

IMPORTANT NOTICES

The following notices are legally required plan disclosures and are provided to you at various times during the year including annual Open Enrollment:

- Summary of Material Modifications
- HIPAA Special Enrollment Rights Notice
- Women's Health and Cancer Rights Act
- Newborns' and Mothers' Health Protection Act
- Medicare Part D Creditable/Non-Creditable Coverage Notice
- Notice of HIPAA Privacy Practices
- Initial COBRA Continuation Notice
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Patient Protection Disclosure (plans requiring a PCP selection)

Please read these notices as they provide valuable information to help you understand your employer-provided health and welfare benefit plans and your rights and options. Please contact the Plan Administrator or our Human Resources department if you have any questions.

If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage. Please see the Medicare Part D Creditable (or Non-Creditable) Coverage Disclosure Notice contained herein for further details.

Summary of Material Modifications (SMM)

The benefit materials described in this Guide describe changes to the employee health and welfare plan sponsored by Lewis & Clark College effective 4/1/19. It is intended to serve as a Summary of Material Modifications (SMM). The SMM supplements the health plan Summary Plan Description(s) for this plan; read it carefully and retain this document with your SPD(s) and other benefits related materials.

Notice of HIPAA Special Enrollment Rights

You may be eligible to participate in the group health plan sponsored by Lewis & Clark College. The federal law titled the Health Insurance Portability and Accountability Act or "HIPAA" requires that we notify eligible participants about the right to enroll in the plan under its "special enrollment provision".

Special Enrollment Provision

Loss of Other Coverage (Excluding Medicaid or State Children's Health Insurance Program). 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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some examples of events that cause an individual to lose eligibility for health coverage (there are other reasons as well):

- Divorce or legal separation;
- A dependent is no longer considered a dependent under the plan;
- Death of the employee covered by the plan;

- Termination of employment;
- Reduction in the number of hours of employment;
- The plan decides to no longer offer any benefits to a class of similarly situated individuals; or
- An individual in an HMO or other arrangement no longer resides, lives, or works in the service area.

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

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state's premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within **60 days** after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

If this plan requires documentation of the reason(s) for declining coverage: As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage.

This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s).

Failing to accurately complete and return this form for each person for whom you are declining coverage may eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you may not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraphs above, however, regarding enrollment in the event of marriage, birth, adoption, placement for adoption, loss of eligibility for Medicaid or a state CHIP, and gaining eligibility for a state premium assistance subsidy through Medicaid or a state CHIP.)]

To request special enrollment or obtain more information, contact:

Helen DeVol, Benefits Analyst
503-768-6234, helen@lclark.edu

Notice of the Women's Health and Cancer Rights Act

Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

Notice of the Newborns' and Mothers' Health Protection Act

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).

Medicare Part D Creditable Coverage Notice

Important Notice from Lewis & Clark College About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Lewis & Clark College has determined that the prescription drug coverage offered by Kaiser 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 Lewis & Clark College health coverage will not be affected. You can keep this coverage as long as you remain eligible and it will coordinate with Medicare Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Lewis & Clark College health coverage, be aware that you and your dependents will not be able to get this coverage back until the next Open Enrollment period or you become eligible by some other qualifying event.

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 Lewis & Clark College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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.

Name of Entity / Sender: Lewis & Clark College
Contact / Position / Office: Helen DeVol, Benefits Analyst
Phone Number: 503-768-6234
Email Address: helen@lclark.edu

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

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

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

IMPORTANT: *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).*

Notice of HIPAA Privacy Practices

A federal law called the Health Insurance Portability and Accountability Act (“HIPAA”) requires that our Health and Welfare Plan (the “Plan”) maintain the privacy of your protected health information and provide you this Notice of Privacy Practices (“Notice”). Your “protected health information” or “PHI” is your personal medical information about all your healthcare services, payment for your healthcare services, and your physical and mental health or conditions. (Your medical records, claims for medical benefits and the explanations of benefits we send in connection with payment of your claims are all examples of your PHI.) This Notice describes the Plan’s legal duties and privacy practices relating to your protected health information, including how your information may be used and disclosed and your rights to access and control that information.

In this Notice, the terms “we,” “us,” or “our” refer to the Health Plan, and the term “the Company” refers to Lewis & Clark College which sponsors the Plan.

When We May Use and Disclose Your Protected Health Information (PHI)

To protect the privacy of your PHI, we limit the way your PHI is used or disclosed to others. Except as allowed by law, we will not use or disclose your PHI unless you have given us your written permission to do so. The ways in which we may use or disclose your PHI without your specific permission are described below. To the extent required by law, we use the minimum amount of PHI necessary to perform these tasks.

- **For Treatment.** To facilitate your health care, we may disclose your PHI to a doctor, nurse, hospital or other health care provider who is involved in taking care of you. For example, we may disclose your prescription information to a pharmacist regarding a drug interaction concern, or contact you to provide information about treatment alternatives.
- **For Payment.** We may use or disclose your PHI to determine your eligibility for Plan benefits and to reimburse you or your health care providers for covered treatments and services. For example, we may use your diagnosis information to determine whether a particular treatment is medically necessary, or share your PHI with another group health plan to determine which plan is responsible for payment. We may also talk to your spouse about payment for your health care, unless you have asked us not to and we agreed to that request (see below under “Your Right to Request Restrictions”).

- **For the Operation and Administration of the Plan.** We may use and disclose your PHI for various administrative and quality control functions necessary to run the Plan. For example, we may use your PHI to conduct studies about the Plan's performance and costs, for fraud and abuse detection activities, or to obtain insurance quotes for the Plan. However, your authorization is required for most uses and disclosures of psychotherapy notes, for uses and disclosures of your PHI for marketing purposes, and for any sale of your PHI. Also, we cannot use or disclose your genetic information for underwriting purposes.
- **To Business Associates.** We may disclose your PHI to individuals or companies (called "Business Associates") that we've hired to perform various functions on the Plan's behalf or to provide certain services. For example, we may hire a company to help process benefit claims. However, before Business Associates can have access to your PHI, they must agree in writing to protect the privacy of your information.
- **To the Company for Plan Administration, Design and Enrollment Functions.** Certain Company employees may use or disclose your PHI for functions related to Plan administration, such as processing benefit claims. The Company may also use information about your enrollment or disenrollment in the Plan. In addition, if your name, address, Social Security Number and certain other identifying information is removed from your PHI, the Company may use this PHI for Plan design purposes (such as changing Plan benefits). However, the Company will not use or disclose your PHI for any other reason – including employment-related reasons – without your written permission.
- **To You or Your Personal Representative.** We may disclose your PHI to you, or to a person you designate or the law permits to receive your information. For example, if permitted by state law, we may disclose a child's PHI to the child's parent.
- **To Your Family Members, Friends, or Others Involved in Your Health Care.** We may share your PHI with these individuals if you are present and you do not object to us sharing your PHI, or in the event of an emergency. We may also share your PHI with these individuals after your death, unless you had asked us not to.

In Certain Other Situations

We may also use and disclose your PHI in certain other situations:

- To comply with federal, state or local law, such as public health disclosure laws. We are also required to disclose your PHI to the Department of Health and Human Services if requested to determine the Plan's compliance with HIPAA.
- For public health activities, including (1) to appropriate governmental authority for the prevention or control of disease, injury or disability, or to report child abuse or neglect; (2) to the Food and Drug Administration; (3) notifying a person who may have been exposed to a contagious disease, or may be at risk of contracting or spreading the disease, if permitted by law; or (4) providing proof of immunization to a school that is required by law to have such proof before admitting a student, if the student (or parent or other guardian, as appropriate) agrees to the disclosure.
- For public health oversight activities such as audits, investigations, inspections, licensure actions, and other government activities relating to health care.
- To report a suspected case of abuse, neglect or domestic violence, as permitted or required by law.
- To avert a serious threat to the health or safety of you, another person, or the public, but we may only disclose your PHI to a person reasonably able to prevent or reduce the threat.
- To organizations that coordinate organ donations or transplants, if you are the donor or recipient of an organ transplant.
- To respond to a request by military command authorities, if you are or were a member of the armed forces.
- To Workers' Compensation or similar programs, as required by law.
- If you are involved in a lawsuit or other dispute, to respond to an order of a court or administrative tribunal. We may also disclose your PHI in response to a subpoena, warrant, summons, or other legal request; however, we will make effort to notify you first or to obtain an order protecting your PHI.
- To a law enforcement official for a law enforcement purpose, as permitted or required by law. For example, we may notify the police if we believe a crime may have been committed. We may also disclose your PHI to federal official for national security purposes.
- If you are in jail or are in the custody of the police, to the jail or police if necessary (1) for the jail to provide you with health care; (2) to protect the health and safety of you or others; or (3) for jail's safety and security.
- To coroners, medical examiners and funeral directors, to allow a coroner or medical examiner to identify you, or to allow a funeral director to carry out his or her duties.

- To researchers, if (1) we have removed all information that could be used to identify you; or (2) the research has been approved by an institutional review board or privacy board and there are procedures in place to protect your PHI.

We will not use or disclose your PHI, except as described above, unless you give us your written permission. You may revoke your permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI except as described above (or as you've otherwise permitted). However, your revocation will only be effective for future uses and disclosures. It will not be effective for any PHI that may have been used or disclosed in reliance upon the permission, before we received your revocation.

Your Rights

HIPAA provides you with certain rights relating to your PHI. An individual with legal authority to make health decisions for you may exercise these rights on your behalf, and parents may exercise these rights on behalf of their children, if allowed under state law.

- **Your Right to Inspect and Copy.** You have the right to inspect and copy certain PHI that may be used to make decisions about your health care benefits. You also have the right to request an electronic copy of this PHI. We will provide the electronic copy to you or to another person you designate.

We may deny your request to inspect and copy in certain very limited circumstances (for example, if the PHI was created in anticipation of a civil, criminal or administrative action or proceeding). In the unlikely event you are denied access to your PHI, you may request that the denial be reviewed.

To inspect and copy your PHI, you must submit your request in writing to the person listed below. We may charge a reasonable fee for the costs of copying (including labor costs), mailing, or other supplies associated with your request.

- **Your Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the person listed below. In addition, you must provide a reason that supports your request. Otherwise, we may deny your request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the PHI kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect and copy; or (4) is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

- **Your Right to an Accounting of Disclosures.** You have the right to request a list (called an "accounting") of certain disclosures of your PHI. The Plan may limit its accounting will to include only those disclosures required by HIPAA.

To request an accounting, you must submit your request in writing to the person listed below. Your request must state a time period to be covered, although the Plan may limit that time period to the extent permitted by HIPAA. Your request should indicate in what form you want the accounting (for example, paper or electronic). You may request one accounting per 12-month period free of charge. We may charge you for the costs of providing additional accountings but we will notify you in advance and you may choose to withdraw or modify your request before you incur any expense. You also have the right to request an access report, to the extent provided by HIPAA.

Contact the person listed below if you have any questions about the type of information that the Plan will include in an accounting or the time period which an accounting can cover.

- **Your Right to Request Restrictions.** You have the right to request a restriction or limitation of our uses or disclosures of your PHI for treatment, payment, or health care operations. You also have the right to request we limit the disclosure of your PHI to someone who is involved in your care, such as a family member. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you that we are no longer honoring the restriction.

To request restrictions, you must make your request in writing to the person listed below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

- **Your Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at work, and not at home. We will accommodate all reasonable requests if you clearly state that the disclosure of all or part of your PHI could endanger you. To request confidential communications, you must make your request in writing to the person listed below.
- **Your Right to be Notification of a Breach.** You have the right to receive notification of any breach of your unsecured PHI.
- **Your Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may request a paper copy at any time by contacting the person listed below, even if you have agreed to receive this Notice electronically.
- **Your Right to File a Complaint.** You have the right to file a complaint with the Plan or with the Officer for Civil Rights of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. We take your complaints very seriously. You will not be penalized, or in any other way retaliated against, for filing a complaint. To file a complaint with the Plan, submit your complaint in writing to the person listed below. This is also the person to contact regarding your rights:

Department of Consumer & Business Services Insurance Division
PO Box 14480
Salem, Oregon 97309-0405
Phone: 503-947-7984
Email: dcbs.insmail@state.or.us
Website: www.insurance.oregon.gov

We are required to abide by the terms of this Notice currently in effect, however, we reserve our right to change this Notice at any time, if permitted or required by law. A change may apply to all of your PHI, even information we received before the change. If we make a significant change to this Notice, we will provide you with an updated copy or notify you of the changes and how to obtain an updated copy. In addition, you may request a current copy of this Notice at any time.

This Notice explains your privacy rights with respect to the Plan. This Notice does not create any right to employment for any individual, nor does it change the Company's right to discipline or discharge any of its employees in accordance with its applicable policies and procedures. In addition, this Notice does not change any other rights or obligations you may have under the Plan. You should refer to Plan documents for additional information regarding Plan benefits.

Initial COBRA Notice – 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 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;
- If the plan provides retiree 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 after the qualifying event occurs. You must provide this notice to the Plan Administrator.

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.

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.

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the 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

Name of Entity / Sender:	Lewis & Clark College
Contact / Position / Office:	Helen DeVol, Benefits Analyst
Phone Number:	503-768-6234
Email Address:	helen@lclark.edu

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877- KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ 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	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website:

	http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid

Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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

Patient Protection Disclosure

Kaiser “the health plan” generally requires or allows the member designation of a primary care provider (refer to the health plan’s Summary Plan Description for requirements). 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. Until you make this designation, the health plan 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 health plan’s insurance carrier or administrator identified in the health plan’s Summary Plan Description.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the health 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 health plan’s insurance carrier or administrator identified in the Summary Plan Description.