

International Brotherhood of Electrical Workers Local 716 Electrical Medical Trust-Houston, Texas

Electrical Medical Trust
Fund Office
8441 Gulf Freeway
Houston, Texas 77017
Phone: 713-643-9300
Toll Free: 866-236-3148
Fax: 866-316-4794

November 23, 2021

Dear EMT participant:

Enclosed please find information regarding the 2022 Electrical Medical Trust plan year. Much of the information included is concerning the Open Enrollment period, which is December 1st 2021 to December 31st 2021. All plan elections (changes) will go into effect on 1-1-2022.

- 2022 Annual Enrollment Form
- Summary of Material Modification – Concerning Short Term Disability Benefit
- Electrical Medical Trust Eligibility Rules
- Summary of Benefits and Coverage (Kelsey Seybold, Memorial Hermann, and Aetna)
- General Information on Kelsey Seybold
- General Information on Aetna
- General Information on Memorial Hermann
- General Information on Navitus (Prescription Drug Coverage)
- Annual Privacy Notice
- Annual COBRA Disclosure
- Women’s Health and Cancer Rights Act Notice
- Medicaid Premium Assistance Annual Notice

Please be advised that if you are enrolling a dependent who has never been covered under the EMT plan, you MUST provide supporting documentation with your enrollment form. (i.e. Birth Certificates for child dependents or marriage certificate for spouse dependents)

Please be aware that the annual enrollment does not REMOVE dependents from your plan. The fund office can provide a Member Termination Request form to remove dependents from your plan. ***You could be held personally liable for any claims incurred by an ineligible dependent who is enrolled on your plan.*** Please contact the Gabriel Garcia at the fund office if you have any questions or concerns about the included documentation at 713-643-9300 or 866-236-3148.

Enrollment forms can be mailed, faxed or emailed.

Fax – 866-316-4794

Email – ggarcia@benefitresourcesinc.com



BENEFITS ENROLLMENT

January 1, 2022 – December 31, 2022

****Please submit form regardless of any changes****



PERSONAL DATA

Employee Name (First, Middle Initial, Last)		Last Four of Social Security Number		Date of Birth (MM/DD/YYYY)
Home Address		City	State	ZIP Code
Home Phone #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Email address	

DEPENDENT DATA

Name (First, MI, Last)	Relationship	Last Four of Social Security Number	Birth Date MM / DD / YYYY	Gender
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Male <input type="checkbox"/> Female

NOTE: Documentation must be provided when adding spouses and/or dependents - marriage license, birth certificate, etc.

MEDICAL

At the time of hire, or if you are already employed, please notify your employer of your plan election

KELSEY HMO \$750 DED	MEMORIAL HERMANN ACO \$1,000 DED	CHOICE POS II \$2,000 DED
<input type="checkbox"/> no employee cost	<input type="checkbox"/> \$1.00/hr through payroll deduction	<input type="checkbox"/> \$4.00/hr through payroll deduction

AUTHORIZATION

With this benefit election form, I hereby authorize my employer to make deductions from my paycheck for my medical elections. I understand that:

- I cannot change this election during the Plan Year unless I have a change in family status, (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse) and such other events as the Plan Administrator determines will permit a change or revocation of an election.
- During Open Enrollment of each year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new form, my current benefit elections will continue to be effective for the new Plan Year.

Employee Signature _____

Date _____

Return completed forms to: Gabe Garcia • ggarcia@benefitresourcesinc.com • 713-643-9300 • Fax: 866-316-4794
Electrical Medical Trust • 8441 Gulf Freeway, Suite 304 • Houston, TX 77017

IBEW Local 716 Electrical Medical Trust

8441 Gulf Freeway, Suite 304
Houston, Texas 77017
Telephone 713-643-9300
Fax: 866-316-4794

THIS IS A SUMMARY OF MATERIAL MODIFICATION TO THE IBEW LOCAL 716 ELECTRICAL MEDICAL TRUST

Dear Participant:

As you are aware, the Trustees are proud of the significant level of benefits that are provided to you and your eligible family members through the IBEW Local 716 Electrical Medical Trust (the “Fund”).

As Trustees to the IBEW Local 716 Electrical Medical Trust, we continually monitor the financial stability of the Plan to ensure the Plan’s financial viability and to provide you and your family members these important benefits on an ongoing basis. Accordingly, we would like to advise you a change that was made under the Plan, **effective January 1, 2022**. This change is described below:

- **The weekly short-term disability payment for eligible employees has increased from \$250 to \$300.**

Please feel free to contact the administrative office with any questions regarding your benefits or eligibility.

This notice is intended to be a Summary of Material Modification (SMM) for the 2022 Edition of the IBEW Local 716 Electrical Medical Trust, as required by the Employee Retirement Income Security Act of 1974. It describes amendments to the Plan, and to information presented in your Summary Plan Description, Plan communication, and any previous SMMs. You should keep this notice with your SPD and other Plan documents in a safe place.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan except to the extent that this SMM modifies the Plan, if any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees (or its duly authorized designee), reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at anytime and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan. (the "Trust Agreement"). The Trust Agreement and the full plan documents are at the fund office and may be inspected by you free of charge during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters, legal and or factual arising under the Plan.

ELIGIBILITY AND ENROLLMENT

Initial Eligibility

- 375 hours during a period of 3 consecutive months, eligible for benefits the 1st day of the 2nd calendar month following that 3-month period; or
- Total of at least 500 hours are contributed during a period of 6 consecutive months, eligible 1st day of the 2nd calendar month following that 6-month period.
- You and your eligible dependents will become initially eligible on the 1st day of the 2nd month following any 3 consecutive calendar months in which you have worked at least 375 hours for Contributing Employers.
- You must enroll your dependents or they will lose their eligibility to participate in the health plan.

Maintenance of Eligibility

Reserve Account (Hour Bank) – hours worked in excess of 140 per month will be credited to the Reserve Account with a maximum of 560 Reserve hours.

Monthly Deductions from Reserve Account

140 hours are deducted from the Active Member's Reserve Account for each month of coverage. A lag month will be used in determining continuing eligibility, i.e., June hours are worked for August eligibility.

Termination for Active Members

- Last day of the month member has less than 140 hours in Reserve Account
- 31st day Collective Bargaining Agreement no longer provides continued remittance of employer contributions

Reinstatement

Member must post 140 hours within a 6-month period immediately following such termination. Reinstatement will take place on the 1st day of the month following the month requirement is met. If Reserve Account does not show 140 hours within such 6-month period all hours will be forfeited unless coverage is continued through self-payment. Once a Reserve Account has been forfeited for this reason Active Member will have to meet the Initial Eligibility requirements again.

Continuation During Total Disability

With prior approval total disability continuing for 30 days or more will not have any hours deducted from the Member's Reserve Account from the 1st day of the month disability commences. Coverage will be continued up to 3 consecutive months. After that 3 month period the Reserve Account will be used. Once the Reserve Account is depleted, the Member may then continue coverage through self-pay provisions.

Eligibility for Dependents

Your lawful spouse and eligible children up to age 26.

Non-Bargaining Employees

Employer must contribute 173 hours per month for each Non-Bargaining Employee.

Non-Bargaining Employees Loss of Eligibility for Insufficient Hours

Once a Non-Bargaining Employee loses eligibility due to a reduction or insufficient hours, coverage may be continued through the self-pay provisions of COBRA.

Enrollment for the Newly Eligible:

- You will need Social Security Number and Date of Birth for all covered family members.
- You should confirm your health care providers participate in the insurance plan before making an appointment.
- You will receive a detailed benefit booklet and ID card at your home after you have enrolled.
- If you have become eligible for the first time and are enrolling in the medical plan, you may be asked to send a HIPAA Certificate of Creditable Coverage to Maggi Vargas.

****At time of hire, or if you are already employed, please notify your employer of your plan election.****



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$2,000 /Family \$4,000 Out-of- <u>Network</u> : Individual \$3,000 /Family \$9,000	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In- <u>Network</u> : Individual \$6,850 /Family \$13,700 Out-of- <u>Network</u> : Individual \$10,000 /Family \$20,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$45 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$55 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$45 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://members.navitus.com .	Generic drugs	\$10 <u>copay</u>	Not covered	Pharmacy coverage administered by Navitus. CVS is excluded from network. Retail: 30 days supply Mail Order: 90 days supply General questions: www.navitus.com . or 1-888-240-2211
	Preferred brand drugs	30% <u>coinsurance</u> up to \$75	Not covered	No charge for ACA-required generic <u>preventive drugs</u> (e.g., contraceptives) or a brand preventive drug if a generic is not medically appropriate.
	Non-preferred brand drugs	30% <u>coinsurance</u> up to \$150	Not covered	Navitus specialty drug program is mandatory. 1-855 847 3553
	<u>Specialty drugs</u>	30% <u>coinsurance</u> up to \$250	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	No coverage for non-urgent use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$55 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visits/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$55 <u>copay</u> /visit	50% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined. Includes treatment of Autism
	<u>Habilitation services</u>	\$55 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult): 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-370-4526.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's** overall **deductible** \$2,000
- **Specialist copayment** \$55
- Hospital (facility) **coinsurance** 30%
- Other **coinsurance** 30%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$240
Coinsurance	\$2,410

What isn't covered

Limits or exclusions \$20

The total Peg would pay is \$4,670

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's** overall **deductible** \$2,000
- **Specialist copayment** \$55
- Hospital (facility) **coinsurance** 30%
- Other **coinsurance** 30%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$780
Coinsurance	\$340

What isn't covered

Limits or exclusions \$70

The total Joe would pay is \$3,190

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's** overall **deductible** \$2,000
- **Specialist copayment** \$55
- Hospital (facility) **coinsurance** 30%
- Other **coinsurance** 30%

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies) Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,930
Copayments	\$520
Coinsurance	\$0

What isn't covered

Limits or exclusions \$0

The total Mia would pay is \$2,450

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your cost. The **plan** would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: Individual \$750 /Family \$2,250 .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In-network office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-network: Individual \$6,850 /Family \$13,700 .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind ; or call 1-800-370-4526 for a list of participating <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	Not covered	None
	<u>Specialist visit</u>	\$35 <u>copay</u> /visit	Not covered	None
	<u>Preventive care / screening / immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25 <u>copay</u> /visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$200 <u>copay</u> /visit	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://members.navitus.com .	Generic drugs	\$10 <u>copay</u>	Not covered	Pharmacy coverage administered by Navitus. CVS is excluded from network. Retail: 30 days supply Mail Order: 90 days supply General questions: www.navitus.com . or 1-888-240-2211 No charge for ACA-required generic <u>preventive drugs</u> (e.g., contraceptives) or a brand preventive drug if a generic is not medically appropriate. Navitus specialty drug program is mandatory. 1-855 847 3553
	Preferred brand drugs	30% <u>coinsurance</u> up to \$75	Not covered	
	Non-preferred brand drugs	30% <u>coinsurance</u> up to \$150	Not covered	
	<u>Specialty drugs</u>	30% <u>coinsurance</u> up to \$250	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> for hospital facility; \$35 <u>copay/visit</u> . <u>deductible</u> doesn't apply for free standing facility	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u> for hospital facility; no charge for free standing facility	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay</u> /visit,	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /visit	Not covered	None
	Inpatient services	20% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	60 visits/calendar year.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	Not covered	60 visits/calendar year/Physical, Occupational & Speech Therapy combined. Includes treatment of Autism.
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit,	Not covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	60 days/calendar year.
	<u>Durable medical equipment</u>	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult): 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-370-4526.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's** overall **deductible** \$750
- **Specialist copayment** \$35
- Hospital (facility) **coinsurance** 20%
- Other **coinsurance** 20%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing

Deductibles	\$750
Copayments	\$160
Coinsurance	\$1,860

What isn't covered

Limits or exclusions	\$20
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The total Peg would pay is \$2,790

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's** overall **deductible** \$750
- **Specialist copayment** \$35
- Hospital (facility) **coinsurance** 20%
- Other **coinsurance** 20%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing

Deductibles	\$750
Copayments	\$450
Coinsurance	\$710

What isn't covered

Limits or exclusions	\$70
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The total Joe would pay is \$1,980

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's** overall **deductible** \$750
- **Specialist copayment** \$35
- Hospital (facility) **coinsurance** 20%
- Other **coinsurance** 20%

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies) Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing

Deductibles	\$750
Copayments	\$340
Coinsurance	\$240

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is \$1,330

NOTE: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs. The **plan** would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: Individual \$1,000 /Family \$3,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes. In-network office visits & preventive care are covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	In-network: Individual \$6,850 /Family \$13,700	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of Memorial Hermann providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Memorial Hermann Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit	Not covered	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	Not covered	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$30 <u>copay</u> /visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://members.navitus.com .	Generic drugs	\$10 <u>copay</u> /prescription	Not covered	Pharmacy coverage administered by Navitus. CVS is excluded from network. Retail: 30 days supply Mail Order: 90 days supply. General questions: www.navitus.com , or 1-888-240-2211
	Preferred brand drugs	30% <u>coinsurance</u> up to \$75	Not covered	No charge for ACA-required <u>generic preventive drugs</u> (e.g., contraceptives) or a brand <u>preventive drug</u> if a generic is not medically appropriate.
	Non-preferred brand drugs	30% <u>coinsurance</u> up to \$150	Not covered	Navitus specialty drug program is mandatory. 1-855 847 3553
	<u>Specialty drugs</u>	30% <u>coinsurance</u> up to \$250	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u> for hospital facility; \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply for freestanding facility	Not covered	None
	Physician/surgeon fees	25% <u>coinsurance</u> for hospital facility; no charge for free standing facility	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Memorial Hermann Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	25% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$30 <u>copay</u> /visit	Not covered	None
	Inpatient services	25% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	Not covered	60 visits/calendar year.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined. Includes treatment of Autism.
	<u>Habilitation services</u>	\$30 <u>copay</u> /visit	Not covered	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	Not covered	60 days/calendar year.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	25% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult): 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-370-4526.

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Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



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Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- Specialist copayment \$30
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$180
Coinsurance	\$2,260

What isn't covered

Limits or exclusions \$20

The total Peg would pay is \$3,460

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist copayment \$30
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$620
Coinsurance	\$640

What isn't covered

Limits or exclusions \$70

The total Joe would pay is \$2,330

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$30
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies) Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$310
Coinsurance	\$230

What isn't covered

Limits or exclusions \$0

The total Mia would pay is \$1,540

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Your KelseyCare Plan in Action

KelseyCare 



Your Convenience

- 24/7 appointment scheduling:
Call 713-442-0000.
- Same-day and next-day appointments with primary care doctors.
- After-Hours Kelsey-Seybold Nurse Hotline – 365 days a year at 713-442-0000.
- Go to any location, see any primary care doctor or specialist, no referral required.
- No running from place to place: Physicians, lab services and routine X-ray available at **all** Kelsey-Seybold Clinic locations and an on-site Kelsey Pharmacy at many locations.
- Saturday appointments from 9 a.m. to 2 p.m. at four locations.

For help with any questions about care at Kelsey-Seybold, contact your KelseyCare Concierge:

Monday - Friday: 8 a.m. to 5 p.m.
713-442-9593

Your MyKelseyOnline

MyKelseyOnline (MKO) keeps you connected with Kelsey-Seybold 24/7. With MKO you can:

- Schedule appointments with primary care doctors and a growing number of medical specialties.
- Email your doctor's office.
- Check family medical records.
- Get most test results.

MyKelseyOnline Help Line:

Monday - Sunday: 7 a.m. to 9 p.m.

713-442-6565

MyKelseyOnline.com

Your Health









- When you choose the **KelseyCare Aetna Plan**, you select Kelsey-Seybold doctors as your healthcare providers.
- See any of the more than 500 Kelsey-Seybold physicians you want with no referral required – at any of our 27 Houston-area locations.
- Kelsey-Seybold physicians can refer to more than 7,000 affiliated medical specialists, and admit to prominent hospitals including Texas Children's Hospital, St. Luke's Health, the Texas Heart Institute, The Woman's Hospital of Texas, select Houston Methodist and Memorial Hermann facilities, and many more.
- Kelsey-Seybold uses a state-of-the-art electronic medical record, so your medical record follows you to any Kelsey-Seybold location.



KelseyCare Members Have Access to All Locations, All Doctors, and Multiple Hospital Partners

KelseyCare 



-  Kelsey-Seybold Clinics
-  Sleep Center
-  St. Luke's Community Emergency Center
-  Open Saturday, 9 a.m. to 2 p.m.
-  Ambulatory Surgery Center
-  Breast Diagnostic Center
-  Cancer Center
-  Partner Hospitals

Kelsey-Seybold Virtual Health

Efficient • Convenient • Kelsey-Seybold Quality

365 Days a Year! Days, Evenings, and Weekends



Primary & Specialty Care Video Visits

Have a real-time conversation with a Kelsey-Seybold board-certified provider.

Primary Care

50 Conditions

Adult Video Visits (18 years+)

- Cold/flu
- Ear infection
- Eczema
- GERD
- Bladder infection
- Sore throat
- Laryngitis
- Shingles
- Sprained ankle/knee
- Pink eye
- Thyroid

24 Conditions

Pediatric Video Visits (4-17 years)*

- Acne
- Allergy
- Burns
- Cold, flu, or sinus infection
- Diarrhea
- Lice
- Rash
- Cuts and scrapes
- Pink eye

Specialty Care

- Endocrinology
- Gastroenterology
- Neurology
- Dermatology
- OB/GYN
- Post-Op Orthopedic Surgery
- Post-Op Plastic Surgery
- Pulmonary Medicine
- Supportive Medicine
- Urology and more

* Video Visits are a covered benefit for many health plans and will accumulate to your MOOP. Check with your health plan for more details. Please note that controlled substances and narcotic pain medications cannot be prescribed.

Hours

Adult Monday – Friday, 8 a.m. to 9 p.m. • Pedi Monday – Friday, 8 a.m. to 5 p.m.
Saturday, Sunday, and Holidays, 10 a.m. to 4 p.m.

(Holiday Hours May Vary)

AETNA WHOLE HEALTH—MEMORIAL HERMANN

Aetna Whole Health — Memorial Hermann Accountable Care Network is a new way of looking at health care. This plan is designed to improve the quality of your care, provide a better experience for you and your family — and do it all while saving you money. You'll have access to a special network of primary care doctors,* specialists and hospitals focused on you. Led by a primary care doctor you pick, your care team will work with you to:

- ✓ **Help keep you healthy or improve your health**, not just treat you when you're sick or injured
- ✓ **Better coordinate your care** and keep tabs on your prescriptions, lab results, health history and more
- ✓ **Spot problems and build personalized care plans** to treat you
- ✓ **Encourage you to play an active and informed role** in your health and health care decisions

Tools to help you save money and manage your health

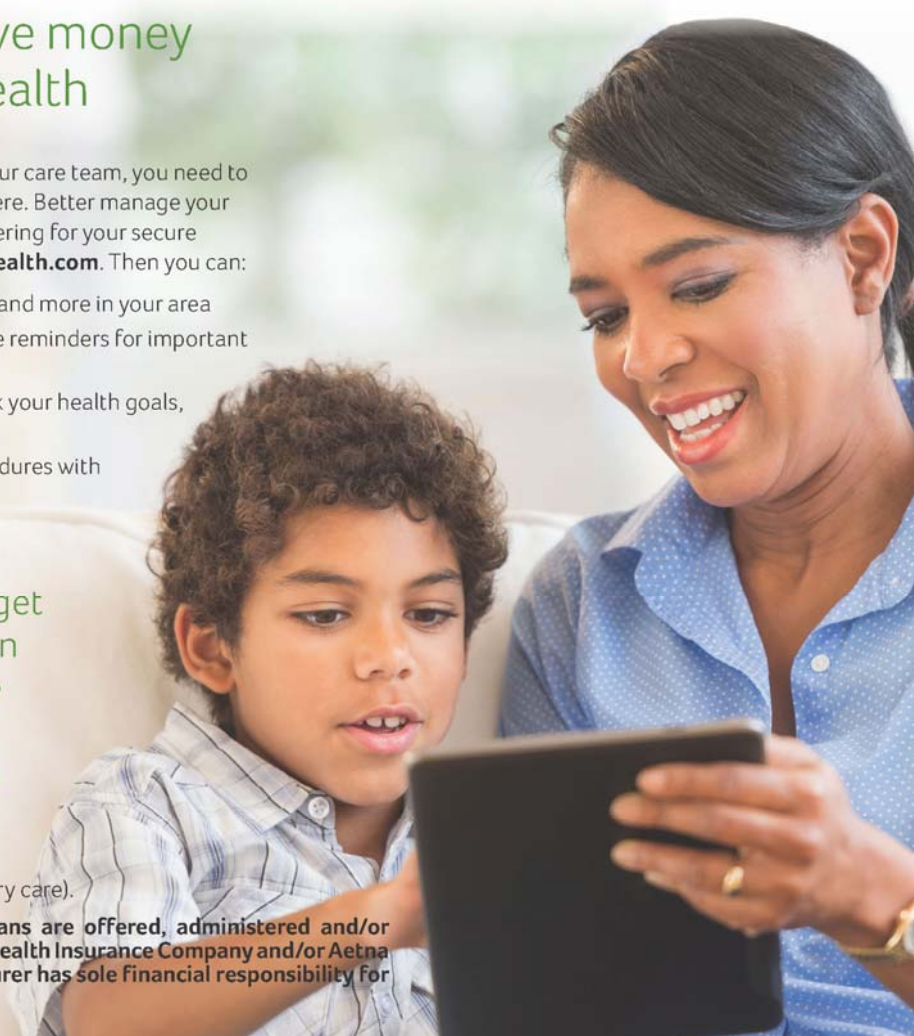
To be an active and informed member of your care team, you need to be in the know. And we can help get you there. Better manage your plan, your health and your budget by registering for your secure member website at www.myaetnawholehealth.com. Then you can:

- Search for doctors, hospitals, pharmacies and more in your area
- Check your personal health record and see reminders for important preventive screenings
- Download the iTriage® app to set and track your health goals, make appointments, and more
- Shop for the best deals on tests and procedures with Member Payment Estimator
- Review your claims and pay your bills

Tip: You'll save money and get more coordinated care when you stay in network and use Aetna Whole Health — Memorial Hermann doctors and hospitals.

*In Texas, PCP is known as physician (primary care).







Health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.



KNOW WHERE TO GO

When you get sick or injured, where do you turn?

Because of high cost and long wait times, it's usually best to save ER trips for true emergencies. When you need non-emergency care, try to visit your doctor who can treat you based on a better understanding of your medical history. If your doctor isn't available, you may be able to get the care you need at another facility with shorter wait times and for a lower cost than an ER trip.

Where to Get Care	What It Is	Visit for ...	Typical Hours and Wait Time	Cost Level
NurseLine 	NurseLine connects you with registered nurses 24/7. Aetna NurseLine: 800-556-1555	Choosing appropriate medical care, finding a doctor or hospital, understanding treatment options, achieving a healthier lifestyle, and answering medication questions.	24/7, little to no wait	No additional cost
Virtual Visit (Teladoc or KelseyCare) 	Speak with a doctor by video or phone—on your smart phone, tablet or computer (see page 9)	Routine care, like for the flu, infections, nausea, rashes, bronchitis, pink eye or shingles—especially when you're traveling or can't easily get out to see a provider	Hours vary; wait time is typically very short	\$
Retail Clinic 	Walk-in clinics found in some grocery stores and pharmacies (For Memorial Hermann ACO and Choice POS II plans ONLY)	Routine care, like for a sinus infection, minor allergic reaction, fever, rash, cut or flu shot	Includes evenings and weekends; shorter wait time	\$\$
Your Doctor 	Physician with traditional office hours	Ongoing and more personalized care based on an understanding of your medical history; annual check-ups; routine care, like for a sinus infection, minor allergic reaction, fever, rash, cut or flu shot	Traditional office hours; call ahead for appointments	\$\$
Urgent Care 	A stand-alone facility that usually has "urgent care" in the name (and NOT "ER" or "emergency")	Problems that need immediate attention but aren't life-threatening, like stitches, sprains, animal bites and x-rays	Hours include evenings, weekends and holidays; shorter wait time than ER	\$\$\$
Traditional ER 	ER attached to a hospital	All life-threatening or disabling conditions, trauma care and major injuries	Open 24 hours; long wait for non-emergency	\$\$\$\$

Finding an Urgent Care or Walk-In Clinic

Get familiar with the urgent care and walk-in clinics in your neighborhood before you need them.

- Visit aetna.com and click on **Find a Doctor**. Select **Urgent Care Facilities** or **Walk-In Clinics**.
- You can also visit concentra.com to find a Concentra urgent care clinic near you.

With the Aetna Mobile app, you can:



Set up touch ID

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aetna®



Living strong

Be proactive about your health

Prevention is the best medicine

When your doctor diagnoses a health condition early, you may be able to delay or even prevent its problems. Getting early treatment can make your condition easier to manage and put you in control of your health.

Your doctor plays a key role in your care

They may suggest:

- **Screening tests**, which find health problems before symptoms appear
- **Diagnostic tests, physicals and self-exams**, which find health problems early in their course

Your doctor may also use guidelines to recommend screenings based on your age, health, gender, lifestyle habits, family history and, if you're a woman, on whether you are preparing for pregnancy.

If you're thinking about getting a test, it's a good idea to talk with your doctor about what the test is, what it costs and what happens if you need further testing. Together, decide what's right for you.

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[aetna.com](https://www.aetna.com)

Screenings for adults

Adult screenings are intended to find health issues as you age. And many are part of your annual preventive exam.* Talk with your doctor about which screenings are right for you.

Preventive screening	Group	Recommendation
Alcohol and tobacco use	Everyone	Annually
Blood pressure	Everyone	Annually
Breast cancer	Women, aged 50 – 74	Mammogram every 2 years. Talk with your doctor to decide if you need them more often. ¹
Cervical cancer	Women, beginning at age 21	Pap smear for women 21 – 65 years of age every 3 years. Women 30 – 65 years of age may have a Pap smear and human papillomavirus (HPV) testing every 5 years. ²
Cholesterol	Everyone, beginning at age 35	Annually
Colorectal cancer	Everyone, beginning at age 45	Every 10 years. Talk to your doctor.
Depression	Everyone	Annually
Diabetes	Everyone	Glucose test every 3 years. Talk to your doctor if you are at increased risk.
Lung cancer	Current or former smokers, aged 55 – 80**	Annually
Osteoporosis	Women	For post-menopausal women; or under age 65 at increased risk for osteoporosis
Sexually transmitted diseases	Everyone	Annually
Vision	Everyone	Annually
Weight	Everyone	Annually

*Plan features and availability may vary by location and group size. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change.

**Smokers or former smokers with a 30 pack per year or more smoking history and, if a former smoker, has quit within the past 15 years.

¹U.S. Preventive Services Task Force. Final recommendation statement. Breast cancer: screening. November 2018.

²U.S. Preventive Services Task Force. Final recommendation statement. Cervical cancer: screening. August 2018.

This message is for informational purposes only, is not medical advice and is not intended to be a substitute for proper medical care provided by a physician. Aetna is not responsible for the decisions you make based on this information. If you have specific health care needs or would like more complete health information, please see your doctor or other health care provider. Health benefits and health insurance plans contain exclusions and limitations. Plan features and availability may vary by location and group size. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. For more information about Aetna® plans, refer to [aetna.com](https://www.aetna.com).



Take control of your mental health, on your terms



Sometimes life can be overwhelming, leading to worry, stress and sadness. These are common feelings with major life changes or chronic pain. But help is now just a phone call away.

With the AbleTo program, you'll get virtual, personalized support that can help you feel better. You'll learn how to better manage your emotions and improve your overall health. And your mental and physical health can improve in as little as eight weeks. Plus, this program is already included in your Aetna® membership.

The program can help you:

- Work through these normal emotions
- Know the types of changes you need to make
- Feel like you're in control of your health and life



Real help that fits your schedule

It's really easy to take the first step. In fact, you can speak to a licensed therapist within seven days or less from calling.

Then, you can attend a private, confidential session virtually, by telephone or secure video chat, right from your home. Simply schedule your sessions at your convenience, including outside normal business hours and on weekends.

So how does it work?

Support when and where you need it

Every week, you'll meet with your experienced care team (a behavioral coach and therapist). You'll work with them to set goals and learn coping strategies in two private sessions per week.

Your team will help you:

Better understand the relationship between thoughts, feelings and actions

Get ahead of challenging issues, including medical conditions, family problems or personal hurdles

Overcome obstacles that keep you from living your best life

Consider AbleTo support if you've had one of these health conditions or life changes:

- Depression, anxiety or panic attacks
- Chronic pain/pain management
- Grief and loss
- Diabetes/weight loss
- Cardiovascular disease
- Caregiver stress (child, elder or person with autism)
- Digestive health issues
- Cancer diagnosis and recovery
- Respiratory issues
- Infertility or postpartum depression
- Alcohol or substance use disorder
- Military transition

Here's what makes this program different

Unlike other telemedicine services, this program has:

- A short-term, eight-week model
- Proven effectiveness
- Therapy plus coaching
- Excellent online member experience
- Flexible scheduling

*You may be able to receive AbleTo services with no out-of-pocket cost to you, depending on your employer. With other employers, associated deductibles will apply before your out-of-pocket expenses are covered. Just call the number on your member ID card to learn more about your options.

¹AbleTo Patient Satisfaction Survey, 2019.

²AbleTo Commercial Outcomes, 2019.

Easy ways to join the program

We'll call you:

If your claims data shows you may benefit from this program, an Aetna or AbleTo representative will call you to explain how it works and why it can help you. In most cases, there's no cost to you.*

Or you can contact us:

- Visit **AbleTo.com/Aetna**
- Call **1-844-330-3648**, Monday–Friday from 9 AM–8 PM ET
- Tell your Aetna case manager you'd like to participate

95% 

of surveyed AbleTo program graduates recommend the program to others.¹

After just 8 weeks of treatment, graduates reported

50% 

improvement in overall health and symptoms of stress, anxiety and depression.²



Special delivery

Explore the Maternity Support Center

Give your baby a healthy start

If you're thinking about starting a family, already pregnant or a new parent, the Maternity Support Center is a great resource for you, your spouse or your partner.

And while it can be a very exciting time in your life, the amount of information about pregnancy and parenting can be overwhelming. So take comfort in knowing you have a trusted, reliable resource for maternity health and benefits information.



Support for all stages

You'll find helpful information for each stage of your journey. Here are just some of the highlights:

Before pregnancy

- Tips for a healthy pregnancy
- Questions to ask when starting a family
- Choosing a doctor and care team
- Understanding your benefits

During pregnancy/delivery

- What to expect in each trimester
- The importance of prenatal visits
- Signs of preterm labor
- Information on labor and delivery, breastfeeding and breast pumps

Caring for your baby at home

- First-year checklist
- Recommended immunization schedule
- Car seat safety
- Helpful sleep tips

Taking care of yourself

- What to expect at your post-pregnancy checkup
- How to quickly find answers about family health
- Understanding "baby blues" and postpartum depression
- Contraception and baby spacing

Get information when it matters most

We're here to give you the information you need during this special time. Whether you want advice on how to safely put your baby to sleep or quick tips to get through those 3 AM feedings, count on us to help.

Visit us before, during and after your pregnancy

- Go to **Aetna.com** and log in to your member website.
- Choose "Stay Healthy."
- Select "Maternity Support Center."



Questions?

Just call the number listed on your ID card.

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This material is for information only and is not a substitute for diagnosis or treatment by a physician or other health care professional. Please consult your physician before making any decisions.

Aetna.com

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90.03.525.1 (12/19)



PRESCRIPTION DRUG PROGRAMS

NAVITUS • 855-673-6504 • navitus.com

Mail Order

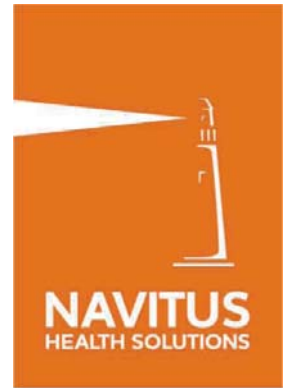
Get maintenance medications (those you take for an extended period of time) delivered to your door using NoviXus Mail Order. It is easy to start using NoviXus. You can sign up online at novixus.com. You can also call NoviXus to enroll. They can be reached toll free at 1-888-240-2211. Please allow 10 to 14 calendar days from the day you submit your order to receive your medicine(s).

Mandatory Specialty Program

Navitus SpecialtyRx helps members who are taking medicine(s) for certain chronic illnesses or complex diseases. It provides services that offer convenience and support. This program is part of your pharmacy benefit and is mandatory. Ordering new prescriptions with this pharmacy is simple. Just call a Patient Care Specialist to get started. They can be reached at 855-847-3553.

Navi-Gate Member Portal

Navi-Gate is the secure member portal for Navitus, where you can find information specific to your plan. You will need your pharmacy benefit unique ID to log into Navi-Gate for Members. Please contact Navitus Customer Care at 855-673-6504 for your pharmacy benefit unique ID. To find the portal, go to navitus.com and click on **Members**, then **Member Login**.



GOODRX

GoodRx can help you find the best deals on prescriptions in your area. Visit goodrx.com, or download the GoodRx app to use it on the go.

- ... Get instant access to the lowest prices at more than 75,000 pharmacies
- ... Find coupons and savings tips
- ... See drug side effects, pharmacy hours and locations, pill descriptions and more



Keep in mind, GoodRx shows the cash price and does not take insurance into account.





Experiencing the Navitus Difference

Navitus Health Solutions is proud to be your pharmacy benefit manager (PBM).

What Does a PBM Do?

As your PBM, Navitus is committed to providing you with robust, 360-degree support when it comes to your pharmacy benefits. You can count on us to:



Make it easier to understand your benefits with our member portal* and mobile app, where you can:

- ▶ Check your medication history
- ▶ Compare drug prices
- ▶ Locate convenient pharmacies within your network



Give you convenient access to more affordable prescriptions through our network of nationwide retail pharmacies and mail order (if applicable)



Provide timely and accurate answers to questions about your medications and pharmacy benefits



Give you the medication support you need through one simple phone call or with the click of a mouse

Experience the Navitus difference for yourself. Register for Navitus' secure member portal at www.navitus.com/members or on your plan's website, or download the mobile app today!**

*The portal is for active members only. Available features may vary by plan. Your out-of-pocket costs may vary based on drug costs, plan design and contracts.

**The mobile app, and individual features of the app, may not be available for all benefit plans managed by Navitus, or for every member of each plan. Please refer to your plan for more information. Mobile app registration is simple and secure and may require your member ID. The app is available to iOS and Android users. You must be 18 years or older and currently covered under Navitus' pharmacy benefit plan. Hover your phone's camera over the code to download the app. For mobile app account assistance, contact Customer Care: 1.855.673.6504. Open 24 hours a day, 7 days a week.





4 Ways to Save Money on Your Prescription Drug Costs

Everyone likes to save money. Here are a few strategies to help you save on your prescriptions:

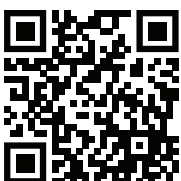
1. Consider a generic substitute, which is often less expensive than the brand-name drug.
2. Take advantage of 90-day refills, which may mean fewer trips to the pharmacy and lower copays.
3. Ask your prescriber about tablet splitting to save up to 50% on out-of-pocket costs for select medications.
4. Compare prices before you visit the pharmacy using our convenient online resources to help you save money.

The 90-Day Refill Advantage



Visit the secure member portal at www.navitus.com/members or on your plan's website, or download Navitus' mobile app* to learn more.

*The mobile app, and individual features of the app, may not be available for all benefit plans managed by Navitus, or for every member of each plan. Please refer to your plan for more information. Mobile app registration is simple and secure and may require your member ID. The app is available to iOS and Android users. You must be 18 years or older and currently covered under Navitus' pharmacy benefit plan. Hover your phone's camera over the code to download the app. For mobile app account assistance, contact Customer Care: 1.844.268.9789. Open 24 hours a day, 7 days a week.





Save More Money with Generics vs. Brands

If you choose a generic drug instead of a brand drug, you can save money. The chart below shows an example of the possible savings you can get from switching.

Are you wondering if your current brand drug has a generic substitute? Ask your prescriber or pharmacist if a generic drug would work for you in place of a brand drug you are using now.

Example of savings using generic medications:

Drug Type	Quantity	Average Cost Per Month
Brand	40 mg	\$140.00
Generic	40 mg	\$14.00

With this example, total cost savings per year is \$1,512.00!

Visit www.navitus.com or your plan's website to explore more ways you can save on your medication.





Compare Prices and Find Pharmacies Using Cost Compare

Did you know that not all pharmacies charge you the same amount for the same prescription? Look up prices before you leave for the pharmacy and save. Cost Compare lets you:

- ▶ Check Rx prices at local pharmacies
- ▶ Estimate your cost in real time
- ▶ Search based on your prescription history

Have questions about your pharmacy benefits? Answers are just a click away!

Information about your pharmacy benefit and tools to help you get your prescriptions are available at your fingertips. Visit Navitus' secure member portal at www.navitus.com or log onto your plan's website to access your:



This portal is for active members only. Available features may vary by plan. Your out-of-pocket costs may vary based on drug costs, plan design and contracts.

RETIREE MEDICAL

Retiree Rates:

Please call the Trust Office at 713-643-9300 for information regarding retiree rates.



SHORT TERM DISABILITY COVERAGE

713-643-9300 • www.benefitresourcesinc.com

Once you have met your initial eligibility requirements you will automatically be enrolled in the Short Term Disability program. In order to maintain your coverage under the Short Term Disability program, all members must work 140 hours or more per month. After being totally disabled for 7 days due to a non-work related covered accident or sickness, and if your disability is approved by the insurance company, you will be eligible to receive a weekly benefit of up to \$250, (not to exceed 70% of weekly salary). This benefit could last for up to 26 weeks as long as you continue to meet the definition of disabled. The benefit reduces to 50% at age 70. You may be considered totally disabled if you are unable to perform each of your main duties of your occupation. If you are unable to perform one or more of your main full-time duties, you may be eligible for a partial disability benefit.

Short Term Disability is not available to Retirees.

Process for Submitting Short Term Disability Claims

Short Term Disability claims can be submitted to Benefit Resources in one of the following ways:

- Traditional Claim form (faxed or mailed)

Short Term Disability Claims Timing:

- Claim receipt is formally acknowledged (via letter) within 2 business days of receipt
- Claim is immediately assigned to Dedicated STD Benefit Analyst for administration
- To expedite claim decisions, outreach for missing information is generally done via phone, fax and/or email.

Disability Claims Contact Information

Benefit Resources
8441 Gulf Freeway Suite304
Houston, TX 77017
Phone: 713-643-9300
Fax: 866-316-4794

**Electrical Medical Trust
IBEW Local Union 716**

PRIVACY NOTICE

PURPOSE OF THIS NOTICE AND EFFECTIVE DATE

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

Effective date. The original effective date of this Notice is April 14, 2003. The revised effective date is December 13, 2019.

This Notice is required by law. The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI),
- Your rights to privacy with respect to your PHI,
- The Fund's duties with respect to your PHI,
- Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Fund's privacy practices.

YOUR PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- ***At your request.*** If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it.
- ***As required by HHS.*** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
- ***To your personal representative, as more fully set forth below.***
- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI in order to carry out treatment, payment, or health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as “business associates.” We will also disclose enrollment information to contributing employers and union representatives.

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example the Fund may use information about your claims to refer into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

Disclosure to the Fund’s Trustees. The Fund will also disclose PHI to the Fund Sponsor, which is the Board of Trustees of the Painters & Allied Trades District Council No. 35 Health Fund, for purposes related to treatment, payment, and health care operations, and has amended the Fund Documents to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan may provide health information for the purpose of evaluating and processing a claim for Health Fund accident and sickness benefits; for evaluating an application for death benefits from the Pension Fund and/or Annuity Fund; or for evaluating a member’s vested status under the Pension Fund. However the Plan will obtain your written authorization before it will use or disclose any health information for these purposes.

In addition, the Fund must generally obtain your written authorization before each of the following uses or disclosures:

- Using or disclosing psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed - notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Fund is not likely to have access to or maintain these types of notes.
- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Fund receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

When You Can Object and Prevent the Fund from Using or Disclosing PHI

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose, without your written consent or authorization, is allowed under federal law if:

- The information is directly relevant to the family or friend’s involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of PHI Without Consent, Authorization or Opportunity to Object

The Fund is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. ***When required by applicable law.***
2. ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been, or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. ***Health oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud, or oversight activities of the Department of Labor).
5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that
 - The requesting party must give the Fund satisfactory assurances a good faith attempt has been made to provide you with written notice,
 - The notice provided sufficient information about the proceeding to permit you to raise an objection, and
 - No objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).
7. ***Law enforcement emergency purposes.*** For law enforcement purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and the Fund in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include the following:
 - identifying or locating a suspect, fugitive, material witness or missing person, and
 - disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
8. ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
10. ***Research.*** For research, subject to certain conditions.
11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. **Workers' compensation programs.** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Any other Fund uses and disclosures not described in this section will be made only if you provide the Fund with written authorization, subject to your right to revoke your authorization.

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

YOUR INDIVIDUAL PRIVACY RIGHTS

Following is a description of your individual privacy rights. The Fund contracts with several vendors, also called "business associates," who provide services to the Fund and services and benefits to you on the Fund's behalf. Once the Fund is notified that you choose to invoke any of the individual rights listed below, it will notify the appropriate vendor on your behalf. Because some of your PHI is maintained and used by these Business Associates to provide or process your benefits, the Fund requires that they administer certain aspects of the individual privacy rights. **You may contact the Privacy Official at the address and phone number listed below:**

Cory Crandell, Privacy Official
Electrical Medical Trust
8441 Gulf Freeway, Suite 304
Houston, Texas 77071
Phone (713) 643-9300
Fax (866) 316-4794

You May Request Restrictions on PHI Uses and Disclosures

You have the right to request that the Plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the Plan restrict the use and disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Official listed at the address listed at the end of this Notice and must state the specific restriction requested and to whom that restriction would apply.

The Fund, however, is not required to agree to your request if the Fund Administrator or Privacy Official determines it to be unreasonable.

You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure through regular means could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Official at the address listed at the end of this Notice.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) contained in a "designated record set," for as long as the Fund maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Fund will honor that request to the extent possible. You also may request a summary of your PHI. The Fund must provide the requested information within 30 days.

A single 30-day extension is allowed if the Fund is unable to comply with the deadline and if the Fund provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

You or your personal representative will be required to complete a form to request access to the PHI. You may be charged a reasonable, cost-based fee for creating or copying the PHI, or preparing a summary of your PHI. Requests for access to PHI should be made to the Privacy Official at the address listed at the end of this Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

Your PHI includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained to make decisions about you.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you for as long as the PHI is maintained. The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the Fund's Privacy Official (at the address listed at the end of this Notice). You or your personal representative will be required to complete a form to request amendment of the PHI.

The covered entity may require individuals to make requests for amendment in writing and to provide a reason to support the requested amendment. The Fund must inform individuals in advance of such requirements. The Fund may deny your request.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. Accounting requests may not be made for periods of time going back more than six years.

If you request more than one accounting within a 12-month period, the Fund may charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address listed at the end of this Notice. This right applies even if you have agreed to receive the Notice electronically.

Your Personal Representative

You may exercise your rights through a personal representative who will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider a spouse to be the personal representative of an individual covered by the Fund. In addition, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse, a parent or child may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Fund restrict information that goes to family members as described above at the beginning of this section.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

THE FUND'S DUTIES

Maintaining Your Privacy

HIPAA requires the Fund to maintain the privacy of your PHI and to provide you with notice of its legal duties and privacy practices. In addition, the Fund may not (and does not) use your genetic information that is PHI for underwriting purposes.

The Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

If material changes are made to this Notice, the Notice will be posted on the Fund's website no later than the effective date of the revision and thereafter sent in the Fund's next annual mailing.

Material changes are changes to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the United States Department of Health and Human Services, pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose “summary health information” to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

YOUR RIGHT TO FILE A COMPLAINT WITH THE FUND OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the Privacy Official at the address listed below.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services (HHS). Filing instructions are available at: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>.

The Fund will not retaliate against you for filing a complaint.

IF YOU NEED MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at National Electrical Contractors Association, IBEW Local 716 Electrical Medical Fund, by phone 1-(713) 643-9300, or by mail at 8441 Gulf Freeway, Suite 304, Houston, Texas 77017.

CONCLUSION

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

Electrical Medical Trust

General Notice of COBRA Continuation Coverage Rights

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when your group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Summary Plan Description (SPD) or contact the Fund Office at 1-(713) 643-9300.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (Exchange). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for special enrollment during the applicable period under another group health plan for which you are eligible (such as a spouse's plan).

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;

General Notice of COBRA Continued

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

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

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

Note: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the NECA IBEW Fund, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

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

The employee, or covered eligible family member must notify the Fund Office of the following qualifying events within 60 days of the event:

- Divorce or legal separation of the employee and spouse;
- Dependent child losing eligibility because of reaching age 26;
- Acquisition of a new dependent to be added to COBRA coverage such as the birth of a child, adoption or placement for adoption of a child.

Note: The Fund office will require the applicable documentation to support the qualifying event as applicable. You will be required to cooperate with the Fund office and Plan Administration to provide the necessary documentation.

General Notice of COBRA Continued

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide documentation of the Social Security determination, to the Fund office, postmarked no later than 60 calendar days after the later of the date: (a) of the disability determination by the Social Security Administration; (b) on which the qualifying event occurs; or (c) on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group

General Notice of COBRA Continued

health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

You may contact the Fund office at 1-713-643-9300, between the hours of 9:00am and 4:30pm Monday thru Friday with any questions you have regarding COBRA continuation coverage.

Electrical Medical Trust

Women's Health and Cancer Rights Act Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance as set forth in the applicable SBC will apply.

If you would like more information on WHCRA benefits, call the Fund office at 1-713-643-9300 between the hours of 9:00am and 4:30pm, Monday thru Friday.

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 July 31, 2020. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	MINNESOTA – Medicaid
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://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
IOWA – Medicaid and CHIP (Hawki)	MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	MONTANA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	NEBRASKA – 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://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	NEVADA – 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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
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: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - 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://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	TEXAS – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	UTAH – Medicaid and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	VERMONT– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	WASHINGTON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	WISCONSIN–Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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 July 31, 2020, 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.

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