PLAN YEAR 2016

CITY OF SAN MARCOS

INITIAL NOTICES

Group Benefits Administrator:
TML MULTISTATE INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL
1821 Rutherford Lane, Suite 300
Austin, Texas 78754-5151

Customer Service: (800) 348-7879
Telefónica en Español: (800) 385-9952
www.iebp.org

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CITY OF SAN MARCOS NOTICE OF PRIVACY PRACTICES

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

The City of San Marcos's Employee Health Plan ("Plan") is required by law to keep your health information private and to notify you if the Plan, or one of its business associates, breaches the privacy or security of your unsecured, identifiable health information. This notice tells you about the Plan's legal duties connected to your health information. It also tells you how the Plan protects the privacy of your health information. The Plan must use and share your health information to pay benefits to you and your healthcare providers. The Plan has physical, electronic and procedural safeguards that protect your health information from inappropriate or unnecessary use or sharing.

Is all my health information protected?

Your individually identifiable health information that the Plan transmits or maintains in writing, electronically, orally or by any other means is protected. This includes information that the Plan creates or receives and that identifies you and relates to your participation in the Plan, your physical or mental health, your receipt of healthcare services and payment for your healthcare services.

How does the Plan use and share my health information?

The Plan's most common use of health information is for its own treatment, payment and healthcare operations. The Plan also may share your health information with healthcare providers, other health plans and healthcare clearinghouses for their treatment, payment and healthcare operations. (Healthcare clearinghouses are organizations that help with electronic claims.) The Plan also may share your health information with a Plan business associate if the business associate needs the information to perform treatment, payment or healthcare operations on the Plan's behalf. For example, your health benefits include a retail and mail order pharmacy network, the Plan must share information with the pharmacy network about your eligibility for benefits. Healthcare providers, other health plans, healthcare clearinghouses and Plan business associates are all required to maintain the privacy of any health information they receive from the Plan. The Plan uses and shares the smallest amount of your health information that it needs to administer your health plan.

What are treatment, payment and healthcare operations?

Treatment is the provision, coordination or management of healthcare and related services. For example, your health information is shared for treatment when your family doctor refers you to a specialist.

Payment includes Plan activities such as billing, claims management, subrogation, plan reimbursement, reviews for appropriateness of care, utilization review and prior notification of healthcare services. For example, the Plan may tell a doctor if you are covered under the Plan and what part of the doctor's bill the Plan will pay.

Healthcare operations include quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting and other activities necessary to create or renew health plans. It also includes disease management, Medical Intelligence Care Management, conducting or arranging for medical review, legal services, auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.
For example, the Plan may use information from your claims to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. Please note that while TML

MultiState IEBP may use and share your health information for underwriting, TML MultiState IEBP is prohibited from using or sharing any of your genetic information for underwriting.

How else does the Plan share my health information?

The Plan may share your health information, when allowed or required by law, as follows:

- Directly with you or your personal representative. A personal representative is a person who has legal authority to make healthcare decisions for you. In the case of a child under 18 years of age, the child's personal representative may be a parent, guardian or conservator. In the case of an adult who cannot make his own medical decisions, a personal representative may be a person who has a medical power of attorney.
- With the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with federal regulations on protecting the privacy and security of health information.
- With your family member, other relative, close personal friend or other person identified by you who is involved directly in your care. The Plan will limit the information shared to what is relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the release of your health information.
- For public health activities.
- To report suspected abuse, neglect or domestic violence to public authorities.
- To a public oversight agency.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- With organ procurement organizations or other organizations to facilitate organ, eye or tissue donation or transplantation.
- With a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties required by law.
- With a funeral director when permitted by law and when necessary for the funeral director to carry out his duties with respect to the deceased person.
- To avert a serious threat to health or safety.
- For specialized government functions, as required by law.
- When otherwise required by law.
- Information that has been de-identified. This means that the Plan has removed all your identifying information and it is reasonable to believe that the organization receiving the information will not be able to identify you from the information it receives.

Can I keep the Plan from using or sharing my health information for any of these purposes?

You have the right to make a written request that the Plan not use or share your health information, unless the use or release of information is required by law. However, since the Plan uses and shares your health information only as necessary to administer your health plan, the Plan does not have to agree to your request.

Are there any other times when the Plan may use or share my health information?

The Plan may not use or share your health information for any purpose not included in this notice, unless the Plan first receives your written authorization. To be valid, your authorization must include: the name of the person or organization releasing your health information; the name of the person or organization receiving

your health information; a description of your health information that may be shared; the reason for sharing your health information; and an end date or end event when the authorization will expire.

You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before TML MultiState IEBP receives your request.

The plan must always have your written authorization to:

- Use or share psychotherapy notes, unless the Plan is using or sharing the psychotherapy notes to defend itself in a legal action or other proceeding brought by you.
- Use or share your identifiable health information for marketing, except for: (1) a face-to-face communication from the Plan, or one its business associates, to you; or (2) a promotional gift of nominal value given by the Plan, or one its business associates, to you.
- Sell your identifiable health information to a third party.

You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before the Plan receives your request.

Can I find out if my health information has been shared with anyone?

You may make a written request to the Plan's Privacy Officer for a list of any disclosures of your health information made by the Plan during the last six years. The list will not include any disclosures made for treatment, payment or healthcare operations; any disclosures made directly to you; any disclosures made based upon your written authorization; any disclosures reported on a previous list; or any disclosures reported on a previous list.

Generally, the Plan will send the list within 60 days of the date the Plan receives your written request. However, the Plan is allowed an additional 30 days if the Plan notifies you, in writing, of the reason for the delay and notifies you of the date by which you can expect the list.

If you request more than one list within a 12-month period, the Plan may charge you a reasonable, cost-based fee for each additional list.

Can I view my health information maintained by the Plan?

You may make a written request to inspect, at the Plan's offices, your enrollment, payment, billing, claims and case or medical management records that the Plan maintains. You also may request paper copies of your records. If you request paper copies, the Plan may charge you a reasonable, cost-based fee for the copies.

Requests to view your health information should be made in writing to:

City of San Marcos
Attn: Director of Human Resources
630 E Hopkins
San Marcos, TX 78666-6397

If I review my health information and find errors, how do I get my records corrected?

You may request that the Plan correct any of your health information that it creates and maintains. All requests for correction must be made to the Plan's Privacy Officer, must be in writing and must include a reason for the correction. Please be aware that the Plan can correct only the information that it creates.

If your request is to correct information that the Plan did not create, the Plan will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be corrected because the diagnosis is incorrect, the Plan will correct the claim if the Plan (or its business associate) made an error in the data entry of the diagnosis.

However, if your healthcare provider submitted the wrong diagnosis to the Plan, the Plan cannot correct the claim without a statement from your healthcare provider that the diagnosis is incorrect.

The Plan has 60 days after it receives your request to respond. If the Plan is not able to respond, it is allowed one 30-day extension. If the Plan denies your request, either in part or in whole, the Plan will send you a written explanation of its denial. You may then submit a written statement disagreeing with the Plan's denial and have that statement included in any future disclosures of the disputed information.

I'm covered as a dependent and do not want any of my health information mailed to the covered employee's address. Will you do that?

If mailing communications to the covered employee's address would place you in danger, the Plan will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the covered employee's address would place you in danger. Please be aware that the Plan is required to send the employee any payment for a claim that is not assigned to a healthcare provider, except under certain medical child support orders.

If I believe my privacy rights have been violated, how do I make a complaint?

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Also, you may file a complaint with the U.S. Department of Health and Human Services. The Plan will not retaliate against you for filing a complaint.

When were the privacy practices described in this notice effective?

This privacy notice was effective September 1, 2013, and it replaced any privacy notice issued by the Plan before that date.

Can the Plan change its privacy practices?

The Plan is required by law to follow the terms of its privacy notice currently in effect. The Plan reserves the right to change its privacy practices and to apply the changes to any health information the Plan received or maintained before the effective date of the change. The Plan will distribute any revised notice to covered employees, either by hand or by mail, before the effective date of the revised notice.

What happens to my health information when I leave the plan?

The Plan is required to maintain your records for at least six years after you leave the Plan. However, the Plan will continue to maintain the privacy of your health information even after you leave the Plan.

How can I get a paper copy of this notice?

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Who can I contact for more information on my privacy rights?

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Is all my health information protected?

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What steps does IEBP take to protect my information?

Because IEBP believes that protecting your health information is of the highest priority, IEBP takes the following steps to ensure that your health information remains confidential:

Business Associate Agreements - IEBP follows the requirements of federal law and makes sure that any IEBP business associate who receives your personal health information signs a written agreement to protect your health information.

Encryption of Health Data - IEBP encrypts your health information that is sent electronically (for example, over the Internet) so that no one, who is not supposed to, can view your health information. To make sure that only the people who need your health information to administer your health plan benefits are able to see it, IEBP reviews the list of people who are allowed to view your personal health information on a regular basis.

Independent Review - IEBP periodically employs an independent security company to review and test IEBP's security controls to make sure they meet the requirements of federal law. The independent security company provides certified security professionals to conduct the review.

Use of Health Information - IEBP's Privacy & Security Officer reviews the use of personal health information by IEBP to ensure that it complies with both federal law and with IEBP's own privacy policies.

How does IEBP use and share my health information?

IEBP's most common use of health information is for its own treatment, payment and healthcare operations. IEBP also may share your health information with healthcare providers, other health plans and healthcare clearinghouses for their treatment, payment and healthcare operations. (Healthcare clearinghouses are organizations that help with electronic claims.) IEBP also may share your health information with an IEBP business associate if the business associate needs the information to perform treatment, payment or healthcare operations on IEBP's behalf.

For example, if your health plan includes a retail and mail order pharmacy network, IEBP must share information with the pharmacy network about your eligibility for benefits. Healthcare providers, other health plans, healthcare clearinghouses and IEBP business associates are all required to maintain the privacy of any

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- With the Secretary of the U.S. Department of Health and Human Services to investigate or determine IEBP's compliance with federal regulations on protecting the privacy and security of health information.
- With your family member, other relative, close personal friend or other person identified by you who is involved directly in your care. IEBP will limit the information shared to what is relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the release of your health information.
- For public health activities.
- To report suspected abuse, neglect or domestic violence to public authorities.
- To a public oversight agency.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- With organ procurement organizations or other organizations to facilitate organ, eye or tissue donation or transplantation.
- With a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties required by law.
- With a funeral director when permitted by law and when necessary for the funeral director to carry out his duties with respect to the deceased person.

- To avert a serious threat to health or safety.
- For specialized government functions, as required by law.
- When otherwise required by law.
- Information that has been de-identified. This means that IEBP has removed all your identifying information and it is reasonable to believe that the organization receiving the information will not be able to identify you from the information it receives.

Can I keep IEBP from using or sharing my health information for any of these purposes?

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- Use or share psychotherapy notes, unless IEBP is using or sharing the psychotherapy notes to defend itself in a legal action or other proceeding brought by you.
- Use or share your identifiable health information for marketing, except for: (1) a face-to-face communication from IEBP, or one its business associates, to you; or (2) a promotional gift of nominal value given by IEBP, or one its business associates, to you.
- Sell your identifiable health information to a third party.

Will IEBP share my health information with my employer?

IEBP shares summary health information with the employer who sponsors your group health plan. Employers need this information to get bids from other health plans or to make decisions to modify, amend or terminate the IEBP group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by the entire group of people covered under a health plan. Summary health information does not include any information that identifies you, such as your name, social security number or date of birth.

Also, IEBP shares with the employer who sponsors your group health plan information on whether you are enrolled in IEBP's group health plan or if you recently added, changed or dropped coverage.

Can I find out if my health information has been shared with anyone?

You may make a written request to IEBP's Privacy and Security Officer for a list of any disclosures of your health information made by IEBP during the last six years. The list will not include any disclosures made for treatment, payment or healthcare operations; any disclosures made directly to you; any disclosures made based upon your written authorization; or any disclosures reported on a previous list.

Generally, IEBP will send the list within 60 days of the date IEBP receives your written request. However, IEBP is allowed an additional 30 days if IEBP notifies you, in writing, of the reason for the delay and notifies you of the date by which you can expect the list.

If you request more than one list within a 12-month period, IEBP may charge you a reasonable, cost-based fee for each additional list.

Can I view my health information maintained by IEBP?

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Requests to view your health information should be made in writing to:

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ATTN: Privacy and Security Officer
1821 Rutherford Lane, Suite 300
Austin, Texas 78754-5151

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Please be aware that IEBP can correct only the information that it creates. If your request is to correct information that IEBP did not create, IEBP will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be corrected because the diagnosis is incorrect, IEBP will correct the claim if IEBP made an error in the data entry of the diagnosis. However, if your healthcare provider submitted the wrong diagnosis to IEBP, IEBP cannot correct the claim without a statement from your healthcare provider that the diagnosis is incorrect.

IEBP has 60 days after it receives your request to respond. If IEBP is not able to respond, it is allowed one 30-day extension. If IEBP denies your request, either in part or in whole, IEBP will send you a written explanation of its denial.

You may then submit a written statement disagreeing with IEBP's denial and have that statement included in any future disclosures of the disputed information.

I'm covered as a dependent and do not want any of my health information mailed to the covered employee's address. Will you do that?

If mailing communications to the covered employee's address would place you in danger, IEBP will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the covered employee's address would place you in danger.

Please be aware that IEBP is required to send the employee any payment for a claim that is not assigned to a healthcare provider, except under certain medical child support orders.

If I believe my privacy rights have been violated, how do I make a complaint?

If you believe your privacy rights have been violated, you may make a complaint to IEBP.

Write to: TML MultiState IEBP
ATTN: Privacy and Security Officer
1821 Rutherford Lane, Suite 300
Austin, Texas 78754-5151

Also, you may file a complaint with the U.S. Department of Health and Human Services. IEBP will not retaliate against you for filing a complaint.

When are the privacy practices described in this notice effective?

This privacy notice has an effective date of September 1, 2013.

Can IEBP change its privacy practices?

IEBP is required by law to follow the terms of its privacy notice currently in effect. IEBP reserves the right to change its privacy practices and to apply the changes to any health information IEBP received or maintained before the effective date of the change. IEBP will maintain its current privacy notice on its website at: www.iebp.org. If a revision is made during your plan year, IEBP will post the revised notice to its website on the date the new notice goes into effect. You will receive a paper copy of the revised privacy notice before the start of your next plan year.

What happens to my health information when I leave the plan?

IEBP is required to maintain your records for at least six years after you leave IEBP's group health plan. However, IEBP will continue to maintain the privacy of your health information even after you leave the plan.

How can I get a paper copy of this notice? Who can I contact for more information on my privacy rights?

To request that IEBP mail you a paper copy of this notice, call (800) 282-5385.

Write to: TML MultiState IEBP
ATTN: Privacy and Security Officer
1821 Rutherford Lane, Suite 300
Austin, Texas 78754-5151

SPECIAL ENROLLMENT NOTICE

If you do not enroll yourself or an eligible dependent in the City of San Marcos's medical plan because you or your dependent has other medical coverage, you may enroll in the medical plan at a later date if you or your dependent **loses** coverage under the other medical plan. To enroll in a medical plan, the loss of other coverage must be due to loss of eligibility for coverage or because the employer who sponsors the other plan stops contributing toward the cost of you or your dependent's coverage. Also, you must request enrollment in the medical plan within thirty-one (31) days of the date you or your dependent's other coverage ends. In general, only the person who **loses** other coverage may enroll in the City of San Marcos's medical plan as a result of this special enrollment opportunity.

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the medical plan if you request enrollment within thirty-one (31) days of the date of the marriage, birth, adoption or placement for adoption.

If you or a dependent becomes eligible for payment assistance through Medicaid or CHIP with the cost of coverage under a City of San Marcos medical plan, you and your plan-eligible dependents will be able to enroll in a City of San Marcos medical plan. You must request coverage within sixty (60) days of the date you or your dependent becomes eligible for payment assistance.

To request special enrollment or for more information about special enrollment opportunities, call TML MultiState IEBP's customer care staff at (800) 282-5385.

INITIAL NOTICE OF BENEFITS FOR WELLNESS SERVICES

PREVENTIVE CARE/WELLNESS BENEFIT/

The **Wellness Benefit** is payable at 100% with no deductible when services are received In-Network (and Non Network for Routine Eye Exams). For Out-of-Network, refer to the Summary of Benefits and Coverage. The Routine procedures will be reimbursed subject to usual, reasonable and customary charges. To be considered under this benefit, the provider's bill must designate a routine diagnosis code (except for refractions). The Wellness Benefit does not include virtual colonoscopies.

TESTS/PROCEDURES

- Routine Physical
- Breast cancer annual chemoprevention counseling for women at high risk
- Genetic Counseling for BRCA testing
- BRCA testing for women without any history of BRCA related cancer.
- Well Baby/Child Exams
- Well Woman Exam
- Routine Mammogram
- Routine Eye Exams (including refractions, regardless of the diagnosis) – charges for contact lens fitting are not covered and will be denied.
- Routine Hearing Exams
- Routine Labs and X-rays
- Routine Venipuncture
- General Health Panel
- Coronary Risk Profile (lipid panel)
- Urinalysis
- Prostate Specific Antigen (PSA)
- (TB) Tuberculosis test
- Handling of specimen to/from physician's office to a laboratory
- Occult Stool Test
- Examination for the detection of skin cancer
- Autism Screenings for 18 (eighteen) and twenty-four (24) months of age

Recommended at and after age 40 (this is a recommendation not a requirement)

- Chest X-Ray (front & lateral)
- EKG (electrocardiogram)
- Digital Rectal Exam
- Osteoporosis Screening

IMMUNIZATIONS/INOCULATIONS – ALL AGES

Charges for immunizations and administrative fees are covered under the plan, subject to usual, reasonable and customary limits. Allergy injections and expenses related to routine newborn care are not considered as part of this benefit.

This benefit included state-mandated and non state-mandated immunizations and is available to all covered persons under the plan, with no age limitations. To be considered under this benefit, the provider's bill must designate a routine diagnosis code. This list is a guideline, not an inclusive list.

- DT (Diphtheria and Tetanus Toxoids)
- DtaP Diphtheria, Tetanus Toxoids and Pertussis
- Td (Tetanus) booster
- MMR (Measles, Mumps, Rubella)
- MMR booster
- Poliomyelitis Vaccine
- Oral Polio
- Varicella Vaccine (Chicken Pox)
- Influenza
- Hepatitis A
- Hepatitis B
- Pneumococcal (Pneumonia)
- Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Absorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined)
- HIB (Hemophilus Influenza B)
- HPV (Genital Human Papillomavirus)
- Rotovirus
- Zosatavax (Shingles Vaccine)

COLON-RECTAL EXAMINATION

Coverage for the medically recognized screening examination for the detection of colorectal cancer for covered individuals at any age who have a personal or family history of polyps (or colon cancer), or who are at normal risk for developing colon cancer. This benefit includes expenses incurred while conducting a medically-recognized screening examination for the detection of colorectal cancer. In addition, the Colon-Rectal Examination benefit will also apply for the first non-routine colon-rectal exam claim received during the 5/10 year time period as noted below.

This includes annual fecal occult blood tests and a flexible sigmoidoscopy performed every five (5) years with a family or personal history of polyps (or colon cancer) or a colonoscopy performed every ten (10) years. This benefit excludes coverage for virtual colonoscopies.

This plan will also cover more frequent colonoscopies, sigmoidoscopies and fecal occult blood tests for all covered individuals at any age, with no limits at regular plan benefits, including when they are billed with a routine or non-routine diagnosis. This includes when they are billed with a diagnosis of personal or family history of polyps (or colon cancer).

NOTICE OF BENEFITS FOR MASTECTOMY AND BREAST RECONSTRUCTION

This medical plan provides comprehensive benefits for evidence-based initial mastectomy/lumpectomy, reconstructive oncology surgery of affected and non-affected breast. Eligible benefits include the initial non-cosmetic removal and replacement prosthetics due to complications. Reconstructive surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.

If you would like more information on benefits for mastectomy or breast reconstruction, call TML MultiState IEBP's customer care staff at (800) 282-5385.

INITIAL NOTICE OF MEDICAID & THE CHILDREN'S HEALTH INSURANCE PROGRAM

PREMIUM ASSISTANCE SUBSIDY

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. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but who also have access to health coverage through their employer. 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 eligible 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or go to 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 for an employer-sponsored health 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 question about enrolling in your employer plan, you can contact the Centers for Medicare & Medicaid Services electronically at www.cms.gov or by calling toll-free (877) 267-2323, ext. 61565.

If you live in one of the following States, you may be eligible for assistance paying for coverage under your employer health plan. The following list of States is current as of January 31, 2015. Contact your State for further information on eligibility.

ALABAMA – Medicaid
Website: www.mayalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529

COLORADO – Medicaid
Website: http://www.colorado.gov/hcpf
Phone: 1-800-221-3943

FLORIDA - Medicaid
Website: https://www.flmedicaidtplrecovery.com
Phone: 1-877-357-3268

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov

Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740 | TTY 1-800-977-6741

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid
Website: http://dwss.nv.gov/
Phone: 1-800-992-0900

NEW HAMSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/if_006254
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov |
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: http://www.conserva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website:http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: https://www.dhs.wisconsin.gov/badgerscareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any other States have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, you can contact either:

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

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

EXCHANGE/INSURANCE MARKETPLACES

Please see the Notification of Exchange/Insurance Marketplaces required notification form.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.6% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** 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*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

* 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)

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

CITY OF SAN MARCOS HIPAA EXEMPTION NOTICE PLAN YEAR 2016

Notice of Election of Exemption under the Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans as follows:

1. Limitations on pre-existing condition exclusion periods;
2. Special enrollment periods for individuals (and dependents) losing other coverage;
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status;
4. Standards relating to benefits for mothers and newborns;
5. Parity in the application of certain limits to mental health benefits; and
6. Required coverage for reconstructive surgery following mastectomies.

However, HIPAA permits certain governmental group health plans the right of exemption from certain provisions of this federal law. For the plan year from January 1, 2016 through December 31, 2016, the City of San Marcos has elected to exempt the City of San Marcos Employee Medical Plan from HIPAA provision 5 above. This exemption provides the City the ability to manage the benefits provided for mental health care, serious mental illness and substance use disorders in compliance with Texas requirements.

If you have any questions, please contact IEBP's customer service staff at (800) 282-5385.