NOTICES

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN)

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE. The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare and Medicaid (CMS) for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the HR Solutions Center at (719) 385-5125.

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. You can get another copy of this Notice from the HR Solutions Center. A full copy of the Privacy Notice is also available in this benefit guide.

AVAILABILITY OF SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENTS

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. In accordance with law, our plan provides you with a Summary of Benefits and Coverage or SBC as a way to help you understand and compare medical plan benefits. The SBC summarizes and compares important information including, what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC. To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, and the Uniform Glossary that defines many terms in the SBC, go to https://coloradosprings.gov/human-resources or for a paper copy, contact the HR Solutions Center at (719) 385-5125.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTIFICATION

The United States Congress passed the Women's Health and Cancer Rights Act of 1998. This act affects both group and individual health plans that provide medical/surgical coverage for a mastectomy. This act requires these health plans to provide coverage for reconstructive surgery and related services that may follow a mastectomy.

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstructive surgery of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses; and
- Physical complications for all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles, co-payment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by the City of Colorado Springs. Please refer to the Medical Benefits Plan for further benefit coverage information. If you have any questions about the Plan provisions, please call AmeriBen Solutions, the claims administrator, at (800) 786-7930.

HIPAA SPECIAL ENROLLMENT NOTICE

IMPORTANT: After the open enrollment period is completed, (or, if you are a new hire, after your initial enrollment election period is over), generally you will not be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment Event, or a Mid-year Permitted Election Change Event as outlined below:

Special Enrollment Event:

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **request enrollment within 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within **request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact HR Solutions Center at HR@coloradosprings.gov or (719) 385-5125

NOTICE OF NEWBORN & MOTHERS HEALTH PROTECTION ACT

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48-hours following a vaginal delivery, or less than 96-hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician or health care practitioner, after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. If you have questions about this Notice, contact the HR Solutions Center at (719) 385-5125.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

The City of Colorado Springs self-funded group health plan including medical, dental, vision, FSA benefits (hereafter referred to as the "Plan"), is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI) and to inform you about the

Plan's legal duties and privacy practices with respect to Protected Health Information.

PHI use and disclosure by the Plan is regulated by the Federal law, Health Insurance Portability and Accountability Act, commonly called HIPAA. You may find these rules in Section 45 of the Code of Federal Regulations, Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations. The Plan will abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not City of Colorado Springs as an employer — that's the way the HIPAA rules work. Different policies may apply to other City of Colorado Springs programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

  The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for

underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with the City of Colorado Springs

Here's how additional information may be shared between the Plan and the City of Colorado Springs, as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose "summary health information" to City of Colorado Springs, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer, may disclose to the City of Colorado Springs information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.
- In addition, you should know that the City of Colorado Springs cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the City of Colorado Springs from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other permitted uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is also permitted to use or disclose your health information without your written authorization for the following activities:

1. Required by law	Disclosures otherwise required by law.
2. Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
3. Proof of Immunization	Disclosures to a school about an individual who is a student or prospective student of the school if the protected health information is limited to proof of immunization.
4. Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has

	escaped from prison or from lawful custody
5. Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
6. Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
7. Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
8. Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
9. Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
10. Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
11. Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
12. Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws

13. Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
14. HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Although the Plan does not routinely obtain psychotherapy notes, generally, an authorization will be required by the Plan before the Plan will use or disclose psychotherapy notes about you. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you. The Plan generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (meaning a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of Protected Health Information if the Plan receives direct or indirect financial remuneration (payment) from the entity to which the PHI is sold. The Plan does not intend to engage in fundraising activities.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a

restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information.
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health

information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information) In addition, your right to an accounting of disclosures to a health

oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your

- request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Breach Notification

If a breach of your unsecured protected health information occurs, the Plan will notify you.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2021. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice emailed to you or mailed to your home address.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, you may send a written complaint to the Plan's Privacy Officer, 30 South Nevada Avenue, Suite 301, Colorado Springs, CO 80903; or you may file a complaint with the Secretary of the Department of Health Human Services, Huber H. Humphrey Building, 2000 Independence Avenue SW., Washington, DC 20211

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Privacy Officer, 30 South Nevada Avenue, Suite 301, Colorado Springs, CO 80903.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

The medical plans offered by the City of Colorado Springs do not require you to select a primary care physician (PCP). You have the ability to visit any in-network (or non-

network) health care provider; however, payment by the Plan may be less for the use of a non-network provider.

Designation of a Primary Care Provider (PCP):
You do not need prior authorization (pre-approval) from the Plan, the Claims Administrator, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from a health care professional in the network who specializes in obstetrics and/or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or for procedures for making referrals.
For a list of participating health care professionals who specialize in obstetrics and/or gynecology, visit www.mycastlighthealth.com.

NOTICES REGARDING THE "REACH YOUR PEAK" EMPLOYEE WELLNESS PROGRAM

REACH YOUR PEAK (RYP) is a voluntary wellness program available to all City of Colorado Springs employees enrolled in the medical plan. Administered by HealthYou, LLC, it is designed to promote health and/or prevent disease. The program is administered according to applicable federal rules regarding employer-sponsored wellness programs that seek to improve overall health to minimize the potential for disease and infirmity. As such, it is compliant with the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act (HIPAA), as amended or applicable, among others.

As a voluntary participant in the program, you must complete a biometric screening, which includes a blood test for cholesterol (High-Density and Low-Density Lipoproteins, aka HDL and LDL respectively, and Cholesterol Risk Ratio), Triglycerides, Blood Glucose, and other routine medical checks such as measuring body weight, Body Mass Index (BMI), Waist Circumference (WC), and Blood Pressure (BP). As a participant in the wellness program, you may also choose to complete a voluntary HealthYou Goal Path Assessment that asks a series of questions about your lifestyle and activities. Although it is in your best interest to do so, you are not required to complete the "Goal Path Assessment;" however, you are required to complete the biometric health screening.

Employees who choose to participate in the wellness program will receive an annual incentive of $400 (USD) for participating in the wellness program's activities, such as completing the HealthYou "Goal Path Assessment," participating in the biometric health screening, health coaching sessions, wellness activities and challenges during the RYP program period from January 1st through November 30th, 2024, with an incentive payout projected to occur during the second pay date in December. Employees will be eligible to receive the $400 financial incentive award by participating in any combination of these wellness program activities to accumulate 400 points. Please be advised that the $400 annual incentive is subject to applicable federal, state, and local taxes.

If you are unable to participate in any of the wellness program activities, there are other means available by which you may earn the incentive. You may be entitled to reasonable accommodation and/or the establishment of an alternative standard. You may request reasonable accommodation and/or an alternative standard by contacting HealthYou at (719) 314-3535 or support@myhealthyou.com.

If you choose these wellness activities, the results from your biometric screening and the information from your HealthYou "Goal Path Assessment" will be used to provide information to help you (or your spouse) better understand your current health and potential health risks. The results may also be used to offer you services from HealthYou through the REACH YOUR PEAK (RYP) wellness program, such as health coaching or participating in community-sponsored programs. You also are encouraged to share your results or concerns with your own Primary Care Physician (PCP).

PROTECTIONS FROM DISCLOSURE OF PERSONAL MEDICAL INFORMATION

Through the employer-sponsored wellness program being offered by the City of Colorado Springs, both HealthYou, LLC, and the REACH YOUR PEAK (RYP) program is required by law to maintain the privacy and security of your individual, personally identifiable health information. Although HealthYou, the wellness program, and the City may use aggregate (deidentified) information it collects to design a program based on identified health risks in the workplace, the City's group health plan, HealthYou, and the REACH YOUR PEAK (RYP) Employee Wellness Program will never disclose any of your personal information publicly or to your employer, except as necessary to respond to a request from you for reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that identifies you in connection with the wellness program will neither be provided to your employer nor to any employer representative and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent explicitly authorized by you or permitted by law to carry out specific activities related to the wellness program. You will not be asked and/or required to waive the confidentiality of your protected health information as a condition of participating in the wellness program or receiving the financial incentive. Anyone who receives your information for the purpose of providing you services as part of the wellness program will always abide by these same confidentiality requirements.

The only individual(s) who will have access to your personally identifiable health information are your assigned health coach and designated health promotion / disease management vendors affiliated with your medical plan to provide you with appropriate services under the wellness program.
Information stored electronically will be encrypted, and information you provide as part of the wellness program will neither be divulged to the City of Colorado Springs nor used in making any employment decisions.

Appropriate precautions have been taken to avert any potential for a data breach; however, in the unlikely event that a data breach does occur involving information you've provided in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment based on race, color, religion, sex, national origin, age, disability, genetic, nor the medical information you provide as part of your voluntary participation in the wellness program, nor may you be subject to retaliation if you choose not to participate.

NOTICE REGARDING SPOUSE PARTICIPATION IN THE "REACH YOUR PEAK" WELLNESS PROGRAM

REACH YOUR PEAK (RYP) is a voluntary wellness program which has been extended to the eligible and covered spouses of all City of Colorado Springs employees enrolled in the medical plan. Administered by HealthYou, LLC, it is designed to promote health and/or prevent disease. The program is administered according to applicable federal rules regarding employer-sponsored wellness programs that seek to improve overall health to minimize the potential for disease and infirmity. As such, it is compliant with the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act (HIPAA), as amended or applicable, among others.

Spouses who are covered dependents under the employee's employer-sponsored medical plan may voluntarily participate to earn an additional $100 (USD) incentive. Spouses who choose to participate must complete a biometric health screening, which includes a blood test for cholesterol (High-Density and Low-Density Lipoproteins, aka HDL and LDL respectively, and Cholesterol Risk Ratio), Triglycerides, Blood Glucose, and other routine medical checks such as measuring body weight, Body Mass Index (BMI), Waist Circumference (WC), and Blood Pressure (BP) by the indicated program deadline in order to earn the required 100 points. Any other wellness program activities, such as tobacco cessation, webinars, or other health programs, are optional. Please be advised that the $100 annual incentive is subject to applicable federal, state, and local taxes.

If you have questions or concerns regarding this notice, or about protections against employment discrimination and/or retaliation, please contact HealthYou at (719) 314-3535 or support@myhealthyou.com.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Colorado Springs and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug

coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of Colorado Springs has determined that the prescription drug coverage offered by the City of Colorado Springs is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current City of Colorado Springs coverage may be affected. If you do decide to join a Medicare drug plan and drop your current City of Colorado Springs coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

Contact the person listed below for further information**. NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Colorado Springs changes. You also may request a copy of this notice at any time. For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 14, 2023
Name of Entity/Sender: City of Colorado Springs
Contact--Position/Office: City HR Solutions Center
Address: 30 South Nevada, Suite 301, Colorado Springs, CO
Phone Number: 719-385-5125

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service.

This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your plan’s deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

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

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

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

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

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

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

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would

pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact https://www.cms.gov/nosurprise/consumers or call 1-800-985-3059 to obtain more information and complaints.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit State Balance-Billing Protections | Commonwealth Fund for more information about your rights under applicable state laws.

Colorado Family and Medical Leave Insurance (FAMLI) - Written Employee Notice

Notice posting date: 09/27/2022

Beginning in 2024, Colorado's paid Family and Medical Leave Insurance (FAMLI) program will provide paid time off when you face life circumstances that pull employees away from their jobs - like growing your family or caring for a loved one with a serious health condition.

The City of Colorado Springs ("City") has decided NOT to participate in the Colorado FAMLI program, per a vote of our governing body on **September 27, 2022**. This notice explains how the vote affects City employees' rights and benefits.

What does the FAMLI program provide?

Under the FAMLI program, covered employees may take up to twelve (12) weeks of paid aggregate family/medical leave (up to sixteen (16) weeks for pregnancy complications) in a twelve (12) month period for:

- Birth, adoption, placement, care of a new child during first year after birth, adoption, or foster care
- Care for a family member with a "serious health condition" (including pregnancy)
- An employee's own serious health condition
- Exigency leave (active-duty military; post deployment or death); or
- "Safe" leave (employee or employee's family member is the victim of domestic abuse, stalking or sexual assault/abuse)

What leave benefits does the City provide?

While the City has voted to decline ALL participation in the state-run FAMLI program and does not currently offer a paid family and medical leave plan, the City provides the following paid and unpaid leave benefits. Please refer to the City's Civilian and Sworn Policies and Procedures Manuals (PPM) for more information.

- Sick Leave
- Healthy Families & Workplaces Act (HFWA) leave, including public health emergency leave and “safe” leave due to domestic abuse, sexual assault, or harassment
- Sick Leave Advance
- Sick Leave Without Pay
- Short-Term Disability (STD) – Employee voluntarily elects and pays the premiums. Benefits are paid up to 60% of weekly wage or $1,250 per week maximum, for up to 25 weeks. If PERA vested, benefits will be paid up to a maximum of 7 weeks. FAMLI benefits will run concurrently with STD benefits.
- Long-Term Disability (LTD) – Employee voluntarily elects and pays the premiums. Benefits are paid up to 66.67% of monthly rate or $7,500 per month maximum.
- Family and Medical Leave Act (FMLA)/Family Care Act (FCA) leave – Unpaid, job-protected leave benefits will run concurrently with FAMLI.
- Americans with Disabilities Act (ADA) – Unpaid, job-protected leave as an accommodation will run concurrently with FAMLI.
- Pregnant Workers Fairness Act – Unpaid, job-protected leave as an accommodation will run concurrently with FAMLI.
- Domestic Abuse Leave
- Workers’ Compensation
- Vacation
- Vacation Buy Program
- Vacation Donation Program
- Holidays
- Personal Holiday
- Leave of Absence (Unpaid)
- Additional leaves – please see the PPM for more information

What the employee does not receive if the City opts out?	What the City provides
Job protection after 180 days vs 12 months under FMLA if eligible	Approved time off using accrued leave or other paid/unpaid leave policies
Ability to take FAMLI time off upon hire vs after 12 months under FMLA unless the employee voluntarily elects FAMLI coverage	Accrued leave and leave policies which allow for extended time off

Paid time off to care for family members vs using accrued leave however can supplement accrued leave to 'make whole' unless the employee voluntarily elects FAMLI coverage	Accrued leave, Vacation Buy, Vacation Donation and Sick Leave Advance policies which allow for the employee to have extended leave with pay. Additional unpaid leave policies available to allow time away from the job to care for family members or other personal reasons are available to employees
Additional 4 weeks off due to pregnancy vs 12 under FMLA unless the employee voluntarily elects FAMLI coverage or qualifies for other accommodations	Flexible work arrangements that may include a temporary reduction in hours or unpaid leave time is available
Potential of up to 24 weeks of time off due to expanded definition of 'Family' under FAMLI vs FMLA	Unpaid leave policies are available for extended period of time to take care of family members or other personal reasons

Short Term Disability vs FAMLI	
STD	**FAMLI**
If not PERA vested, or in the PERA Defined Contribution Plan, up to 25 weeks If PERA vested up to 7 weeks	Up to 12 weeks, or 16 weeks if pregnancy-related
60% of weekly earnings, max of $1,250	37% - 90% of weekly earnings, max of $1,100
Employee only	Employee and family members
Premium varies based on age and salary	0.45% of weekly salary, City Employee average is approximately $32/month
Voluntary Program, employee pays 100% of the premiums	Mandated if Employer Participates, otherwise Employee can opt in on their own

What are my options for paid and unpaid leave?

You still have the choice to voluntarily opt into FAMLI as an individual: As a Colorado worker, you have the right to opt into FAMLI benefits pursuant to Colorado Revised Statute 8-13.3-514 C.R.S You can self-elect coverage and submit your employee premium along with your wage data every quarter directly to the FAMLI Division by creating an account at famli.colorado.gov once the online FAMLI portal is live. If you create your own online account, you will need the FEIN # of your employer. Please reach out to your HR representative for assistance and to review your options. You can learn more about the FAMLI program by contacting the Division at CDLE_FAMLI_info@state.co.us or by visiting famli.colorado.gov.

You could be eligible for FMLA: The Family and Medical Leave Act (FMLA) is a federal program that provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. It also requires that their group health benefits be maintained during the

leave. FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees. Employees of the City who are eligible for FMLA job protection include employees who have worked for the City for a minimum of twelve (12) months and 1,250 hours.

FMLA-eligible employees are entitled to leave for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or
- Twenty-six (26) workweeks of leave during a single twelve (12) month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave).

COLORADO
Family and Medical Leave Insurance Program (FAMLI)
Department of Labor and Employment

2023 FAMLI Program Notice

Deductions from Employee Wages start January 1, 2023

- The employee share of FAMLI premiums is set at 0.45% of employee wages through 2024. For 2025 and beyond, the director of the FAMLI Division sets the premium rate according to a formula based on the monetary value of the fund each year. Employers with ten or more employees must also contribute an additional 0.45% of wages for a total of 0.9%, but employers with nine or fewer employees are only responsible for the 0.45% employee share.
- Employers are not required to deduct FAMLI contributions from employees' wages. However, **starting in 2023, employers are allowed to deduct up to 0.45% from employees' wages for FAMLI contributions.** For every $100.00 an employee makes, an employer may deduct up to $0.45.

Benefits start January 1, 2024

- Starting in 2024, paid family and medical leave benefits are available to most Colorado employees who have a qualifying condition and who earned $2,500 over the previous year for work performed in Colorado.
- The qualifying conditions for paid family and medical leave are:
  - Caring for a new child during the first year after the birth, adoption, or foster care placement of that child.
  - Caring for a family member with a serious health condition.
  - Caring for your own serious health condition.
  - Making arrangements for a family member's military deployment.
  - Obtaining safe housing, care, and/or legal assistance in response to domestic violence, stalking, sexual assault, or sexual abuse.
- Covered employees are entitled to up to 12 weeks of paid family and medical leave per year. Individuals with serious health conditions caused by pregnancy complications or childbirth complications are entitled to up to 4 more weeks of paid family and medical leave per year for a total of 16 weeks.
- Leave may be taken continuously, intermittently, or in the form of a reduced schedule.
- Leave will be paid at a rate of up to 90% of the employee's average weekly wage, based on a sliding scale. Employees may estimate their benefits by using the benefits calculator available at famli.colorado.gov.
- You don't have to work for your employer a minimum amount of time in order to qualify for paid family and medical leave benefits.
- If FAMLI leave is used for a reason that also qualifies as leave under the federal FMLA, then the leave will also count as FMLA leave used.
- Employees may choose to use sick leave or other paid time off before using FAMLI benefits, but they are not required to do so.
- Employers and employees may mutually agree to supplement FAMLI benefits with sick leave or other paid time off in order to provide full wage replacement.

Filing Claims

- Employees will not be able to file for benefits until the last quarter of 2023. Benefits will be available starting January 2024. Instructions on how to apply for benefits will be available on famli.colorado.gov in the last quarter of 2023.
- Employees or their designated representatives apply for FAMLI benefits by submitting an application, along with required documentation, directly to the FAMLI Division. Employers cannot make employees apply for FAMLI benefits.

- Applications may be submitted in advance of the absence from work, and in some circumstances, they may be submitted after the absence has begun.
- Approved applications will be paid by the FAMLI Division within two weeks after the claim is properly filed, and every two weeks thereafter for the duration of the approved leave.
- Employees can appeal claim determinations to the FAMLI Division.
- Individuals who attempt to defraud the FAMLI program may be disqualified from receiving benefits.

Job protection and continued benefits

- Employers must maintain health care benefits for employees while they are on FAMLI leave, and both the employer and the employee remain responsible for paying for those benefits in the same amounts as before the leave began.
- An employee who has worked for the employer for at least 180 days is entitled to return to the same position, or an equivalent position, upon their return from FAMLI leave.

Retaliation, Discrimination, and Interference Prohibited

- Employers may not interfere with employees' rights under FAMLI, and may not discriminate or retaliate against them for exercising those rights.
- Employees who suffer retaliation, discrimination, or interference may file suit in court, or may file a complaint with the FAMLI Division.

Other Important Information

- An employer may offer a private plan that provides the same benefits as the state FAMLI plan, and imposes no additional costs or restrictions. Private plans must be approved by the FAMLI Division.
- Employees and employers are encouraged to report FAMLI violations to the FAMLI Division.

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

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**

Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)