

REQUIRED HEALTH COVERAGE NOTICES

Plumbers and Pipefitters Local Union 344 Health and Welfare Plan
4337 SW 44th St, Oklahoma City, OK 73119
Phone: 405-682-4581



Local 344 H&W Plan Participants,

The following pages provide employee benefit plan notices. Please read them carefully as we generally provide these once a year during annual open enrollment. You may see some of these notices in other documents as well, but we consolidate the following notices here for your convenience:

- [NOTICE OF PRIVACY PRACTICES](#)
- [MEDICARE PART D PRESCRIPTION DRUG CREDITABLE COVERAGE](#)
- [GENERAL NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA](#)
- [NEWBORNS & MOTHERS HEALTH PROTECTION ACT DISCLOSURE](#)
- [WOMEN'S HEALTH AND CANCER RIGHTS ACT](#)
- [HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS](#)
- [PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM \(CHIP\)](#)
- [YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS](#)

If you (and/or your dependents) have Medicare or will be eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 3 for more details.

The Health & Welfare Fund Office requires an updated blue enrollment form each year on all eligible participants. Take a moment to complete the form, both sides if applicable, and return to the Benefits Office at 4337 SW 44th St, Oklahoma City, OK 73119. **All information is required and the member must sign the form. You must turn in your blue form to the Benefit Office on or before December 15, 2025 in order to receive health insurance for you and/or your dependents. You can e-mail the forms and documents to andrea@local344.com. A confirmation e-mail will be sent back once received.** It is important to return the form as soon as possible.

To request coverage for a child who has not attained age 26, the attached enrollment form must be completed as well as a copy of each dependent's Birth Certificate and Social Security Card and **MUST** be returned to the benefits office on or before December 15, 2025 in order to be covered by January 1, 2026. **If the Blue form and/or other documents are not received by December 15th, 2025, the dependents will not be eligible until the next open enrollment period.**

Online enrollments are now available through the PP344 website at pp344.com in the benefits section.

Your sign in is:

USERNAME: last 4 digits of SSN + 1st initial of first name + Full last name in ALL CAPS

PASSWORD: your UHC Member ID # (enter the numbers **after** the 374)

****This password is good as long as you haven't changed in the past, if you don't remember the password, click on forgot password and the system will send you an e-mail to reset the password.***

Members can fill out all the information including address changes, and update any other information required on the "Blue Form" and can be submitted online. Once completed, you will receive a confirmation number, please make note of that number.

ACCIDENT INFORMATION: If you have any type of "accident" whether it be a cut finger, broken bone, or anything that can be considered as an accident, the Doctor's office will code your claim as an accident. This prompts the Claims office to send out an Accident Form for you to fill out and return in order for your claim to be processed. ALL claims that are coded ACCIDENTS will not get paid until you fill out, sign, and return the form to the Claims office or Benefit office.

CLAIMS/EOB Portal: sign on at: <https://portal.benefitresourcesinc.com/> Click "register a New Account" and follow the instructions. You will need three pieces of information to activate your Portal: 1) Your SS number (most likely only the last 4 of your SSN) 2) An active e-mail address and 3) date of birth. This will allow ALL members to view or print their EOB's that have been processed. The spouse will need to sign up on their own due to privacy.

Throughout these pages you are invited to contact the Benefit office for assistance. For any questions or requests you may have about the pages below, including Health and Welfare benefits or request a paper copy of this notice packet or the Summary Plan Description (SPD), contact Andrea Peery (benefit office) at 405-682-4581. An electronic version of the SPD is available on the aforementioned website.

Before we get into the notices, some basic rules governing our plan are summarized below:

- You may only enroll when first eligible or during our annual open enrollment each Fall
- **Your election is locked** for the entire plan year, January 1 to December 31.
- You can generally submit an election change form **within 60 days of a qualifying life event** to request a benefit change during the plan year. We may require substantiating documentation of the event, and we may determine the event does not qualify to make the requested change.
- At any time, we may audit dependent status and require current substantiating documentation.
- **Please keep us informed of address or beneficiary changes.**
- When first enrolling in health coverage, a **general notice of rights and responsibilities to continue health coverage under COBRA** is mailed to the home. It explains that when certain life events make an enrolled individual no longer eligible to stay on the plan, coverage might be able to continue for a limited time under COBRA so long as you or your spouse follow our procedures to notify us within 60 days of the qualifying life event.

OTHER IMPORTANT NOTICES

Please refer to the following notices pertaining to the Plumbers and Pipefitters Local 344 Health and Welfare Plan.

- [SPECIAL ENROLLMENT NOTICE UNDER HIPAA](#)
- [UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT \(USERRA\)](#)
- [MICHELLE'S LAW](#)

NOTICE OF PRIVACY PRACTICES

Please note: the following notice provided by the Department of Health and Human Services contains language for both health plans as well as physicians' offices and other providers. Therefore, some language may not be applicable to your employer's health plan.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

YOUR RIGHTS

You have the right to:

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

YOUR CHOICES

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

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OTHER USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

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

Get a copy of health and claims records.

You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

YOUR CHOICES

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

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

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

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

- Marketing purposes
- Sale of your information

OTHER USES AND DISCLOSURES

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

OTHER RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

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

Effective Date of this Notice: September 20, 2025

Name or title of the privacy official: Human Resources

Email Address: andrea@local344.com

Phone Number: (405) 682-4581

Note: Some states have health information privacy laws with stricter requirements than HIPAA. Those can be located at: <https://www.seyfarth.com/a/web/bhRXWBkMif111KfVwiQN6V/50-state-survey-of-health-care-information-privacy-laws-2023-2024-edition.pdf>

Attention: Medicare Eligible Employees and Dependents**Important Notice from Plumbers and Pipefitters Local 344 Health and Welfare Plan About Your Prescription Drug Coverage and Medicare (Creditable Coverage)**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Plumbers and Pipefitters Local 344 Health and Welfare Plan 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. Plumbers and Pipefitters Local 344 Health and Welfare Plan has determined that the prescription drug coverage offered by Plumbers and Pipefitters Local 344 Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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 Plumbers and Pipefitters Local 344 Health and Welfare Plan coverage will be affected. For those individuals that elect Medicare D coverage, coverage under the group plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current Plumbers and Pipefitters Local 344 Health and Welfare Plan 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 Plumbers and Pipefitters Local 344 Health and Welfare Plan 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 Human Resources Department at the phone number shown below for further information. *NOTE:* You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Plumbers and Pipefitters Local 344 Health and Welfare Plan changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare Prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at 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).

9/20/2025

Name of Entity/Sender: Plumbers and Pipefitters Local 344

Health and Welfare Plan

Contact/Office: Human Resources

Address: 4337 SW 44th Street, Oklahoma City, OK 73119

Phone Number: (405) 682-4581

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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

Introduction

You are receiving this notice because you have recently become eligible for coverage under the Plumbers and Pipefitters Local 344 Health and Welfare Plan ("Plan"). This notice contains 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 the right to receive 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 others 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 and 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 coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs, 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 a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

If you're an employee, you will 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 (under 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Plumbers and Pipefitters Local 344 Health and Welfare Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event 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 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 notify Plumbers and Pipefitters Local 344 Health and Welfare Plan of the qualifying event by calling Plumbers and Pipefitters Local 344 Health and Welfare Plan at (405) 682-4581.

How Is COBRA 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. As stated below, 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.

You, your covered spouse or your covered dependents must notify Plumbers and Pipefitters Local 344 Health and Welfare Plan within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period in order to receive the coverage extension. To notify Plumbers and Pipefitters Local 344 Health and Welfare Plan of the disability determination, call Plumbers and Pipefitters Local 344 Health and Welfare Plan at (405) 682-4581.

You, your covered spouse or your covered dependents must notify Plumbers and Pipefitters Local 344 Health and Welfare Plan within 30 days of the date the disability ends by calling the Plumbers and Pipefitters Local 344 Health and Welfare Plan at (405) 682-4581.

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.

You, your covered spouse or your covered dependents must notify Plumbers and Pipefitters Local 344 Health and Welfare Plan within 60 days after the event occurs in order to receive this additional coverage. To notify Plumbers and Pipefitters Local 344 Health and Welfare Plan of the qualifying event, call Human Resources at (405) 682-4581.

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, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), 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.

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 period¹ 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. 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: Plumbers and Pipefitters Local 344
Health and Welfare Plan
Contact/Office: Human Resources
Address: 4337 SW 44th Street, Oklahoma City, OK 73119
Phone Number: (405) 682-4581

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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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 states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to your medical plan's Summary of Benefits and Coverage for this information. For more information on WHCRA benefits, contact Human Resources Department at (405) 682-4581.

Final rules issued September 9, 2024 provided additional protections within the MHPAEA requirements, which are critical to addressing barriers to access to MH/SUD benefits. Below are some of the additional protections put in place.

- Made it clear that MHPAEA protects plan participants, beneficiaries, and enrollees from facing greater restrictions on access to MH/SUD benefits as compared to medical/surgical benefits.
- Reinforced that health plans and issuers cannot use "non-quantitative treatment limitations" (NQTs) applicable to MH/SUD benefits that are more restrictive than the predominant NQTs applied to substantially all medical/surgical benefits in the same classification.
- Required plans and issuers to collect and evaluate data and take reasonable action, as necessary, to address material differences in access to MH/SUD benefits as compared to medical/surgical benefits that result from application of NQTs, where the relevant data suggest that the NQTL contributes to material differences in access.
- Codified the requirement in MHPAEA, as amended by the Consolidated Appropriations Act of 2021, that health plans and issuers conduct comparative analyses to measure the impact of NQTs. This includes evaluating standards related to network composition, out-of-network reimbursement rates, and medical management and prior authorization NQTs.
- Prohibited plans and issuers from using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits when designing NQTs.
- Implemented the sunset provision for self-funded non-Federal governmental plan elections to opt out of compliance with MHPAEA.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE



Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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. If your share of the premium cost of all plans offered to you through your employment is more than **9.96%**² 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 **9.96%** of the employee's household income.¹³

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

² Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

³ An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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.

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.

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 Plumbers and Pipefitters Local 344 Health and Welfare Plan, 4337 SW 44th Street, Oklahoma City, OK 73119, (405) 682-4581.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 Plumbers and Pipefitters Local 344 Health and Welfare Plan	4. Employer Identification Number (EIN)
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5. Employer address 4337 SW 44 th Street		6. Employer phone number (405) 682-4581	
7. City Oklahoma City		8. State OK	9. ZIP code 73119
10. Who can we contact about employee health coverage at this job? Human Resources			
11. Phone number (if different from above)		12. Email address andrea@local344.com	

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

As your employer, we offer a health plan to:

(X)

	All Employees - eligible employees are:
X	Some employees - eligible employees are: Regular, full-time employees working 25 hours or more per week

With respect to dependents:

X	We do offer coverage - eligible dependents are: The employee's lawful spouse, eligible dependents under the age of 26, and mentally or physically disabled children of any age who are incapable of self-support and were disabled prior to age 26
	We do not offer coverage

X	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.
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**** 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 you may contact Human Resources for assistance with this information.

(X)

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible for coverage 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 the 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 two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly	
If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.	
16. What change will the employer make for the new plan year?	
	Employer won't offer health coverage
	Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. (See question 15.))
a. How much would the employee have to pay in premiums for this plan? \$_____	
b. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly	

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

SPECIAL ENROLLMENT NOTICE UNDER HIPAA

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a state CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact Human Resources at (405) 682-4581.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

YOUR RIGHTS UNDER USERRA

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

Reemployment Rights

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

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

Right to Be Free from Discrimination and Retaliation

If you:

- are a past or present member of the uniformed service,
- have applied for membership in the uniformed service, or
- are obligated to serve in the uniformed service;

then an employer may not deny you:

- initial employment
- reemployment
- retention in employment
- promotion, or
- any benefit of employment

because of this status.

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

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your

employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at <https://www.dol.gov/agencies/vets/>. An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra>
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <https://www.dol.gov/agencies/vets/programs/userra/poster>

Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

MICHELLE'S LAW

This notice is only applicable to medical plans that offer dependent coverage post 26 and require certification of student status, as well as integrated dental or vision plans that require student status certification beyond the normal eligibility date.

Michelle's Law requires group health plans to allow seriously ill or injured college students who are covered dependents to continue their coverage for up to one year while on medically necessary leaves of absence that begin during such plan years. To receive the extension of coverage, your dependent child must be covered under the Plan immediately before the leave by reason of being a student at a post-secondary educational institution, and the leave must cause that dependent child to lose student status for purposes of coverage under the Plan's terms.

The extension of coverage continues until the earlier of (a) one year after the first day of the leave, or (b) the date that coverage would otherwise terminate under the Plan's terms (e.g., due to an age limitation). If the coverage provided by the Plan is changed during this one-year period, the Plan will provide the changed coverage for your dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the Plan no longer provides coverage for dependent children. If you believe your dependent child is eligible for this continued coverage, the dependent child's treating physician must provide a written certification to the plan stating that your dependent child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

Coordination with COBRA Continuation Coverage:

If your dependent child is eligible for Michelle's Law's continued coverage and loses coverage under the Plan at the end of

the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

FORMAL NOTICE TO EMPLOYEE

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the Plumbers and Pipefitters Local 344 Health and Welfare Plan group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of Plumbers and Pipefitters Local 344 Health and Welfare Plan group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the Plumbers and Pipefitters Local 344 Health and Welfare Plan group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the Plumbers and Pipefitters Local 344 Health and Welfare Plan group health plan, whichever is earlier.

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

- The Plumbers and Pipefitters Local 344 Health and Welfare Plan group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary

Plan Administrator's Contact Information for Michelle's Law

Plumbers and Pipefitters Local 344 Health and Welfare Plan
Human Resources Department
Contact/Office: Human Resources
Address: 4337 SW 44th Street, Oklahoma City, OK 73119
Phone Number: (405) 682-4581

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfir/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/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: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP 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 Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult 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 Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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)
Menu Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid. 1-877-267-2323,

Paperwork Reduction Act Statement

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

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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.

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 the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). 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 balance billed for these post-stabilization services.

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

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

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

You're 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.

When balance billing isn't allowed, you also have the following 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 contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint. or, you can submit a complaint [online](#).

(https://nsa-idr.cms.gov/consumercomplaints/s/?language=en_US)

Visit [this website](#) for more information about your rights under federal law.

(<https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills#:~:text=The%20No%20Surprises%20Act%20protects,network%20air%20ambulance%20service%20providers>).

Please note: in addition to the federal protections under the No Surprises Act, several states have also implemented laws to help protect consumers against balance billing. Please see the following pages which indicate a summary of those protections and visit <https://www.commonwealthfund.org/node/27021> to learn more.

State Balance-Billing Protections

Last Updated February 5, 2021



Affordable, quality health care. For everyone.

State	Setting		Type of managed care plan		Type of protection		State-specific method for payment	
	Emergency department	Nonemergency care in network hospital*	HMO	PPO	Hold harmless	Provider prohibition	Payment standard	Dispute resolution process
Comprehensive Approach (18 states)								
California	✓	✓	✓	✓ (a)	✓	✓	✓ (m)	(n)
Colorado	✓	✓	✓	✓	✓	✓	✓	(v)
Connecticut	✓	✓	✓	✓	✓	✓	✓	
Florida	✓	✓	✓	✓	✓	✓	✓ (b)	✓
Georgia	✓	✓	✓	✓	✓	✓ (aa)	✓	✓
Illinois	✓ (y)	✓ (y)	✓	✓	✓ (c)	✓ (d)		✓
Maine	✓	✓	✓	✓	✓	✓	✓	✓ (h)
Maryland	✓	✓	✓	✓	✓ (e)	✓ (d)	✓ (e)	
Michigan	✓	✓ (ee)	✓	✓		✓	✓	✓ (ff)
New Hampshire	✓ (k,y)	✓ (y)	✓	✓		✓		✓
New Jersey	✓	✓	✓	✓	✓	✓		✓ (o)
New Mexico	✓	✓	✓	✓	✓	✓	✓	
New York	✓	✓	✓	✓	✓	✓ (d)		✓ (p)
Ohio	✓	✓	✓	✓		✓	✓	✓ (ff)
Oregon	✓ (k)	✓	✓	✓		✓	✓	
Texas	✓	✓	✓	✓	✓ (w)	✓		✓ (x)
Virginia	✓	✓ (y)	✓	✓	✓	✓		✓
Washington	✓	✓ (y)	✓	✓	✓	✓		✓ (z)
Limited approach (15 states)								
Arizona	✓ (k)	✓ (s)	✓ (t)	✓ (q)	✓	(r)		(l)
Delaware	✓ (f)	✓ (bb)	✓	✓	✓ (f)	✓ (bb)	(cc)	(cc)
Indiana	✓ (i)	✓ (i)	✓	✓ (i)		✓		
Iowa	✓		✓	✓	✓			
Massachusetts	✓ (k)	✓	✓	✓	✓			
Minnesota		✓ (j)	✓	✓	✓			✓
Mississippi	✓	✓	✓	✓	✓	✓ (d)		
Missouri	✓ (k)		✓	✓		✓		✓
Nebraska	✓		✓	✓	✓	✓	✓	(dd)
Nevada	✓		✓	✓	✓	✓	(u)	✓
North Carolina	✓		✓	✓	✓			
Pennsylvania	✓		✓	✓ (g)	✓			
Rhode Island	✓	✓	✓		✓			
Vermont	✓		✓	✓	✓			
West Virginia	✓		✓		✓			

* Most states provide an exception from protections for nonemergency services in cases where the enrollee has consented or chosen to receive services from an out-of-network provider. The scope of this exception differs by state.

More details are available in the interactive map at <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>.

NOTES

- ^a In California, balance-billing protections in the emergency department setting only apply to those plans regulated by the California Department of Managed Care, which includes HMOs and most PPOs.
- ^b In Florida, payment standards apply to PPOs but for HMOs they apply only for nonnetwork providers of emergency services.
- ^c In Illinois, protections apply only to facility-based providers.
- ^d In Maryland, Mississippi, and New York, balance-billing protections attach when the consumer assigns the benefit to the provider. The linkages to assignment apply to PPOs in Maryland only. In Illinois, the provider prohibition protection attaches when the consumer assigns the benefit to the provider, but the hold harmless protection applies even without assignment.
- ^e In Maryland, the hold harmless and payment standards for PPOs apply only to on-call physicians and hospital-based physicians who obtain assignment of benefits. They apply to HMO providers in all situations.
- ^f Delaware requires insurers to hold enrollees harmless for emergency services provided but does not ban balance billing.
- ^g In Pennsylvania, emergency service balance-billing protections apply only to HMOs and PPOs that require gatekeepers.
- ^h In Maine, dispute resolution is provided only for emergency services.
- ⁱ In Indiana, protections for emergency services apply only to HMOs. Thus, PPO protections are for nonemergency services only.
- ^j In Minnesota, the protection applies when the service is provided due to unavailability of a participating provider or without the enrollee's knowledge or due to the need for unforeseen services arising at the time the service is rendered.
- ^k In Arizona, Massachusetts, Missouri, New Hampshire, and Oregon, the protection applies only for emergency services provided by a nonparticipating provider in a network hospital.
- ^l In Arizona, a dispute resolution process is available for claims exceeding a specified amount.
- ^m In California, the payment standard is less specific in situations involving emergency services.
- ⁿ California has available a dispute resolution process for out-of-network care at network facilities if the regular process for applying the payment standard fails in some way. The state also has a voluntary, nonbinding dispute resolution process for emergency services, but it has never been used.
- ^o In New Jersey, there is a \$1,000 threshold for invoking the dispute resolution process, but the consumer is held harmless even if dispute resolution is not used.
- ^p In New York, certain emergency services (specified by CPT codes) are exempt from the independent dispute resolution process if the bill does not exceed 120 percent of the usual and customary cost and the fee disputed is \$672.01 (adjusted annually for inflation rates) or less after any applicable coinsurance, copayment, and deductible. The consumer is held harmless for emergency services even if dispute resolution is not used.
- ^q In Arizona, protections only apply to health plans that cover out-of-network care.
- ^r In Arizona, providers are not prohibited from balance billing PPO members. But in cases where a dispute resolution process is used, a balance bill cannot be submitted after the arbitrator has made a decision.
- ^s In Arizona, protection in nonemergency situations is contingent on disclosure to the consumer. But if the consumer declines to agree to the disclosure, the protections still apply.
- ^t According to state interpretation, the Arizona protection covers enrollees in HMOs.
- ^u Nevada provides a payment standard for a provider or facility that recently had a participation contract in place with the insurer.
- ^v In Colorado, a provider or facility that is not satisfied with the reimbursement rate dictated by the payment standard, given the complexity of the services provided, is allowed to initiate binding arbitration.
- ^w In Texas, hold harmless protection only applies to HMOs and EPOs, but not PPOs.
- ^x For facilities in Texas, there is a mediation process instead of binding arbitration.
- ^y In Illinois, New Hampshire, Virginia, and Washington, with respect to nonemergency services provided by out-of-network providers at in-network facilities, protections are limited to a set of designated specialties. The same restrictions also apply to emergency services in Illinois and New Hampshire.
- ^z In Washington, the result of arbitration is not described in the statute as binding.
- ^{aa} In Georgia, the payment standard does not apply to out-of-network facilities. Insurers are required to make some payment but there is no specific formula to use.
- ^{bb} Delaware bans billing for nonemergency services, but there is no hold-harmless requirement.
- ^{cc} In Delaware, insurers are required to reimburse the highest allowable charge for each emergency care service allowed by the insurer for any other network or nonnetwork emergency care provider in the year before the date of the performed service. In the event the provider of emergency services and insurer cannot agree upon an appropriate rate, the provider shall be entitled to the charges allowed by the insurance commissioner following an arbitration of the dispute.
- ^{dd} Nebraska has a voluntary, non-binding mediation process that applies if a provider deems the payment made by the insurer to be unreasonable.
- ^{ee} In Michigan, in cases involving emergency services, a non-participating provider can request an additional payment (25% of the payment standard amount) if a complicating factor is identified. If the carrier rejects the request, a non-participating provider can initiate binding arbitration.
- ^{ff} In Ohio, parties can request binding arbitration if the service was provided not more than one year earlier and the total amount of individual or bundled claims exceeds \$750.