**2025 Legal Notices**

# Your Rights and Protections Against Surprise Medical Bills

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

**What is “balance billing” (sometimes called “surprise billing”)?**

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

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

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

**You are protected from balance billing for:**

**Emergency services**

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

Certain states have enacted balance billing protections for patients receiving emergency services. New Hampshire, Maine, Massachusetts and Vermont all have laws protecting patients from balance billings, although the specific laws are different in each state.

For example, if you receive care at an in-network hospital or surgical center in New Hampshire, the law prevents certain providers (radiology, anesthesiology, pathology and emergency medicine) from charging any amount other than your standard co-pay, coinsurance or deductible, even if they are not in-network for your insurance plan.[[1]](#footnote-1) Maine has procedures for health insurance carriers to pay out-of-network providers for covered emergency services, including emergency ambulance services and includes an independent dispute resolution process.[[2]](#footnote-2) Massachusetts’ requires insurers to hold participants harmless for amounts beyond in-network levels of cost sharing and requires health insurance carriers to notify consumers of any additional charges for out-of-network providers with a summary and description of the services provided and also requires providers to provide certain notices to patients.[[3]](#footnote-3) Vermont provides surprise and balance billing protections by requiring a hold harmless provision for amounts beyond in-network levels of cost sharing and no liability notice requirement for both emergency and non-emergency healthcare services.[[4]](#footnote-4)]

**Certain services at an in-network hospital or ambulatory surgical center**

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

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

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

State law prohibitions against balance billing may also apply. For example, New Hampshire law prohibits balance billing by in-network providers, and out-of-network providers at in-network hospitals and ambulatory surgery centers are prevented from billing patients for more than regular cost sharing, even if the provider is out-of-network. Maine law prevents balance billing by out-of-network providers unless the patient knowingly elected to obtain an out-of-network provider’s services.

**When balance billing isn’t allowed, you also have these protections:**

* You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
* Your health plan generally must:
* Cover emergency services without requiring you to get approval for services in advance (prior authorization).
* Cover emergency services by out-of-network providers.
* Base what you owe the provider or facility (cost-sharing) on what it would pay an in‑network provider or facility and show that amount in your explanation of benefits.
* Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you’ve been wrongly billed**, You may also contact the New Hampshire Insurance Department at (800) 735-2964 or the Department of Labor’s Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1-866-444-EBSA (3272) or the No Surprises helpdesk at 1-800-985-3059.

Visit [*www.cms.gov/nosurprises/consumers*](http://www.cms.gov/nosurprises/consumers)for more information about your rights under federal law.

*For more information about your rights under Maine state law visit:* [*www.maine.gov/pfr/insurance/*](http://www.maine.gov/pfr/insurance/)

*For more information about your rights under New Hampshire state law visit:* [*https://www.insurance.nh.gov/*](https://www.insurance.nh.gov/)

*For more information about your rights under Massachusetts state law visit:* [*https://www.mass.gov/orgs/division-of-insurance*](https://www.mass.gov/orgs/division-of-insurance)

*For more information about your rights under Vermont state law visit* [*https://dfr.vermont.gov/insurance*](https://dfr.vermont.gov/insurance)

# Requesting Documentation of Mental Health and Substance Use Disorder Treatment Coverage Criteria and Limitations

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), health plans and insurers must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to MH/SUD benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits.

You are entitled to

* General information about treatment limitations, like your plan’s preauthorization policies for both medical/surgical and MH/SUD treatment, and your plan’s criteria for determining medical necessity.
* Specific information about why benefits were denied. For example, you can ask about the criteria for “failure to show medical necessity” that your health insurance company may have used to deny your claim.

In addition, health plans and insurers that offer coverage that provides both medical/surgical benefits and MH/SUD benefits, and that imposes non-quantitative treatment limitations (NQTLs), must analyze how any NQTLs are designed and applied. Plan participants and beneficiaries are entitled to a copy of this comparative analysis upon request.

If you would like to request this information, please contact your Plan Administrator or HR Department at hrservicerequests@ledyard.bank You can find a copy of a form to use to request this information at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf>.

# The Health Insurance and Portability and Accountability Act of 1996 (HIPAA)

HIPAA places limitations on a group health plan's ability to impose preexisting condition exclusions, provides special enrollment rights for certain individuals and prohibits discrimination in group health plans based on health status. In addition, HIPAA establishes a set of national standards to address the use and disclosure of individuals' health information - called protected health information or “PHI.”

**HIPAA Notice of Privacy Practices**

The Ledyard National Bank's health plan (the Plan) complies with HIPAA and the Plan’s HIPAA Notice of Privacy Practices is available upon request. To obtain a copy of the Plan's HIPAA Notice of Privacy Practices, please contact your Ledyard National Bank, HR Department <https://nhbankers.trgportal.com/> . For more information on the Plan's privacy policies or your rights under HIPAA, contact the HR Department at hrservicerequests@ledyard.bank

**HIPAA Special Enrollment Rights**

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Ledyard National Bank's health plan under "special enrollment provisions" briefly described below.

* Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Ledyard National Bank's health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after your or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
* New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under
Ledyard National Bank's health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
* Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in Ledyard National Bank's health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the Plan Administrator at 603.640.2721 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

# Continuation Coverage Rights Under COBRA

**This Notice is directed to employees who enroll in the** **Ledyard National Bank Group Health Plan (the Plan). Receipt of this notice by an employee who is not enrolled in the Plan does not create a right to any benefit or continuation coverage.**

**Introduction**

If you have coverage under the Ledyard National Bank 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 must 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."

**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; 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 after the qualifying event occurs. You must provide this notice to: WageWorks/Health Equity.**

**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.

**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.

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[[5]](#footnote-5) to sign up for Medicare Part A or B, beginning on the earlier of

• The month after your employment ends; or

• The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

**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.eov.](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**

HR Department at HRServiceRequests@ledyard.bank , 66 Benning Street, Suite 5, West Lebanon NH 03784

# 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)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –**

|  |  |
| --- | --- |
| **ALABAMA – Medicaid** | **ALASKA – Medicaid** |
| Website: <http://myalhipp.com/>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment ProgramWebsite: <http://myakhipp.com/>Phone: 1-866-251-4861Email: CustomerService@MyAKHIPP.comMedicaid Eligibility: [https://health.alaska.gov/dpa/Pages/default.aspx](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhealth.alaska.gov%2Fdpa%2FPages%2Fdefault.aspx&data=05%7C01%7CBerman.Nathaniel%40dol.gov%7Ca5722ebf007e4847fe8808da69a45fb9%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C637938452103798639%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=A5Fggwg0lR2c%2FOwofWNVpVk8b5%2FFX1kaOQNuuEwAAAE%3D&reserved=0) |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: <http://myarhipp.com/>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:<http://dhcs.ca.gov/hipp>Phone: 916-445-8322Fax: 916-440-5676Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website: <https://www.healthfirstcolorado.com/> Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711CHP+: <https://hcpf.colorado.gov/child-health-plan-plus> CHP+ Customer Service: 1-800-359-1991/State Relay 711Health Insurance Buy-In Program (HIBI):  <https://www.mycohibi.com/>HIBI Customer Service: 1-855-692-6442 | Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>Phone: 1-877-357-3268 |
|  |  |
| **GEORGIA – Medicaid** | **INDIANA – Medicaid** |
| GA HIPP Website: [https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp](https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmedicaid.georgia.gov%2Fhealth-insurance-premium-payment-program-hipp&data=02%7C01%7Cstashlaw%40dch.ga.gov%7C98b18a96ce1b49d087f708d709449652%7C512da10d071b4b948abc9ec4044d1516%7C0%7C0%7C636988062560854968&sdata=7rziGawQfBKcW1N2%2Bdi2j8cyHpaCYURGdtF8Hk%2By6FM%3D&reserved=0)Phone: 678-564-1162, Press 1GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment ProgramAll other MedicaidWebsite: <https://www.in.gov/medicaid/><http://www.in.gov/fssa/dfr/> Family and Social Services Administration Phone: 1-800-403-0864Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:[Iowa Medicaid | Health & Human Services](https://hhs.iowa.gov/programs/welcome-iowa-medicaid)Medicaid Phone: 1-800-338-8366Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki)Hawki Phone: 1-800-257-8563HIPP Website: [Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)](https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp)HIPP Phone: 1-888-346-9562 | Website: <https://www.kancare.ks.gov/>Phone: 1-800-792-4884HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>Phone: 1-855-459-6328Email: KIHIPP.PROGRAM@ky.govKCHIP Website: [https://kynect.ky.gov](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fkynect.ky.gov%2F&data=05%7C02%7CClinton.Latisha.M%40dol.gov%7C0ea7063fc3ad45daa23708dc1624e4e6%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638409595278820551%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=0fmlL3Js913dnHPUVk4VzO2B01U79vtVl5AUex6NXJE%3D&reserved=0) Phone: 1-877-524-4718Kentucky Medicaid Website: [https://chfs.ky.gov/agencies/dms](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fchfs.ky.gov%2Fagencies%2Fdms&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7Cceea86848e7e41f7dd9008db83d50dfb%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638248724653548159%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=DJ8rl0bkdcKwMIE92YY23XQc%2FZI71iLtdbD0L2XkS38%3D&reserved=0) | Website: [www.medicaid.la.gov](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331) or [www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)  |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website: [https://www.mymaineconnection.gov/benefits/s/?language=en\_US](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.mymaineconnection.gov%2Fbenefits%2Fs%2F%3Flanguage%3Den_US&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7Cb96a31a5c25e4e1da49908daf4ae9bf1%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638091328210827160%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=GeBtSEsUoaCw5ukO%2F6O2IUy%2B9FzGqgY%2FJ2C9OgAhxE4%3D&reserved=0)Phone: 1-800-442-6003TTY: Maine relay 711Private Health Insurance Premium Webpage:<https://www.maine.gov/dhhs/ofi/applications-forms>Phone: 1-800-977-6740 TTY: Maine relay 711 | Website: [https://www.mass.gov/masshealth/pa](https://www.mass.gov/masshealth/pa%20) Phone: 1-800-862-4840TTY: 711Email: masspremassistance@accenture.com  |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website: <https://mn.gov/dhs/health-care-coverage/>Phone: 1-800-657-3672 | Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>Phone: 1-800-694-3084Email: HHSHIPPProgram@mt.gov | Website: <http://www.ACCESSNebraska.ne.gov>Phone: 1-855-632-7633Lincoln: 402-473-7000Omaha: 402-595-1178  |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: <http://dhcfp.nv.gov>Medicaid Phone: 1-800-992-0900 | Website: [https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.dhhs.nh.gov%2Fprograms-services%2Fmedicaid%2Fhealth-insurance-premium-program&data=05%7C01%7CGoodwin.Carolyn%40dol.gov%7C6aa7b22dba29413479c108da73eb96c6%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C637949752922233349%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=mUgACydlz9JGXnHMgi%2FUkDGD0QyTI1U6Tjwue%2Bq8D0Q%3D&reserved=0)Phone: 603-271-5218Toll free number for the HIPP program: 1-800-852-3345, ext. 15218Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website: [http://www.state.nj.us/humanservices/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)[dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)Phone: 1-800-356-1561CHIP Premium Assistance Phone: 609-631-2392CHIP Website: <http://www.njfamilycare.org/index.html>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: <https://www.health.ny.gov/health_care/medicaid/>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: <https://medicaid.ncdhhs.gov/>Phone: 919-855-4100 | Website: [https://www.hhs.nd.gov/healthcare](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hhs.nd.gov%2Fhealthcare&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7C64da7b9f730b4fb2467608db7fe082e3%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638244374885371946%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=RO%2BrOZKJxqNsa0Ewzhle%2FkVaDGnl7hpPQnJUnW1mwDU%3D&reserved=0)Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org/)Phone: 1-888-365-3742 | Website: <http://healthcare.oregon.gov/Pages/index.aspx>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>Phone: 1-800-692-7462CHIP Website: [Children's Health Insurance Program (CHIP) (pa.gov)](https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx)CHIP Phone: 1-800-986-KIDS (5437) | Website: <http://www.eohhs.ri.gov/>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: <https://www.scdhhs.gov>Phone: 1-888-549-0820 | Website: [http://dss.sd.gov](http://dss.sd.gov/)Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: [Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services](https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program)Phone: 1-800-440-0493 | Utah’s Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>Email: upp@utah.govPhone: 1-888-222-2542Adult Expansion Website: <https://medicaid.utah.gov/expansion/>Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>CHIP Website: <https://chip.utah.gov/> |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: [Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdvha.vermont.gov%2Fmembers%2Fmedicaid%2Fhipp-program&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7C3daa411d0e934769e75c08daf4bf842e%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638091400777632051%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=7ao%2BrltzkBEMojzmZ9O8UllrAdaRI%2Fmzhq3FE%2Bf%2B2nk%3D&reserved=0)Phone: 1-800-250-8427 | Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select> [https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcoverva.dmas.virginia.gov%2Flearn%2Fpremium-assistance%2Fhealth-insurance-premium-payment-hipp-programs&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7Caa3a5092aeb14ed08af708db81758880%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638246115240341681%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=rI%2BZX53PVAmr9gcvTJt3KrfWxCtIx6VIxQ36deaOXTs%3D&reserved=0) Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: <https://www.hca.wa.gov/> Phone: 1-800-562-3022 | Website: <https://dhhr.wv.gov/bms/>  <http://mywvhipp.com/>Medicaid Phone: 304-558-1700CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>Phone: 1-800-362-3002 | Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration Centers for Medicare & Medicaid Services

[**www.dol.gov/agencies/ebsa**](https://www.dol.gov/agencies/ebsa)[**www.cms.hhs.gov**](http://www.cms.hhs.gov/)

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

# Women's Health & Cancer Rights Act of 1998

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;
* Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this Plan. Therefore, the deductibles and coinsurance for your health plan apply.

If you would like more information on WHCRA benefits, call your Plan Administrator at 603.640.2721.

# Newborns' and Mothers' Health Protection Act of 1996

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

# Important Notice 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 IngenioRx 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. New Hampshire Bankers Association Insurance Trust has determined that the prescription drug coverage offered by the Anthem Preferred Blue PPO SOS 2000/0%/6500; Anthem Preferred Blue PPO SOS 3000/0%/6500; Anthem Preferred Blue PPO SOS 4000/0%/6500; Anthem Preferred Blue PPO SOS 5000/0%/6500; Anthem Preferred Blue PPO HSA 3200/0%/3200; Anthem Preferred Blue PPO HSA 5000/0%/5000 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

***When Can You Join A Medicare Drug Plan?***

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

***What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?***

If you decide to join a Medicare drug plan, your current IngenioRx coverage will be affected. You can choose to retain your existing coverage and choose not to enroll in a Part D plan or you can enroll in Medicate drug plan as a supplement to your existing coverage. If you do decide to join a Medicare drug plan and drop your current IngenioRx coverage, be aware that you and your dependents will not be able to get this coverage back.

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 IngenioRx coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with IngenioRx 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 Human Resources at 603.640.2721. 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 IngenioRx 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; or
* 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).**

|  |
| --- |
| Medicare Eligible Individual's Name:Individual's DOB or unique 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] and from: [Insert MM/DD/YY] To: [Insert MM/DD/YY] |

Date:

Name of Entity/Sender:

Contact--Position/Office:

Address:

Phone Number:

# Patient Protection Disclosure

**New Hampshire Bankers Association Group Health Plan (the Plan)** generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you and/or your family members. For information on how to select a primary care provider, and for a list of participating primary care providers, contact the HR Department or Anthem at [(800) 870-3122](https://www.google.com/search?q=anthem+blue+cross+blue+shield+nh&sca_esv=7ccae99158416780&rlz=1C1GCEA_enUS1034US1034&sxsrf=ADLYWILSobth-vkYOpDoOKJAJ1d6faF_ZQ%3A1727882995696&ei=82b9ZsOXKuuh5NoPzrvMmAI&gs_ssp=eJzj4tVP1zc0TDLPyctNMi8zYLRSNaiwsEw1Mkk2MkszSDJLSkuytDKoMDc2SEu1NEszTjJKszAxMPZSSMwryUjNVUjKKU1VSC7KLy6GMIszMlNzUhTyMgB6zxtm&oq=anthem+&gs_lp=Egxnd3Mtd2l6LXNlcnAiB2FudGhlbSAqAggGMgQQIxgnMgoQIxiABBgnGIoFMgoQIxiABBgnGIoFMhcQLhiABBiRAhixAxjRAxiDARjHARiKBTIREAAYgAQYkQIYsQMYgwEYigUyCxAAGIAEGJECGIoFMgsQLhiABBjHARivATIFEAAYgAQyCBAAGIAEGLEDMgUQLhiABDIaEC4YgAQYxwEYrwEYlwUY3AQY3gQY4ATYAQFI9GJQshVY4zlwBHgBkAEAmAGFAaABwgSqAQMwLjW4AQHIAQD4AQGYAgqgArkjwgIKEAAYsAMY1gQYR8ICCxAAGIAEGLEDGIMBwgINEC4YgAQY0QMYxwEYCsICGhAuGIAEGJECGLEDGNEDGIMBGMcBGMkDGIoFwgIOEC4YgAQYkgMYxwEYrwHCAgsQABiABBiSAxiKBZgDAIgGAZAGCLoGBggBEAEYFJIHBzQuNS45LTGgB7dH&sclient=gws-wiz-serp)

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

You do not need prior authorization from **New Hampshire Bankers Association Group Health Plan (the Plan)** 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 HR Department or Anthem at [(800) 870-3122](https://www.google.com/search?q=anthem+blue+cross+blue+shield+nh&sca_esv=7ccae99158416780&rlz=1C1GCEA_enUS1034US1034&sxsrf=ADLYWILSobth-vkYOpDoOKJAJ1d6faF_ZQ%3A1727882995696&ei=82b9ZsOXKuuh5NoPzrvMmAI&gs_ssp=eJzj4tVP1zc0TDLPyctNMi8zYLRSNaiwsEw1Mkk2MkszSDJLSkuytDKoMDc2SEu1NEszTjJKszAxMPZSSMwryUjNVUjKKU1VSC7KLy6GMIszMlNzUhTyMgB6zxtm&oq=anthem+&gs_lp=Egxnd3Mtd2l6LXNlcnAiB2FudGhlbSAqAggGMgQQIxgnMgoQIxiABBgnGIoFMgoQIxiABBgnGIoFMhcQLhiABBiRAhixAxjRAxiDARjHARiKBTIREAAYgAQYkQIYsQMYgwEYigUyCxAAGIAEGJECGIoFMgsQLhiABBjHARivATIFEAAYgAQyCBAAGIAEGLEDMgUQLhiABDIaEC4YgAQYxwEYrwEYlwUY3AQY3gQY4ATYAQFI9GJQshVY4zlwBHgBkAEAmAGFAaABwgSqAQMwLjW4AQHIAQD4AQGYAgqgArkjwgIKEAAYsAMY1gQYR8ICCxAAGIAEGLEDGIMBwgINEC4YgAQY0QMYxwEYCsICGhAuGIAEGJECGLEDGNEDGIMBGMcBGMkDGIoFwgIOEC4YgAQYkgMYxwEYrwHCAgsQABiABBiSAxiKBZgDAIgGAZAGCLoGBggBEAEYFJIHBzQuNS45LTGgB7dH&sclient=gws-wiz-serp).

# Summary of Benefits and Coverage ("SBC") and Uniform Glossary

The Affordable Care Act requires that employers must provide an SBC to all eligible employees and beneficiaries with any application for enrollment (including annual open enrollment) and upon request. A copy of the Plan's SBC is contained with your annual enrollment materials. If you have any questions, or did not receive one, please contact Human Resources.

# Health Insurance Marketplace Coverage Options and Your Health Coverage

**PART A: General Information**

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

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. For Plan Years beginning in 2025, if your share of the premium cost of all plans offered to you through your employment is more than 9.02% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 8.39% of the employee’s household income.

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

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

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

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

**What about Alternatives to Marketplace Health Insurance Coverage?**

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

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

**How Can I Get More Information?**

For more information about your coverage offered through your employment, please check your health plan’s summary plan description or contact your HR department at hrservicerequests@ledyard.bank

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

**Part B: Information About Health Coverage Offered by Your Employer**

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

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

Here is some basic information about the health coverage offered:

As your employer, we offer a health plan to employees who meet the following eligibility requirements:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For eligible employees, we also offer coverage to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Spouses, Dependents, Domestic Partners, etc.]

The coverage we offer for 2024-2025 is intended to meet the minimum value standard, and the cost of this coverage is intended to meet ACA requirements for affordability.[[6]](#footnote-6)

\*\* Even though we intend 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.

**Marketplace Employer Coverage Tool**

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

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

|  |
| --- |
| 13**. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?****🞎 Yes** (continue)13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/yyyy) (Continue)**🞎 No** (STOP and return this form to employee) |
| 14. Does the employer offer a health plan that meets the minimum value standard?[[7]](#footnote-7)\* **🞎 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 thediscount 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 |

1. For more information, please review the New Hampshire Bureau of Insurance’s fact sheet on balance billing, available at <https://www.nh.gov/insurance/consumers/documents/balance_billing_surprise_billing.pdf> or go online to nh.gov/insurance. [↑](#footnote-ref-1)
2. For more information, please go to the Maine Bureau of Insurance’s website for consumers, available at <https://www.maine.gov/pfr/insurance/consumer/index.html>. [↑](#footnote-ref-2)
3. For more information, please review the Massachusetts Division of Insurance fact sheet on balance billing, available at <https://www.mass.gov/doc/no-surprises-act-faq/download>. [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)
5. 4 <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>. [↑](#footnote-ref-5)
6. 5 This is subject to future regulations and legal requirements, as well as employer decisions regarding health care coverage. In no way is this statement intended to act as an agreement or contract to offer health care coverage that meets the minimum value standard and is affordable (as defined under the health care law reform rules and regulations). [↑](#footnote-ref-6)
7. \* 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) [↑](#footnote-ref-7)