other health plans providing benefits to you, and your approved family member or guardian responsible for amounts, such as deductibles and co-insurance, not covered by the Ivy Tech Community College Health Plans.

For example, the Ivy Tech Community College Health Plans may use or disclose your PHI, including information about any medical procedures and treatments you have received, are receiving, or will receive, to your doctor, your spouse's doctor or other health plan under which you are covered, and your spouse or other family members, unless you object, in order to process your benefits under the Ivy Tech Community College Health Plans. Examples of other payment activities include determinations of your eligibility or coverage under the Ivy Tech Community College Health Plans, annual premium calculations based on health status and demographic characteristics of persons covered under the Ivy Tech Community College Health Plans, billing, claims management, reinsurance claim, and review of health care services with respect to medical necessity, utilization review activities, and disclosures to consumer reporting agencies.

LEGAL NOTICES FOR 2023

Uses and Disclosures for Health Care Operations – The Ivy Tech Community College Health Plans may use and disclose your PHI as necessary for health care operations without obtaining an authorization from you. Health care operations are those functions of the Ivy Tech Community College Health Plans it needs to operate on a day-to-day basis and those activities that help it to evaluate its performance. Examples of health care operations include underwriting, premium rating or other activities relating to the creation, amendment or termination of the Ivy Tech Community College Health Plans, and obtaining reinsurance coverage. Other functions considered to be health care operations include business planning and development; conducting or arranging for quality assessment and improvement activities, medical review, and legal services and auditing functions; and performing business management and general administrative duties of the Ivy Tech Community College Health Plans, including the provision of customer services to you and your covered dependents.

Use or Disclosure of Genetic Information Prohibited – the Genetic Information Nondiscrimination Act of 2009 (GINA), and regulations promulgated thereunder, specific prohibit the use, disclosure or request of PHI that is genetic information for underwriting purposes. Genetic information is defined as (1) your genetic tests; (2) genetic tests of your family member; (3) family medical history, or (4) any request of or receipt by you or your family members genetic services. This means that your genetic information cannot be used for enrollment, continued eligibility, computation of premiums, or other activities related to underwriting, even if those activities are for purposes of health care operations or being performed pursuant to your written authorization.

Family and Friends Involved in Your Care – If you are available and do not object, the Ivy Tech Community College Health Plans may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and the Ivy Tech Community College Health Plans determine that a limited disclosure is in your best interest, the Ivy Tech Community College Health Plans, may share limited PHI with such individuals. For example, the Ivy Tech Community College Health Plans may use its professional judgment to disclose PHI to your spouse concerning the processing of a claim. If you do not wish us to share PHI with your spouse or others, you may exercise your right to request a restriction on your disclosure of your PHI (see below), including having correspondence the Ivy Tech Community College Health Plans send to you mailed to an alternative address. The Ivy Tech Community College Health Plans are also required to abide by certain state laws that are more stringent than the HIPAA Privacy Standards, for example, some states give a minor child the right to consent to his or her own treatment and, under HIPAA, to direct who may know about the care he or she receives. There may be an instance when your minor child would request for you not to be informed of his or her treatment and the Ivy Tech Community College Health Plans would be required to honor that request.

Business Associates – Certain aspects and components of the Ivy Tech Community College Health Plans' services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our third-party administrator, reinsurance carrier, agents, attorney, accountants, banks and consultants. At times it may be necessary for use to provide certain of your PHI to one or more of these outside persons or organizations. However, if the Ivy Tech Community College Health Plans do provide your PHI to any or all of these outside persons or organizations, they will be required, though contract or by law, to follow the same policies and procedures with your PHI as detailed in this Notice.

Plan Sponsor – The Ivy Tech Community College Health Plans may disclose a subset of your PHI, called summary health information, to the Plan Sponsor in certain situations. Summary health information summarizes claims history, claim expenses, and types of claims experience by individuals under the Ivy Tech Community College Health Plans, but all information that could effectively identify whose claims history has been summarized has been removed. Summary health information may be given to the Plan Sponsor when requested for the purpose of obtaining premium bids, for providing coverage under the Ivy Tech Community College Health Plans, or for modifying, amending or terminating the Ivy Tech Community College Health Plans. The Ivy Tech Community College Health Plans may also disclose to the Plan Sponsor whether you are enrolled in or have disenrolled from the Ivy Tech Community College Health Plans.

Other Products and Services – The Ivy Tech Community College Health Plans may contact you to provide information about other health-related products and services that may be of interest to you without obtaining your authorizations. For example, the Ivy Tech Community College Health Plans may use and disclose your PHI for the purpose of communicating to you about the health benefit products or services that could enhance or substitute for existing coverage under the Ivy Tech Community College Health Plans, such as long-term health benefits for flexible spending accounts. The Ivy Tech Community College Health Plans may also contact you about health-related products and services, like disease management programs that may add value to you, as a covered person under the Ivy Tech Community College Health Plans. However, the Ivy Tech Community College Health Plans must obtain your authorization before the Ivy Tech Community College Health Plans send you information regarding non-health related products or services, such as information concerning movie passes, life insurance products, or other discounts or services offered to the general public at large.

Other Uses and Disclosures – Unless otherwise prohibited by the law, the Ivy Tech Community College Health Plans may make certain other uses and disclosures of your PHI without your authorization, including the following:

- The Ivy Tech Community College Health Plans may use or disclose your PHI to the extent that the use or disclosure is required by law.
- The Ivy Tech Community College Health Plans may disclose your PHI to the proper authorities if the Ivy Tech Community College Health Plans suspect child abuse or neglect; the Ivy Tech Community College Health Plans may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- The Ivy Tech Community College Health Plans may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or a civil or criminal proceeding.

LEGAL NOTICES FOR 2023

- The Ivy Tech Community College Health Plans may disclose your PHI in response to a court order specifically authorizing the disclosure, or in the course of a judicial or administrative proceeding (e.g. to response to a subpoena or discovery request), provided written and documented efforts by the requesting party have been made to (1) notify you of the disclosure and the purpose of the litigation, or (2) obtain a qualified protective order prohibiting the use or disclosure of your PHI for any other purpose than the litigation or proceeding for which it was requested.
- The Ivy Tech Community College Health Plans may disclose your PHI to the proper authorities for law enforcement purposes, including the disclosure of certain identifying information requested by police officers for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; the disclosure of your PHI if you are suspected to be a victim of a crime and you are incapacitated; or if you are suspected of committing a crime on the Ivy Tech Community College Health Plans (e.g., fraud).
- The Ivy Tech Community College Health Plans may use or disclose PHI to avert a serious threat to health or safety.
- The Ivy Tech Community College Health Plans may use or disclose your PHI if you are a member of the military, as required by armed forces services, and the Ivy Tech Community College Health Plans may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
  The Ivy Tech Community College Health Plans may disclose your PHI to state or federal workers' compensation agencies for your workers' compensation benefit determination.
- The Ivy Tech Community College Health Plans may, as required by law, release your PHI to the Secretary of Department Health and Human Services for enforcement of HIPAA Privacy Rules.

Verification Requirement – Before the Ivy Tech Community College Health Plans discloses your PHI to anyone requesting it, the Ivy Tech Community College Health Plans are required to verify the identity of the requester's authority to access your PHI. The Ivy Tech Community College Health Plans may rely on reasonable evidence of authority such as a badge, official credentials, written statements on appropriate government letterhead, written or oral statements of legal authority, warrants, subpoenas, or court orders.

RIGHTS THAT YOU HAVE

To request to inspect, copy, amend or get and accounting of PHI pertaining to your PHI in the Ivy Tech Community College Health Plans, you may contact the Privacy Officer.

Right to Inspect and Copy your PHI – You have the right to request a copy of and/or to inspect your PHI that the Ivy Tech Community College Health Plans maintain, unless the PHI was compiled in reasonable anticipation of litigation or contains psychotherapy notes. In certain limited circumstances, the Ivy Tech Community College Health Plans may deny your request to copy and/or inspect your PHI. In most of those limited circumstances, a licensed health care provider must determine that the release of the PHI to you or a person authorized by you, as your "personal representative," may cause you or someone else identified in the PHI harm. If your request is denied, you may have the right to have the denial reviewed by a designated licensed health care professional that did not participate in the original decision. Request for access to your PHI must be in writing and signed by you or your personal representative. You must ask for a Participant PHI Inspection Form from the Ivy Tech Community College Health Plans through the Privacy Officer at the address below. If you request that the Ivy Tech Community College Health Plans copy or mail your PHI to you, the Ivy Tech Community College Health Plans may charge you a fee for the cost of copying your PHI and the postage for mailing your PHI to you. If you ask the Ivy Tech Community College Health Plans to prepare a summary of PHI, and the Ivy Tech Community College Health Plans agree to provide that explanation, the Ivy Tech Community College Health Plans may also charge you for the cost associated with the preparation of the summary.

Right to Request Amendments to Your PHI – You have the right to request that PHI the Ivy Tech Community College Health Plans maintain about you be amended or corrected. The Ivy Tech Community College Health Plans are not obligated to make requested amendments to PHI that is not created by the Ivy Tech Community College Health Plans, not maintained by the Ivy Tech Community College Health Plans, not available for inspection, or that is accurate and complete. The Ivy Tech Community College Health Plans will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your personal representative, must state the reasons for the amendment request, and must sent to the Privacy Office at the address below. If the Ivy Tech Community College Health Plans deny your amendment request, the Ivy Tech Community College Health Plans will provide you with its basis for the denial, advise you of your right to prepare a statement of disagreement which it will place with your PHI, and describe how you may file a complaint with the Ivy Tech Community College Health Plans or the Secretary of the US Department of Health and Human Services. The Ivy Tech Community College Health Plans may limit the length of your statement of disagreement and submit its own rebuttal to accompany your statement of disagreement. If the Ivy Tech Community College Health Plans accept your amendment request, it must make a reasonable effort to provide the amendment to persons you identify as needing the amendment or persons it believes would rely on your unamended PHI to your detriment.

Right to Request an Accounting for Disclosures of Your PHI – You have the right to request an accounting of disclosures of your PHI that the Ivy Tech Community College Health Plans make. Your request for an accounting of disclosures must state a time period that may not be longer than six years and may not include dates before April 14, 2004. Not all disclosures of your PHI must be included in the accounting of the disclosures. Examples of disclosures that the Ivy Tech Community College Health Plans are required to account for include those pursuant to valid legal process, or for law enforcement purposes. Examples of disclosures that are not subject to an accounting include those made to carry out the Ivy Tech Community College Health Plans' payment or health care operations, or those made with your authorization. To be considered, your accounting requests must be in writing and signed by you or your personal representative, and sent to the Privacy Office at the address below. The first accounting in any 12-month period is free; however, the Ivy Tech Community College Health Plans may charge you a fee for each subsequent accounting you request within the same 12-month period.

LEGAL NOTICES FOR 2023

Right to Place Restrictions on the Use and Disclosure of Your PHI – You have the right to request restrictions on certain of the Ivy Tech Community College Health Plans' uses and disclosures of your PHI for payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that the Ivy Tech Community College Health Plans not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. The Ivy Tech Community College Health Plans are not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate. The Ivy Tech Community College Health Plans retain the right to terminate an agreed-to restriction if it believes such termination is appropriate. In the event of a termination by the Ivy Tech Community College Health Plans, it will notify you of the termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made by contacting the Ivy Tech Community College Health Plans through the Privacy Office at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. The Ivy Tech Community College Health Plans are required to accommodate reasonable requests if you inform the Ivy Tech Community College Health Plans that disclosure of all or part of your information could place you in danger. The Ivy Tech Community College Health Plans may grant other requests for confidential communications in its sole discretion. Requests for confidential communications must be in writing, signed by you or your personal representative, and sent to the Privacy Office at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting the Privacy Office at the telephone number or address below.

Right to Notice of Breach - You have the right to receive notice if your PHI is improperly used or disclosed as a result of a breach of unsecured PHI.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with the Ivy Tech Community College Health Plans through the Privacy Office in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact our Privacy Officer.

Ivy Tech Community College University
Jason Reeves
Director, Employee Benefits and Experience Chief Privacy Officer
50 W Fall Creek Pkwy N Drive
Indianapolis, IN 46208
(317) 917-5977
jreeves36@ivytech.edu

Legal Notices for 2023

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

NOTICE REGARDING WELLBEING PROGRAM

Notice of Extension of Dependent Coverage to Age 26. The limiting age for eligible children has been extended to age 26. Coverage will terminate based on the plan document rules.

Legal Notices for 2023

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

Legal Notices for 2023

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 four 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, 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)

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) DISCLOSURES

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

The MHPAEA imposes parity requirements on group health plans that provide benefits for mental health or substance use disorders. For example, plans must offer the same access to care and patient costs for mental health and substance use disorder benefits as those that apply to general medical or surgical benefits.

The MHPAEA applies to group health plans offering mental health and substance use disorder benefits. There is an exception for health plans that can demonstrate a certain cost increase and an exception for small health plans with fewer than two participants who are current employees (for example, retiree health plans). There is also an exception for employers with 50 or fewer employees during the preceding calendar year. However, in order to satisfy the essential health benefits requirement, mental health and substance use disorder benefits must be provided in a manner that complies with the MHPAEA. Thus, through this ACA mandate, small employers with insured plans are also subject to the mental health parity requirements.

Under the MHPAEA, the plan administrator or the health insurance issuer must disclose the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits to any current or potential participant, beneficiary or contracting provider upon request and the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits to the participant or beneficiary.

Legal Notices for 2023

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 surgery 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 you and may **not** ask you to give up your protections not to be balanced 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 <u>never</u> 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 toward your deductible and out-of-pocket limit.

Legal Notices for 2023

USERRA NOTICE

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

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

B. Reemployment Rights

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

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

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

C. Right to Be Free from Discrimination and Retaliation

If you:

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

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

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

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

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

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

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

Family Medical Leave Act (FMLA)

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

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

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

Benefits & Protections

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

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

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

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

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

Eligibility Requirements

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

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

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

Family Medical Leave Act (FMLA)

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

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

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

Employer Responsibilities

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

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

Enforcement

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

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

Medicare Part D Creditable

IMPORTANT NOTICE FROM IVY TECH COMMUNITY COLLEGE 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 **Ivy Tech Community College** 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. Ivy Tech Community College has determined that the prescription drug coverage offered by the Ivy Tech Community College Choice High Deductible Plan, Ivy Tech Community College Standard PPO 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 **Ivy Tech Community College** coverage may be affected. Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current **Ivy Tech Community College** 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 **Ivy Tech Community College** 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.

HEALTH ACTUARIES
A DIVISION OF RISK STRATEGIES

11611 N. MERIDIAN STREET
SUITE 330
CARMEL, IN 46032
317-575-7671

September 29, 2022

Michael Piercefield
Account Manager
LHD Benefit Advisors
250 W. 96th Street, Suite 350
Indianapolis, IN 46260

RE: **Ivy Tech - Prescription Drug Plan Creditable Coverage Tests for 2023**

Dear Michael,

As requested by LHD Benefit Advisors ("LHD"), UHAS has conducted the 2023 Part D Creditable Coverage testing for Ivy Tech's 2023 Proposed plans. We have deemed the coverage offered by each of the PPO and HDHP plans to be creditable.

Methodology

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D, as demonstrated through the use of generally accepted actuarial principles and in accordance with actuarial guidelines promulgated by the Centers for Medicare and Medicaid Services (CMS). In general, the actuarial equivalence test measures whether expected paid claims under the employer's prescription drug coverage is equal to or exceeds the expected paid claims under the standard Part D benefit. This is also known as the Actuarial Gross Value Test.

Normative claim distributions were used to test Ivy Tech's plan designs against the Standard Part D plan based on 2023 benefit parameters. The following data and assumptions were used for 2023 testing:

- We used the Willis Towers Watson 2022 HealthMAPS software to model all plan designs. The Standard Part D plan and all the plan designs that were tested were modeled using 2023 projected claims costs.
- Claim cost values recorded from the HealthMAPS software were those relating to Retirees.

- Benefit designs were provided by LHD.

- 2023 Standard Part D Benefit parameters:
    - Deductible – $505
    - Initial Coverage Limit – $4,660
    - Out-of-Pocket Threshold – $7,400

- Catastrophic Coverage – greater of 5% or $4.15 for multi-source drugs and $10.35 for single-source drugs

- For plans that did not fit well into the HealthMAPS software plan design descriptions, we tested similar plans such that the tested plan would (a) fit into the HealthMAPS inputs; and (b) be intuitively less rich than the actual plan design. For example, HealthMAPS does not support inputs for cost share variations related to Therapeutic drugs. Therefore, for plans which have lower copays for Therapeutic drugs, we tested the plan without the Therapeutic class distinction. Since the tested plan is less rich than the actual plan, and the tested plan passes as creditable coverage, then the actual plan also passes by reference.

Notes on Test Results

Following are notes regarding the test results for specific plans or plan categories.

- The PPO plan passed the testing with a margin of 41%.

- The HDHP plan passed the testing with a margin of 32%.

Caveats and Limitations

My review is based on the plan design parameters provided by LHD. I have reviewed these parameters for reasonableness and for consistency with plan design parameters which LHD provided in the past, but I have not performed a detailed audit.

This analysis is based on assumptions which I believe to be reasonable individually and in the aggregate. However, other knowledgeable individuals may have different opinions about the appropriateness of any or all of the assumptions used.

This letter and its attachments are not intended to serve as complete documentation for the project. Additional work papers may be found in the project files and can be provided upon request.

I understand that this letter is a statement of actuarial opinion as that term is defined by the American Academy of Actuaries ("Academy"). I am a member of the Academy and meet that organization's qualification standards for signing this statement of actuarial opinion.

Please feel free to contact me with questions or comments regarding anything above. My contact information is shown below my signature.

Thank you for the opportunity to serve LHD and its clients in this way.

Sincerely,

Ben Brandon, FSA, MAAA, FCA
Senior Consulting Actuary
phone: 732.425.3036
email: bbrandon@uhasinc.com

Market Exchange

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact 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 for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Market Exchange

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 ✓ Ivy Tech Community College		4. Employer Identification Number (EIN) 04-3459447
5. Employer address 50 W. Fall Creek Parkway North Dr.		6. Employer phone number
7.City Indianapolis	8. State IN	9. ZIP code 46208
10. Who can we contact about employee health coverage at this job? Benefits and Leaves Hub		
11. Phone number (if different from above)	12. Email address statewide-benefitsleaves@ivytech.edu	

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.

Market Exchange

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