

# Benefits Notices Templates for Large Employers

**FOR EMPLOYERS WITH 50+ EMPLOYEES**



# Benefits Notices Templates for Large Employers

## For Employers with 50+ Employees

The following is a list of key model benefits notices that may apply to group health plans under federal law. These model notices are for **general reference purposes** only—your company may be exempt from certain requirements and/or subject to additional obligations under your state's laws. As changes in the law, rules, regulations, and interpretations can occur, please contact a knowledgeable attorney to review any forms or documentation you intend to distribute to employees.

### Table of Contents

- [Summary of Material Modifications](#)\* (SMM) and [Summary of Material Reduction in Covered Services or Benefits](#)\*
- [Health Insurance Exchange Notice](#)\*
- [Disclosure of Grandfathered Status](#)\*
- [Notice of Patient Protections](#)\*
- [Notice of Special Enrollment Rights](#)\*
- [Wellness Program Disclosure](#)\*
- [Notice of Privacy Practices](#)\*
- [Women's Health & Cancer Rights Act \(WHCRA\) Notices](#)\*
- [Mental Health Parity & Addiction Equity Act \(MHPAEA\) Disclosure](#)\*
- [Employer Children's Health Insurance Program \(CHIP\) Notice](#)
- [Michelle's Law Notice](#)\*
- [Newborns' and Mothers' Health Protection Act Notice](#)
- [Medicare Part D Creditable Coverage Disclosure Notice](#)\* or [Medicare Part D Non-Creditable Coverage Disclosure Notice](#)\*
- [Genetic Information Nondiscrimination Act \(GINA\) Disclosures](#)
- [ADA Notice Regarding Wellness Program](#)\*
- [ACA Section 1557 Nondiscrimination Notice & Taglines](#)\*
- [Uniformed Services Employment and Reemployment Rights Act \(USERRA\) Notice](#)
- [General Notice of COBRA Rights](#)\*
- [COBRA Election Notice](#)\*
- [Notice of Unavailability of COBRA Coverage](#)\*
- [Notice of Underpayment of COBRA Premium](#)\*
- [Notice of Early Termination of COBRA Coverage](#)\*
- [General FMLA Notice](#)
- [Notice of FMLA Eligibility and Rights & Responsibilities](#)\*
- [FMLA Designation Notice](#)\*

**\*Important Note:** Customization will be required before distribution of the model notices marked above. While some customization will be minimal (e.g., inserting applicable contact information), employers and plan administrators are advised to tailor each notice to meet their particular company's needs prior to distribution.

## Summary of Required Benefits Notices for Employers with 50+ Employees

Employee Retirement Income Security Act (ERISA) Notices		
Notice	Provide To	When Due
<a href="#">Summary of Material Modifications (SMM)</a> and <a href="#">Summary of Material Reduction in Covered Services or Benefits</a>	Group health plan participants	No later than 210 days after the end of the plan year in which the change is adopted, for material changes to the plan that do not result in a material reduction in covered services or benefits  Within 60 days of adoption of a material reduction in covered services or benefits (alternatively, notice may be provided with plan information that is furnished at regular intervals of not more than 90 days, if <a href="#">certain conditions</a> are met)
Health Care Reform Notices		
Notice	Provide To	When Due
<a href="#">Health Insurance Exchange Notice</a>	All new employees	Within 14 days of an employee's start date
<a href="#">Disclosure of Grandfathered Status</a>	Group health plan participants & beneficiaries	In any plan materials for a grandfathered group health plan, provided to a participant or beneficiary, describing the plan benefits
<a href="#">Notice of Patient Protections</a>	Group health plan participants	Whenever a participant in a non-grandfathered group health plan requiring or providing for the designation of a participating primary care provider is furnished a Summary Plan Description (SPD) or other similar description of plan benefits

**Health Insurance Portability and Accountability Act (HIPAA) Notices**

Notice	Provide To	When Due
<a href="#">Notice of Special Enrollment Rights</a>	Employees eligible to enroll in the employer's group health plan	At or before the time an employee is initially offered the opportunity to enroll in the plan
<a href="#">Wellness Program Disclosure</a>	Group health plan participants & beneficiaries eligible to participate in a <a href="#">health-contingent wellness program</a>	<p>In all plan materials that describe the terms of a health contingent wellness program (both activity-only and outcome-based wellness programs). For outcome-based wellness programs, this notice must also be included in any disclosure of an individual's failure to satisfy an initial outcome-based standard.</p> <p>If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.</p>
<a href="#">Notice of Privacy Practices</a>  <b>Note:</b> Fully insured group health plans that do not create or receive protected health information (PHI)— other than summary health and enrollment information—are not required to develop this notice	Individuals enrolled in the plan	<p>Fully insured group plans that create or receive PHI in addition to summary health information and enrollment information must maintain a notice and provide it to any person upon request. Other health plans must provide the notice as follows:</p> <p><b>To new enrollees:</b> At the time of enrollment</p> <p><b>To individuals covered by the plan:</b> Within 60 days of a material revision to the policy (special rules apply for website notice postings)</p> <p>A health plan also must notify individuals covered by the plan of the availability of, and how to obtain, the notice at least once every 3 years, and make it available to any person who asks for it.</p>

**Special Health Care Notices**

Notice	Provide To	When Due
<a href="#">Women's Health &amp; Cancer Rights Act (WHCRA) Notices</a>	Group health plan participants & beneficiaries	Upon enrollment in a plan that provides coverage for medical and surgical benefits related to a mastectomy, and annually thereafter
<a href="#">Mental Health Parity &amp; Addiction Equity Act (MHPAEA) Disclosure</a>	Any current or potential group health plan participant, beneficiary, or contract provider	<p>Upon request for a plan offering medical/surgical benefits and mental health or substance use disorder benefits</p> <p><b>Note:</b> Certain plans that are <a href="#">exempt from the MHPAEA requirements</a> based on increased cost may be subject to <a href="#">alternative disclosure rules</a></p>

### Special Health Care Notices (continued)

Notice	Provide To	When Due
<a href="#">Employer Children's Health Insurance Program (CHIP) Notice</a>	All employees in states with group health plan premium assistance	Annually before the start of each plan year (may be provided with enrollment packets, open season materials, or the SPD)
<a href="#">Michelle's Law Notice</a>	Group health plan participants	With any notice regarding a student status certification requirement under a plan that bases coverage eligibility on student status (and that provides dependent coverage <a href="#">beyond age 26</a> )
<a href="#">Newborns' and Mothers' Health Protection Act Notice</a>	Group health plan participants	Must be included in the SPD for a plan providing maternity or newborn infant coverage
<a href="#">Medicare Part D Creditable Coverage Disclosure Notice</a> or <a href="#">Medicare Part D Non-Creditable Coverage Disclosure Notice</a>	<a href="#">Medicare-eligible individuals</a> (including certain dependents) who are offered prescription drug coverage under the employer's group health plan	Annually prior to October 15th, upon request, and at various <a href="#">other times</a> as required under the law  An <a href="#">online disclosure</a> to the Centers for Medicare & Medicaid Services (CMS) is also required annually, no later than 60 days from the beginning of a plan year, and at certain <a href="#">other times</a>
<a href="#">Genetic Information Nondiscrimination Act (GINA) Disclosures</a>	Entities from whom requests for health-related information are made	Whenever an applicant or employee is sent to a health care provider for a medical examination by an employer with 15 or more employees  An additional "warning" is required when requests for health-related information are made by employers with 15 or more employees (e.g., to support an employee's request for reasonable accommodation or a request for sick leave), but only if the request for medical documentation is made in a way that is likely to result in receipt of genetic information
<a href="#">ADA Notice Regarding Wellness Program</a>	All employees offered participation in a wellness program that collects employee health information	Must be provided before the employee provides any health information, with enough time for the employee to decide whether to participate in the program

### Special Health Care Notices (continued)

Notice	Provide To	When Due
<a href="#">ACA Section 1557 Nondiscrimination Notice &amp; Taglines</a>	Beneficiaries, enrollees, applicants, and members of the public that participate (or may participate) in certain health programs or activities that receive federal financial assistance	<p>Notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services are generally required to be posted in: (1) significant publications and communications targeted to beneficiaries, enrollees, applicants, and members of the public; (2) conspicuous physical locations where an entity interacts with the public; and (3) a conspicuous location on the entity's website, accessible from the homepage.</p> <p><b>Note:</b> The content requirements are modified for small-sized significant communications (such as postcards).</p>
<a href="#">Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice</a>	All employees	May be posted where employers customarily place notices for employees

### Consolidated Omnibus Budget Reconciliation Act (COBRA)\*\* Notices

Notice	Provide To	When Due
<a href="#">General Notice of COBRA Rights</a>	Covered employees & their spouses	<p>Within the first 90 days of coverage</p> <p><b>Note:</b> This requirement may be satisfied by including the general notice in the SPD and giving it to the employee and spouse within the first 90 days of coverage</p>
<a href="#">COBRA Election Notice</a>	Covered employees, spouses, & dependent children who are <a href="#">qualified beneficiaries</a>	<p>Generally within 14 days after receiving notice of a qualifying event</p> <p><b>Note:</b> If the employer is also the plan administrator, the notice must be provided not later than 44 days after the date the qualifying event occurred or the date of loss of coverage due to the qualifying event (if the plan provides that COBRA coverage starts on the date of loss of coverage)</p>
<a href="#">Notice of Unavailability of COBRA Coverage</a>	Individuals who have submitted a Notice of Qualifying Event who are determined ineligible for COBRA	Generally within 14 days after receiving notice of a qualifying event, unless the employer is also the plan administrator (see above under "COBRA Election Notice")
<a href="#">Notice of Underpayment of COBRA Premium</a>	Qualified beneficiary who makes timely payment in an amount not significantly less than the amount due for a period of COBRA coverage	A plan must provide notice and grant a reasonable period of time (no less than 30 days) for payment of a deficiency, where the incorrect amount is not significantly less than the amount due, before taking action to terminate coverage

**Consolidated Omnibus Budget Reconciliation Act (COBRA)\*\* Notices (continued)**

Notice	Provide To	When Due
<a href="#">Notice of Early Termination of COBRA Coverage</a>	Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage	As soon as practicable following the plan administrator's determination that COBRA coverage will terminate

**Family and Medical Leave Act (FMLA)\*\*\* Notices**

Notice	Provide To	When Due
<a href="#">General FMLA Notice</a>	All employees	<p>Must be posted prominently where it can be readily seen by employees and applicants, even if no employees are eligible for FMLA leave</p> <p>The notice must also be provided to each eligible employee by including it in employee handbooks or other written guidance concerning employee benefits or leave rights (if such written materials exist), or by distributing a copy to each new employee upon hiring, but only if the employer has any FMLA-eligible employees</p>
<a href="#">Notice of FMLA Eligibility and Rights &amp; Responsibilities</a>	Employees requesting FMLA leave	<p>Generally within 5 business days of the employee notifying the employer of the need for FMLA leave (or when the employer acquires knowledge that an employee's leave may be for an FMLA-qualifying reason)</p> <p><b>Note:</b> <a href="#">Written notice</a> of any change in the employee's eligibility status, or the specific information provided by the notice of rights and responsibilities, is also required (generally within 5 business days)</p>
<a href="#">FMLA Designation Notice</a>	Employees requesting FMLA leave	<p>Generally within 5 business days after the employer has enough information to determine whether the leave is being taken for an FMLA-qualifying reason (if leave is not designated as FMLA-qualifying, the notice may be in the form of a simple written statement)</p> <p><b>Note:</b> <a href="#">Written notice</a> of any change to the information provided in the designation notice is also required, within 5 business days of receipt of the employee's first notice of the need for leave subsequent to any change.</p>

\*\* Under [COBRA](#), this includes **both** full- and part-time employees. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full time. Companies that are part of a controlled group or which have common ownership interests should contact the U.S. Department of Labor or a knowledgeable attorney for issues related to headcount.

\*\*\* Private sector employers who employ 50 or more employees for at least 20 workweeks in the current or preceding calendar year are [subject to FMLA](#). An employee must work at a location where the company employs 50 or more employees **within 75 miles** (and meet certain other requirements with respect to time worked) to be eligible for FMLA leave. Any employee whose name appears on the employer's payroll will be considered employed each working day of the calendar week, and must be counted regardless of whether any compensation is received for the week.

**Note:** The information and materials herein are provided for general information purposes only and have been taken from sources believed to be reliable, but there is no guarantee as to its accuracy.

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**Provided by:**



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**SUMMARY OF MATERIAL MODIFICATIONS/SUMMARY OF MATERIAL  
REDUCTION IN COVERED SERVICES TO [NAME OF WELFARE BENEFIT  
PLAN]**

**This Summary of Material Modifications (“SMM”) modifies some of the information contained in the Summary Plan Description (“SPD”) for the [Name of Welfare Benefit Plan] (the “Plan”) that describes the Plan as of [Date] .**

Note: In the event of any discrepancy between this SMM and the Summary Plan Description, the provisions of this SMM will govern.

**Modification(s)**

Important changes under the Plan will go into effect on [Effective Date] . In particular, coverage for [Types of Benefits] shall be amended as follows:

[Nature of Changes]

If you have questions about these changes in benefits, please contact your Plan Administrator at [Phone Number of Plan Administrator] .

## **HEALTH INSURANCE EXCHANGE NOTICE**

*For Employers Who Offer a Health Plan to Some or All Employees*

# **New Health Insurance Marketplace Coverage Options and Your Health Coverage**

## **PART A: General Information**

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

### **What is the Health Insurance Marketplace?**

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

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

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

### **Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.<sup>1</sup>

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

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

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact

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

## PART B: Information About Health Coverage Offered by Your Employer

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

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

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

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

- With respect to dependents:

We do not offer coverage.

We do offer coverage. Eligible dependents are:

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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

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

**Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? [mm/dd/yyyy] (Continue)

**No** (STOP and return this form to employee)

**14. Does the employer offer a health plan that meets the minimum value standard\*?**

Yes (Go to question 15)  No (STOP and return form to employee)

**15. For the lowest-cost plan that meets the minimum value standard\* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.**

a. How much would the employee have to pay in premiums for this plan? \$

b. How often?  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  Yearly

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

**16. What change will the employer make for the new plan year?**

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ \_\_\_\_\_

b. How often?  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  Yearly

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

**HEALTH INSURANCE EXCHANGE NOTICE**  
*For Employers Who Do Not Offer a Health Plan*

## New Health Insurance Marketplace Coverage Options and Your Health Coverage

### PART A: General Information

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

#### What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.<sup>1</sup>

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

#### How Can I Get More Information?

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

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

## PART B: Information About Health Coverage Offered by Your Employer

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

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

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

## **GRANDFATHER NOTICE**

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information] . [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal government plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov)]



## **NOTICE OF PATIENT PROTECTIONS**

*For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:*

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information] .

*For plans and issuers that require or allow for the designation of a primary care provider for a child, add:*

For children, you may designate a pediatrician as the primary care provider.

*For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:*

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information] .

## **NOTICE OF SPECIAL ENROLLMENT RIGHTS**

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative] .

## **WELLNESS PROGRAM DISCLOSURE**

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

## **NOTICE OF PRIVACY PRACTICES**

[Covered Entity's Name]

[Covered Entity's Address]

[Covered Entity's Website]

[Privacy Official's phone, e-mail  
and other contact information]

### **Your Information. Your Rights. Our Responsibilities.**

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.**

### **Your Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### **Your Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### **Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

## **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

## **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us at [contact info] .
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

## **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

## **Other Instructions for Notice**

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."



## **WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICES**

### ***Enrollment Notice***

If you have had or are going to have a mastectomy, you 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 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 following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits] . If you would like more information on WHCRA benefits, call your plan administrator [insert phone number] .

### ***Annual Notice***

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, 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? Call your plan administrator at [insert phone number] for more information.

## **MENTAL HEALTH PARITY & ADDICTION EQUITY ACT DISCLOSURE**

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the [Name of Plan] with respect to mental health or substance use disorder benefits, please contact your plan administrator at [insert phone number] .

## EMPLOYER CHIP NOTICE

### **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](http://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](http://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](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –**

<b>ALABAMA – Medicaid</b>	<b>FLORIDA – Medicaid</b>
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	Website: <a href="http://flmedicaidplrecovery.com/hipp/">http://flmedicaidplrecovery.com/hipp/</a> Phone: 1-877-357-3268
<b>ALASKA – Medicaid</b>	<b>GEORGIA – Medicaid</b>
The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>	Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
<b>ARKANSAS – Medicaid</b>	<b>INDIANA – Medicaid</b>
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864

<b>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b>	<b>IOWA – Medicaid</b>
<p>Health First Colorado Website:  <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a>  Health First Colorado Member Contact Center:  1-800-221-3943/ State Relay 711  CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus  CHP+ Customer Service: 1-800-359-1991/  State Relay 711</p>	<p>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a>  Phone: 1-888-346-9562</p>

<b>KANSAS – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
<p>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a>  Phone: 1-785-296-3512</p>	<p>Website: <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</a>  Phone: 603-271-5218</p>

<b>KENTUCKY – Medicaid</b>	<b>NEW JERSEY – Medicaid and CHIP</b>
<p>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a>  Phone: 1-800-635-2570</p>	<p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Medicaid Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710</p>

<b>LOUISIANA – Medicaid</b>	<b>NEW YORK – Medicaid</b>
<p>Website:  <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a>  Phone: 1-888-695-2447</p>	<p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>

<b>MAINE – Medicaid</b>	<b>NORTH CAROLINA – Medicaid</b>
<p>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a>  Phone: 1-800-442-6003  TTY: Maine relay 711</p>	<p>Website: <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a>  Phone: 919-855-4100</p>

<b>MASSACHUSETTS – Medicaid and CHIP</b>	<b>NORTH DAKOTA – Medicaid</b>
<p>Website:  <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a>  Phone: 1-800-462-1120</p>	<p>Website:  <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a>  Phone: 1-844-854-4825</p>

<b>MINNESOTA – Medicaid</b>	<b>OKLAHOMA – Medicaid and CHIP</b>
<p>Website: <a href="http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp">http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp</a>  Phone: 1-800-657-3739</p>	<p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>

<b>MISSOURI – Medicaid</b>	<b>OREGON – Medicaid</b>
Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005	Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075
<b>MONTANA – Medicaid</b>	<b>PENNSYLVANIA – Medicaid</b>
Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084	Website: <a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a> Phone: 1-800-692-7462

<b>NEBRASKA – Medicaid</b>	<b>RHODE ISLAND – Medicaid</b>
Website: <a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a> Phone: 1-855-632-7633	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 401-462-5300
<b>NEVADA – Medicaid</b>	<b>SOUTH CAROLINA – Medicaid</b>
Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900	Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a> Phone: 1-888-549-0820

<b>SOUTH DAKOTA - Medicaid</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a> Phone: 1-800-562-3022 ext. 15473
<b>TEXAS – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493	Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a> Phone: 1-877-598-5820, HMS Third Party Liability
<b>UTAH – Medicaid and CHIP</b>	<b>WISCONSIN – Medicaid and CHIP</b>
Website: Medicaid: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669	Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a> Phone: 1-800-362-3002
<b>VERMONT– Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427	Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a> Phone: 307-777-7531
<b>VIRGINIA – Medicaid and CHIP</b>	
Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a> Medicaid Phone: 1-800-432-5924 CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a> CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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

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

## MICHELLE'S LAW NOTICE

**Plan Administrator Note:** *This notice must be provided with any notice regarding a requirement for certification of student status for coverage under the plan.*

*Note: Pursuant to Michelle's Law, you are being provided with the following notice because the [Employer Name] group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.*

When a dependent child loses student status for purposes of [Employer Name] group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the [Employer Name] group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the [Employer Name] group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The [Employer Name] group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- [Insert any other permissible eligibility conditions here, such as being enrolled in the plan immediately prior to the first day of the medically necessary leave of absence] .

To obtain additional information, please contact: [ ] .

## **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE**

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



## **MEDICARE PART D CREDITABLE COVERAGE NOTICE**

### **Important Notice from [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] 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. [Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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### **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 15<sup>th</sup> to December 7<sup>th</sup>.

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 [Insert Name of Entity] coverage will [or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become

eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current [Insert Name of Entity] coverage, be aware that you and your dependents [will or will not] [Medigap issuers must insert "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 [Insert Name of Entity] 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 [or call [Insert Alternative Contact] at [(XXX) XXX-XXXX] . **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 [Insert Name of Entity] 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](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

**[Optional Insert - Entities can choose to insert the following information box if they choose to provide a personalized disclosure notice.]**

Medicare Eligible Individual's Name: [Insert Full Name of Medicare Eligible Individual]

Individual's DOB or unique Member ID: [Insert Individual's Date of Birth] , or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

**From:** [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

**From:** [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

Date: [Insert MM/DD/YY]  
Name of Entity/Sender: [Insert Name of Entity]  
Contact--Position/Office: [Insert Position/Office]  
Address: [Insert Street Address, City, State & Zip Code of Entity]  
Phone Number: [Insert Entity Phone Number]

## MEDICARE PART D NON-CREDITABLE COVERAGE NOTICE

### Important Notice From [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. [Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [Insert Name of Plan] . This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
  
3. You can keep your current coverage from [Insert Name of Plan] . However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

### 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 15<sup>TH</sup> to December 7<sup>th</sup>.

**[INSERT IF EMPLOYER/UNION SPONSORED GROUP PLAN:** However, if you decide to drop your current coverage with [Insert Name of Entity] , since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under [Insert Name of Plan] .]

**[INSERT IF PREVIOUS COVERAGE PROVIDED BY THE ENTITY WAS CREDITABLE**

**COVERAGE:** Since you are losing creditable prescription drug coverage under the [Insert Name of Plan] , you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.]

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

Since the coverage under [Insert Name of Plan] , is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**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 [Insert Name of Entity] coverage will [or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current [Insert Name of Entity] coverage, be aware that you and your dependents will [or will not] [Medigap issuers must insert "will not"] be able to get this coverage back.

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

Contact the person listed below for further information [or call [Insert Alternative Contract] at [(XXX) XXX-XXXX] . **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 [Insert Name of Entity] 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](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

**[Optional Insert – If a beneficiary has had creditable coverage under the entities plan for any period of time since May 15, 2006, entities can insert the following information box if they choose to provide a personalized disclosure notice.]**

Medicare Eligible Individual’s Name: [Insert Full Name of Medicare Eligible Individual]

Individual’s DOB or unique Member ID: [Insert Individual's Date of Birth] , or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

**From:** [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

**From:** [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

Date: [Insert MM/DD/YY]  
Name of Entity/Sender: [Insert Name of Entity]  
Contact--Position/Office: [Insert Position/Office]  
Address: [Insert Street Address, City, State & Zip Code of Entity]  
Phone Number: [Insert Entity Phone Number]

## **GINA DISCLOSURES**

### ***General Disclosure***

#### **GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008**

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

### ***Additional "Warning" Language***

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

## **ADA NOTICE REGARDING WELLNESS PROGRAM**

[Name of wellness program] is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested] . You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of [indicate the incentive] for [specify criteria] . Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive [the incentive] .

Additional incentives of up to [indicate the additional incentives] may be available for employees who participate in certain health-related activities [specify activities, if any] or achieve certain health outcomes [specify particular health outcomes to be achieved, if any] . If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting [name] at [contact information] .

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as [indicate services that may be offered] . You also are encouraged to share your results or concerns with your own doctor.

### **Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers 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 permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.] Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact [insert name of appropriate contact] at [contact information] .

## ACA SECTION 1557 NONDISCRIMINATION NOTICE

### **Discrimination is Against the Law**

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of covered entity] :

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact [Name of Civil Rights Coordinator]

If you believe that [Name of covered entity] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: [Name and Title of Civil Rights Coordinator] , [Mailing Address] , [Telephone number] , [TTY number—if covered entity has one] , [Fax] , [Email] . You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## **USERRA NOTICE**

### **Your Rights Under USERRA**

#### **A. The Uniformed Services Employment and Reemployment Rights Act**

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

#### **B. Reemployment Rights**

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

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

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

#### **C. Right To Be Free From Discrimination and Retaliation**

If you:

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

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

#### **D. Health Insurance Protection**

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

#### **E. Enforcement**

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

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

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

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

**GENERAL NOTICE OF COBRA RIGHTS**  
**(For use by single-employer group health plans)**

**\*\* Continuation Coverage Rights Under COBRA\*\***

**Introduction**

You're getting 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 group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

**What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information: must pay or aren't required to pay*] for COBRA continuation coverage.

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

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

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

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

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

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

*[If the Plan provides retiree health coverage, add the following paragraph:]*

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 *[enter name of employer sponsoring the Plan]*, 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 Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;]* ; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days *[or enter longer period permitted under the terms of the Plan]* after the qualifying event occurs. You must provide this notice to: *[Enter name of***

*appropriate party]* . *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]*

### **How is COBRA continuation coverage provided?**

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

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

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

#### ***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

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

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



## **Are there other coverage options besides COBRA Continuation Coverage?**

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

## **Keep your Plan informed of address changes**

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

## **Plan contact information**

*[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]*

**COBRA ELECTION NOTICE**  
**(For use by single-employer group health plans)**

**IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives**

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

**This notice has important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

**Why am I getting this notice?**

You're getting this notice because your coverage under the Plan will end on [enter date] due to [check appropriate box] :

- |  |   |
|--|---|
| <input type="checkbox"/> End of employment       | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee       | <input type="checkbox"/> Divorce or legal separation      |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> Loss of dependent child status   |

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

**What's COBRA continuation coverage?**

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

**Who are the qualified beneficiaries?**

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it’s important that you choose carefully between COBRA continuation coverage and other coverage options, because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

**If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?**

If elected, COBRA continuation coverage will begin on *[enter date]* and can last until *[enter date]* .

*[Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options] .]*

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

**Can I extend the length of COBRA continuation coverage?**

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify *[enter name of party responsible for COBRA administration]* of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don’t provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <http://www.dol.gov/ebsa/publications/cobraemployee.html>.

### **How much does COBRA continuation coverage cost?**

COBRA continuation coverage will cost: *[enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]*

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

**You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** You can learn more about the Marketplace below.

### **What is the Health Insurance Marketplace?**

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from [Medicaid](#) or the [Children's Health Insurance Program \(CHIP\)](#). You can access the Marketplace for your state at [www.HealthCare.gov](http://www.HealthCare.gov).

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

### **When can I enroll in Marketplace coverage?**

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit [www.HealthCare.gov](http://www.HealthCare.gov).

## **If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?**

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

## **Can I enroll in another group health plan?**

You may be eligible to enroll in coverage under another group health plan (like a spouse’s plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

## **What factors should I consider when choosing coverage options?**

When considering your options for health coverage, you may want to think about:

- **Premiums**: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.
- **Provider Networks**: If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies**: If you’re currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments**: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA

payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

### **For more information**

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact *[enter name of party responsible for COBRA administration for the Plan, with telephone number and address]* .

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep Your Plan Informed of Address Changes**

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

**COBRA ELECTION NOTICE**

**COBRA Continuation Coverage Election Form**

**Instructions:** To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: *[Enter Name and Address]*

This Election Form must be completed and returned by mail *[or describe other means of submission and due date]*. If mailed, it must be post-marked no later than *[enter date]*.

If you don't submit a completed Election Form by the due date shown above, you'll lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the *[enter name of plan]* (the Plan) listed below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____			
		<i>[Add if appropriate: Coverage option elected</i>	<i>]</i>
b. _____			
		<i>[Add if appropriate: Coverage option elected</i>	<i>]</i>
c. _____			
		<i>[Add if appropriate: Coverage option elected</i>	<i>]</i>

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed above

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Print Address

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Telephone number

### **Important Information About Payment**

#### *First payment for continuation coverage*

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact *[enter appropriate contact information, e.g. the Plan Administrator or other party responsible for COBRA administration under the Plan]* to confirm the correct amount of your first payment.

#### *Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due *[enter due day for each monthly payment]* for that coverage period. *[If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates: [insert dates] .]* If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan *[select one: will or will not]* send periodic notices of payments due for these coverage periods.

#### *Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period *[or enter longer period permitted by Plan]* to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. *[If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you*



submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

*[enter appropriate payment address]*

**NOTICE OF UNAVAILABILITY OF COBRA COVERAGE**

[Date]

To: [Name of Applicant]  
[Address]  
[City, State, Zip]

We have received your notice requesting COBRA continuation coverage or an extension of COBRA continuation coverage through the following Group Health Care Plan:

[Name of Plan]

Your request is based upon (check all that apply):

- Your divorce or legal separation from a covered employee under the plan
- Your loss of status as an eligible dependent child under the plan
- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in the number of hours of employment
- Death of the covered employee
- You and/or your dependents who are qualified beneficiaries and are currently receiving COBRA continuation coverage have experienced a second qualifying event
- You or a qualified beneficiary currently receiving COBRA continuation coverage have become disabled
- Other \_\_\_\_\_

We have determined that you and/or your qualified beneficiary dependent(s) do not qualify for COBRA continuation coverage or for an extension of COBRA continuation coverage for the following reason(s) (check all that apply):

- No qualifying event as defined by law has occurred.
- You and/or your dependents were not covered under the plan on the day before the qualifying event.
- You and/or your dependents did not provide notice of your divorce, legal separation, or loss of dependent child status within \_\_\_\_\_ days of the event, as required under the plan.
- The circumstances you have described do not constitute a "second qualifying event" under COBRA.
- You and/or your eligible dependents did not provide timely notice of the determination of disability by the Social Security Administration as required by the plan.

- The Social Security Administration has determined that you are not disabled, or, if you were disabled, you are no longer disabled.
- Other \_\_\_\_\_.

If you have any questions about this determination, please contact:

**Plan Administrator Note:** There are [two circumstances](#) in which individuals who are entitled to an 18-month maximum period of COBRA can become entitled to an extension of continuation coverage—when a second qualifying event occurs (allowing an extension of up to 18 months) or when a qualified beneficiary is determined by the Social Security Administration to be disabled (allowing an extension of up to 11 months).

Your plan rules should describe the notice required in either instance for the qualified beneficiary to extend COBRA. A plan may set a time limit for providing notice, but the time limit cannot be shorter than 60 days, starting from the latest of (1) the date on which the qualifying event occurs; (2) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; (3) the date on which the qualified beneficiary is informed, through the furnishing of the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so; or (4), in the case of an extension due to a disability determination, the date on which the Social Security Administration issues the disability determination.

**NOTICE OF UNDERPAYMENT OF COBRA PREMIUM**

[Date]

To:     [Name of Qualified Beneficiary]  
          [Address]  
          [City, State, Zip]

Please be advised that your most recent COBRA premium payment for the month of [Insert Month] , in the amount of [Insert Amount] , is insufficient to satisfy your premium cost for the month. Should you wish to continue your COBRA coverage, [Name of Plan] must receive the remainder of your monthly premium payment, in the amount of [Insert Amount of Underpayment] , by [Date — No Earlier Than 30 Days From Date of Notice] .

Please note that, under federal law, [Name of Plan] is permitted to terminate your COBRA continuation coverage if full payment is not received before the end of this grace period. In the event coverage is terminated early due to failure to make a timely payment, you will receive a Notice of Early Termination of Continuation Coverage from [Name of Plan] .

Please contact \_\_\_\_\_ for additional details and to schedule payment.

**NOTICE OF EARLY TERMINATION OF COBRA COVERAGE**

Date:

Name of Qualified Beneficiary:

Address of Beneficiary:

City, State, Zip:

Status of Qualified Beneficiary:    Employee/Former Employee  
   Spouse            Dependent

Please be advised that your COBRA continuation coverage will end on [Date] for the following reason(s):

- Failure to make payment of the required premium for continuation coverage on time or within specified grace period
- [Name of Company] has terminated or will terminate group health care coverage for all employees
- You are now covered by another group health care plan
- Subsequent to your election of COBRA continuation coverage, you became entitled to Medicare benefits
- The Social Security Administration has determined that you or another qualified beneficiary whose disability resulted in extension of your maximum COBRA coverage period is no longer disabled
- For cause (e.g., fraud)
- Other \_\_\_\_\_

If you have any questions about the termination of your COBRA continuation coverage benefits, please contact [Name, Phone Number, and Email of Contact Person] .

*[Optional Provisions--An employer may insert the following, if applicable]*

Conversion Rights. You may have the right to convert your COBRA continuation coverage under a group plan to individual coverage. For information on converting your coverage, please contact [Name, Phone Number, and Email of Contact Person] .

Right to Appeal. Instructions regarding the appeal process, should you wish to appeal this determination, are enclosed with this notice.

## GENERAL FMLA NOTICE

# EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

### **LEAVE ENTITLEMENTS**

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

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

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

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

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

### **BENEFITS & PROTECTIONS**

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

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

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

## ELIGIBILITY REQUIREMENTS

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

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

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

## REQUESTING LEAVE

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

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

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

## EMPLOYER RESPONSIBILITIES

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

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

## ENFORCEMENT

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

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

For additional information or to file a complaint:

**1-866-4-USWAGE**

(1-866-487-9243) TTY: 1-877-889-5627

[www.dol.gov/whd](http://www.dol.gov/whd)

U.S. Department of Labor | Wage and Hour Division

**NOTICE OF FMLA ELIGIBILITY AND RIGHTS & RESPONSIBILITIES**

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

**[Part A – NOTICE OF ELIGIBILITY]**

TO: \_\_\_\_\_  
Employee

FROM: \_\_\_\_\_  
Employer Representative

DATE: \_\_\_\_\_

On \_\_\_\_\_, you informed us that you needed leave beginning on \_\_\_\_\_ for:

- \_\_\_\_\_ The birth of a child, or placement of a child with you for adoption or foster care;
- \_\_\_\_\_ Your own serious health condition;
- \_\_\_\_\_ Because you are needed to care for your \_\_\_\_\_ spouse; \_\_\_\_\_ child; \_\_\_\_\_ parent due to his/her serious health condition.
- \_\_\_\_\_ Because of a qualifying exigency arising out of the fact that your \_\_\_\_\_ spouse; \_\_\_\_\_ son or daughter; \_\_\_\_\_ parent is on covered active duty or call to covered active duty status with the Armed Forces.
- \_\_\_\_\_ Because you are the \_\_\_\_\_ spouse; \_\_\_\_\_ son or daughter; \_\_\_\_\_ parent; \_\_\_\_\_ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

- \_\_\_\_\_ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- \_\_\_\_\_ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
  - \_\_\_\_\_ You have not met the FMLA’s 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately \_\_\_\_\_ months towards this requirement.
  - \_\_\_\_\_ You have not met the FMLA’s hours of service requirement.
  - \_\_\_\_\_ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact \_\_\_\_\_ or view the FMLA poster located in \_\_\_\_\_.

**[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]**

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by \_\_\_\_\_.** (If a certification is requested,



employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

\_\_\_\_\_ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request \_\_\_\_\_ is/ \_\_\_\_\_ is not enclosed.

\_\_\_\_\_ Sufficient documentation to establish the required relationship between you and your family member.

\_\_\_\_\_ Other information needed (such as documentation for military family leave):

\_\_\_\_\_ No additional information requested.

**If your leave does qualify** as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

\_\_\_\_\_ Contact \_\_\_\_\_ at \_\_\_\_\_ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

\_\_\_\_\_ You will be required to use your available paid \_\_\_\_\_ sick, \_\_\_\_\_ vacation, and/or \_\_\_\_\_ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

\_\_\_\_\_ Due to your status within the company, you are considered a “key employee” as defined in the FMLA. As a “key employee,” restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We have/ \_\_\_\_\_ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

\_\_\_\_\_ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every \_\_\_\_\_

(Indicate interval of periodic reports, as appropriate for the particular leave situation).

**If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.**

**If your leave does qualify** as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

\_\_\_\_\_ the calendar year (January – December).

\_\_\_\_\_ a fixed leave year based on \_\_\_\_\_.

\_\_\_\_\_ the 12-month period measured forward from the date of your first FMLA leave usage.

\_\_\_\_\_ a “rolling” 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a

- covered servicemember with a serious injury or illness. This single 12-month period commenced on \_\_\_\_\_.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
  - You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
  - If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
  - If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have \_\_\_\_\_ sick, \_\_\_\_\_ vacation, and/or \_\_\_\_\_ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

\_\_\_\_\_ For a copy of conditions applicable to sick/vacation/other leave usage please refer to \_\_\_\_\_ available at: \_\_\_\_\_.

\_\_\_\_\_ Applicable conditions for use of paid leave:

**Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:**

\_\_\_\_\_ at \_\_\_\_\_.

## FMLA DESIGNATION NOTICE

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

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To: \_\_\_\_\_

Date: \_\_\_\_\_

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on  and decided:

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**Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

**The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:**

Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_

Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

We are requiring you to substitute or use paid leave during your FMLA leave.

You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position  **is**  **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

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**Additional information is needed to determine if your FMLA leave request can be approved:**

The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than (provide at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

(Specify information needed to make the certification complete and sufficient)

We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

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- Your FMLA Leave request is Not Approved.
- The FMLA does not apply to your leave request.
- You have exhausted your FMLA leave entitlement in the applicable 12-month period.