These documents will remain posted electronically and in an area available for future use.

Shari Kline dba TL at Home

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

The attached information is provided so that you are aware of rights you may have under state and/or federal law as an eligible participant in the Shari Kline dba TL at Home health insurance plan(s).

- Federal & State COBRA Rights Notification
- Notice of HIPAA Special Enrollment Rights
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Patient Protection Disclosure to Participants of Non-Grandfathered Plans
- Notice of Medical Loss Ratio (MLR) Status
- The Women's Health and Cancer Rights Act of 1998
- Medicare Part D Notification of Creditable Coverage provided by our
  CDPHP Gold Triple Zero 224 $0 / $50 / $80 and
  CDPHP Silver Copay First 425 Phase 1: $10 / $30 / $50; Phase 2: Deductible then Covered in Full – 9/1/22 - 8/31/23 Health Plans
- Notice of HIPAA Privacy Practices
- Notice of Availability of Coverage in the Health Insurance Marketplace
- Additional Notices for New York Employees
  CDPHP Gold Triple Zero 224 Summary of Benefits and Coverage (SBC)
  CDPHP Silver Copay First 425 Summary of Benefits and Coverage (SBC)

Shari Kline dba TL at Home

For additional information on the attached notices, please contact:

Name **Shari Kline**
Title: **GBA**
Telephone Number: **5188513975**

Reminder of Federal Continuation Coverage Rights under COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This life event is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both); and

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days (*or another time frame if permitted under the terms of the Plan*) after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

For more information concerning your Plan or your COBRA continuation coverage rights, please contact your Plan Administrator or HMS Agency, Inc. at (518) 690-0360.

If you qualify for COBRA coverage, you will receive more information from **Shari Kline dba TL at Home** following the specific event.

Notice of HIPAA Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage under the Health Insurance Portability and Accountability Act (HIPAA). You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

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, 2020. Contact your State for more information on eligibility

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First CO Member Contact Cntr: 1(800)221.3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-484
INDIANA – Medicaid	**MINNESOTA - Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1.877.438.4479 All other Medicaid – Website: htps://www.in.gov/Medicaid/ Phone: 1.800.457.4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1.800.657.3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI - Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1.800.338.8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1.800.257.8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573.751.2005
KANSAS – Medicaid	**MONTANA - Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1.800.792.4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1.800.694.3084
KENTUCKY – Medicaid	**NEBRASKA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1.877.524.4718 / Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://ACCESSNebraska.ne.gov Phone: 1.855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

LOUISIANA – Medicaid	NEVADA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms 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.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number HIPP program: 1-800-852- 3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/ HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2020, or for more information on special enrollment rights, contact either:

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

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

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

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.

OMB Control Number 1210-0137 (expires 1/31/2023)

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

Patient Protection Disclosure to Participants of Non-Grandfathered Plans

For the **9/1/22 - 8/31/23** plan year **Shari Kline dba TL at Home CDPHP Gold Triple Zero 224** and **CDPHP Silver Copay First 425** hold Non-Grandfathered Status in accordance with the Patient Protection and Affordable Care Act (the Affordable Care Act).

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

Notice of Medical Loss Ratio (MLR) Status

For the **2021** MLR Reporting Year, **Shari Kline dba TL at Home** health insurance plan offering met or exceeded the Medical Loss Ratio rules in accordance with the Patient Protection and Affordable Care Act (the Affordable Care Act). The Plan and/ or its participants will not be receiving a rebate check.

The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, **2022**, health insurers must send any rebates due for the **2021** plan year and information to employers and individuals regarding any rebates due.

You are receiving this notice because your health insurer had a Medical Loss Ratio for the **2021** that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio, visit www.HealthCare.gov

The Women's Health and Cancer Rights Act of 1998

Enrollment Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on applicable deductible amounts, coinsurance amounts or WHCRA benefits, please contact your Plan Administrator or HMS Agency, Inc. at (518) 690-0360.

Annual Notice
Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Please contact your Plan Administrator or HMS Agency, Inc. at (518) 690-0360 for more information.

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

Medicare Part D Notification of Creditable Coverage provided by our CDPHP Gold Triple Zero 224 $0 / $50 / $80 and CDPHP Silver Copay First 425 Phase 1: $10 / $30 / $50; Phase 2: Deductible then Covered in Full – 9/1/22 - 8/31/23 Health Plans

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Shari Kline dba TL at Home** 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.

1. **Shari Kline dba TL at Home** has determined that the prescription drug coverage offered by the **CDPHP Gold Triple Zero 224 $0 / $50 / $80** and **CDPHP Silver Copay First 425 Phase 1: $10 / $30 / $50; Phase 2: Deductible then Covered in Full – 9/1/22 - 8/31/23** are, 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 through 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 **Shari Kline dba TL at Home** coverage **will not** be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Shari Kline dba TL at Home coverage, be aware that you and your dependents **may 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 **Shari Kline dba TL at Home** 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:

You may contact the person listed below for further information or call HMS Agency, Inc. at (518) 690-0360. **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 Shari Kline dba TL at Home] 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.

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

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; or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date: November 15, 2022
Name of Entity/Sender: **Shari Kline dba TL at Home**
Contact/Position: **Shari Kline**
Address: **29 NY 9H, Claverack, NY 12513**
Phone Number: **5188513975**

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

HMS Agency, Inc.
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.

This Notice describes the legal obligations of affiliate HMS Agency, Inc. and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices (the "Notice") to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact:

HIPAA Compliance and Privacy Officer
HMS Agency Inc.
454 Sand Creek Road
Albany, NY 12205
Telephone 518-690-0360; Fax 518-690-0355

Effective Date: This Notice is effective August 8, 2013.

Our Responsibilities

The Plan is required by law to maintain the privacy of PHI and to provide participants with notice of its legal duties and privacy practices.

State Law Issues
To the extent that State law is more restrictive with respect to our ability to use or disclose your Patient Information, or to the extent that it affords you greater rights with respect to the control of your information, we will follow applicable State law. This may arise if your Health Information contains information relating to HIV/AIDS, mental health, substance abuse/chemical dependency and genetic testing, among others.

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices **by mail or by email to your last-known address on file.**

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. Minimum Necessary Standard will be used when using or disclosing PHI or when requesting PHI from another covered entity. The Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Minimum Necessary Standard does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and there is no reasonable basis to believe that the information can be used to identify an individual or an individual's health information.

The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may have been the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information as required by federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official, if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information and approves the research.

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

More specifically, the Plan may not, without your written authorization, use or disclose any of your protected health information for marketing purposes or make any disclosures that constitute a sale of such protected health information. Further, if the Plan maintains any psychotherapy notes, such notes may not be used or disclosed without your written authorization.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to:

HIPAA Compliance and Privacy Officer
HMS Agency Inc.
454 Sand Creek Road
Albany, NY 12205
Telephone 518-690-0360; Fax 518-690-0355

If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the **HIPAA Compliance Department**.

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

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

To request an amendment, your request must be made in writing and submitted to the HIPAA Compliance and Privacy Officer, HMS Agency, Inc. at above address. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

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

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorizations; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to:

HIPAA Compliance and Privacy Officer
HMS Agency Inc.
454 Sand Creek Road
Albany, NY 12205
Telephone 518-690-0360; Fax 518-690-0355

Your request must state a time period of no longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke them, or we notify you.

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), we will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

To request restrictions, you must send your request in writing to:

HIPAA Compliance and Privacy Officer
HMS Agency Inc.
454 Sand Creek Road
Albany, NY 12205
Telephone 518-690-0360; Fax 518-690-0355

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosure to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the HIPAA Compliance and Privacy Officer, HMS Agency Inc.

We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, www.hmsagency.com

To obtain a paper copy of this notice, send request to:

HIPAA Compliance and Privacy Officer
HMS Agency Inc.
454 Sand Creek Road
Albany, NY 12205
Telephone 518-690-0360; Fax 518-690-0355

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services, 150 S. Independence Mall West Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111(tel: 215.861.4441; 800.368.1019). To file a complaint with the Plan, contact HIPAA Compliance and Privacy Officer, HMS Agency Inc., 454 Sand Creek Road Albany, NY 12205 phone 518-690-0360 and fax 518-690-0355. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us.

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there became 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 Health Insurance Marketplace and employment-based health coverage offered by **Shari Kline dba TL at Home.**

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 occurs between October and December each year.

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

You may qualify to save money and lower your monthly premium if you qualify for available federal subsidies and premium credits, but only if:

- You do not meet the eligibility requirements to enroll in our plan.
- The plans offered by your employer do not meet the minimum coverage requirements of the Affordable Care Act. Please note that the plan(s) offered by **Shari Kline dba TL at Home** do meet the minimum coverage guidelines.
- A health plan option is available to you that does not require you to contribute more than 9.66% (9.69% for 2017 tax year) of your gross wages from your employer towards the cost of individual coverage.

  If you are eligible to apply through the Health Insurance Marketplace, the savings on your premium that you may be eligible for will depend 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 the standards noted above, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, 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 would be made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by **Shari Kline dba TL at Home**, please review the benefits information (plan description and summary of benefits and coverage) which have been provided to you or contact **Shari Kline** if you have not yet been provided the benefits information or have questions about the information provided.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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.

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

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.

Employer name: **Shari Kline dba TL at Home**

Employer Identification Number (EIN): **45-4098731**

Employer address: **29 NY 9H, Claverack, NY 12513**

Employer phone number: **5188513975**

Employer contact for information on employee health coverage at this job: **Shari Kline**

Phone number (if different from above): **5188513975**

Email address: **shari@traditionslinens.com**

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

As your employer, we offer a health plan to:

__X__ **All Eligible Employees** following the eligibility guidelines provided below

Eligible employees are (eligibility guidelines): **Full-Time Employee working 30 hours or more per week**

Eligible employees also have the option to enroll their dependents for coverage.

__X__ If checked, available coverage meets the minimum value standards of the affordable care act.

The cost of this coverage to you will be deemed to be affordable under the Affordable Care Act if the amount you are required to contribute towards the lowest cost individual plan does not exceed 9.66% (9.69% for 2017 tax year) of the wages you earn from **Shari Kline dba TL at Home.**

Please note that even if our employer group plan is deemed 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, www.HealthCare.gov will guide you through the process. HMS Agency, Inc. also has trained staff available to assist individuals and families in comparing health coverage options available through the New York State of Health Insurance Marketplace. These Marketplace Facilitated Enrollers can assist you in applying online, answer questions on eligibility, and assist in making changes on the Marketplace. For more information contact HMS Agency, Inc. at (518) 690-0360.

2022 Benefit Plan Year
State & Federal Employee Health Plan Required Notices

ADDITIONAL NOTICES FOR NEW YORK EMPLOYEES

New York State COBRA Rights Notification

On July 29, 2009, Governor David A. Paterson signed into law Chapter 236 of the Laws of 2009, which extends state continuation coverage for a period of 36 months. This extension will assist employees and their dependents that are eligible for Federal COBRA coverage in fully insured products or New York State continuation coverage.

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees who work for employers with 20 or more employees to continue their current group health insurance once they leave employment or have a reduction in hours that makes them ineligible for employer-sponsored coverage. New York State continuation coverage, also known as "mini-COBRA," gives the same right to employees who work for employers with fewer than 20 employees.

Under the NYS law, people eligible for mini-COBRA (state continuation coverage) may continue their coverage for a total of 36 months, regardless of the type of Qualifying Event causing coverage loss.

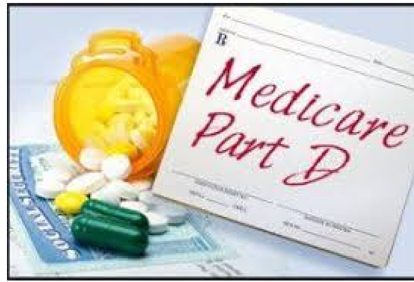
For those eligible for federal COBRA, they may elect 18 months of COBRA and then an additional 18 months of mini-COBRA, for a total of 36 months.

This notice does not fully describe continuation coverage or other rights with respect to your coverage. **For more information** concerning your Plan or your COBRA continuation coverage rights please contact your Plan Administrator or HMS Agency, Inc. at (518) 690-0360. For information about your New York State continuation coverage rights, please contact the New York State Department of Financial Services at (800) 342-3736 or http://dfs.ny.gov/insurance/ihealth.htm.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

HMS Agency, Inc. has trained staff available to assist individuals and families in comparing health coverage options available through the New York State of Health Insurance Marketplace. These Marketplace Facilitated Enrollers can assist you in applying online, answer questions on eligibility, and assist in making changes on the Marketplace. For more information contact HMS Agency, Inc. at (518) 690-0360.

COMPLIANCE UPDATE



It's time again to let your employees know if your group prescription drug coverage is creditable or non-creditable for Medicare Part D purposes.

What is Part D?
Part D is the Medicare prescription drug program that began January 1, 2006.

Why do we have to do this?
If an individual who is eligible for the Medicare drug benefit (Part D) is covered under your group health plan, and your prescription drug coverage is deemed to be as good as the Medicare drug benefit, then your prescription drug coverage will be 'creditable'. These individuals will not be charged a late enrollment penalty if they choose to continue on your group coverage and enroll in a Medicare prescription drug program at a later date. If your prescription drug coverage is not as good as the Medicare prescription drug coverage (non-creditable) and participants who are eligible to enroll in Medicare Part D enroll after their initial open enrollment period, they will pay a late enrollment penalty for the rest of the time they are enrolled in the Medicare part D prescription drug program.

Who must receive the notice?
All of your employees or their dependents who are eligible for Medicare Part D and received their prescription drug coverage through your group health plan must receive a notice, regardless of whether your coverage is primary or secondary to Medicare. The notice must be provided to active employees as well as those who are covered as retirees, disabled or on COBRA.

It may be difficult for me to keep track of this information; is there an easier way to meet the notice requirement?
The simplest way is to provide the notice to all employees, retirees, and COBRA participants covered by your health plan.

Is there a simple way to determine if the coverage provided under our plan is as good as the Medicare program?
Unless you are applying for the retiree prescription drug subsidy, a statement by an actuary is not necessary.
Your prescription drug plan is as good as Medicare if it meets all four of the following standards:

1. Provides for brand and generic prescriptions
2. Provides reasonable access to retail providers and optionally for mail order coverage
3. The plan is designed to pay on average at least 60% of participants prescription drug expenses
4. Satisfies at least one of the following:
    a. The prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000 or

b. The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 per Medicare eligible individual
c. For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has not annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000 and has no less than a $1,000,000 lifetime combined benefit maximum. An integrated plan is a plan that has one or more benefits combined such as medical and prescription drug, medical, dental and prescription drug, etc.

What should the disclosure notice say?
CMS has developed sample model notices for creditable and non-creditable coverage.

When should the employer/union disclosure notices be distributed?

1. Prior to October 15th of each year
2. Prior to an individual's initial enrollment period for Part D
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan
4. Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and
5. Upon a beneficiary's request

Note: Items 1 and 2 will be deemed to be met if the notice is provided to all plan participants at least once per year prior to October 15th. This is recommended within 60 days of the beginning of the plan year for which you are providing notice; you must notify the Centers for Medicare and Medicaid Services (CMS) that you have provided the creditable and non-creditable notice to your employees and their dependents. You can do this by going to the CMS website and completing the Disclosure Form. The form is located at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

You may also refer to the creditable coverage disclosure to CMS guidance at https://www.cms.gov/creditablecoverage/downloads/2009-06-29_ccdisclosure2cmsupdatedguidance.pdf

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HMS Agency, Inc.
Insuring Today. Securing Tomorrow.

454 Sand Creek Road
Albany, NY 12205
www.hmsagency.com

To: All Eligible Full Time Employees of TL at Home

Re: HEALTH/DENTAL INSURANCE 2022-2023

Open enrollment for TL at Home Health and Dental coverage is available now.

The weekly deduction in pre-tax dollars for each health plan, including dental coverage is as follows:

	CDPHP EPO & GUARDIAN	**CDPHP HMO & GUARDIAN**
Single Employee	$ 75.27	$ 85.27
Employee and Child	$193.34	$210.35
Employee and Domestic Partner	$231.82	$251.83
Family	$372.09	$400.60

To enroll, completed forms must be returned to Human Resources by August 26, 2022.

________________________________ __________________________

Employee Signature Date

Sincerely,

Shari

P.O. BOX 416 | 29 ROUTE 9H | CLAVERACK, NY 12513 | P 518.851.3975 | F 518.851.3986

www.TLatHome.com

CDPHP® HMO Plan Benefit Summary

Marketing Plan ID: 224
Plan Code: SHGF5120
Group ID: PROSPECT
Presented For: PROSPECT
Date Prepared:
Effective Date: 20220101
Metal Tier: GOLD

	In-Network
Cost Sharing Information	
Deductible	N/A Single / N/A Family
Out of Pocket Maximum	$7,900 Single / $15,800 Family (Embedded)
Dependent Coverage	Covered to Age 26
Domestic Partner Coverage	Covered
Office Visits	
Enhanced Primary Care	Covered in full
PCP	$50 Copayment
*PCP Cost share waived for members that are under age of 19	
Specialist	$50 Copayment
Telemedicine	
Preferred Live Video Doctor Visits (Doctor on Demand, Foodsmart, MovN)	Covered in Full
Other Participating Telemedicine Providers (Valera, aptihealth, Brave)	$50 Copayment
Telehealth services from a CDPHP Network provider (PCP or Specialist)	PCP or Specialist cost share based on provider
Preventive and Well Care Services*	
Well Baby and Child Care including immunizations	Covered in full
Annual Adult Exam (One exam per plan year regardless if 365 days have passed)	Covered in full
Mammography	Covered in full
Annual Pap Test and Ob/Gyn Exam	Covered in full
Prostate Cancer Screening	Covered in full
Bone Density Tests	Covered in full
*Cost sharing may apply to diagnostic care	
Retail Prescription Drugs	
Tier 1 Drugs	$0 Copayment
Tier 2 Drugs	$50 Copayment
Tier 3 Drugs	$80 Copayment
Specialty Drugs	$80 Copayment
Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Mail order, 2.0 copayments for a 90 day supply. Prescriptions must be written by a duly licensed health care provider and filled at a participating pharmacy, unless otherwise authorized in advance by CDPHP. Specialty drugs are not eligible for the mail order program and require preauthorization to be obtained through CDPHP's participating specialty vendors. This plan uses the Premier network and Formulary 2.	
Hospital Services	
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	$1,500 Copayment
Outpatient Surgery * Cost share may be reduced at a preferred ambulatory surgery center.	$250 Copayment
Maternity Services*	
Maternity - Routine Prenatal Care and Postnatal Care	Covered in Full*
Maternity - Inpatient Hospital Services	$1,500 Copayment
Newborn Nursery	Covered in full
*(Non-routine services may result in an additional cost share)	
Emergency Care	
Worldwide Emergency Room Care (waived if admitted inpatient)	$500 Copayment
Ambulance	$500 Copayment
Urgent Care	

CDPHP® HMO Plan Benefit Summary

Marketing Plan ID: 224
Plan Code: SHGF5120
Group ID: PROSPECT
Presented For: PROSPECT
Date Prepared:
Effective Date: 20220101
Metal Tier: GOLD

	In-Network
Nonparticipating urgent care facility services within the CDPHP service area are not covered	$100 Copayment
Diagnostic Testing*	
Outpatient Hospital or Office Based Laboratory Services: * Copayment waived if provider is a preferred laboratory.	$50 Copayment
Outpatient Hospital or Office Based Radiology Services: * Copayment waived if provider is a preferred center.	$50 Copayment
Prescription Drugs Administered in Office or Outpatient Facilities*	
PCP Office	20% Coinsurance
Specialist Office	20% Coinsurance
Outpatient Facility	20% Coinsurance
*the cost share applies to the drug only, there is no separate cost share for the administration of the drug	
Behavioral Health Services	
Mental Health/Substance Use Inpatient Services	$1,500 Copayment
Mental Health/Substance Use Outpatient Services	$50 Copayment
*(Up to 20 visits per plan year may be used for substance use family counseling.)	
Condition Support Services	
Outpatient Rehabilitation/ Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) *(60 visits per condition per plan year combined therapies for OT, PT, ST)	$50 Copayment
Home Health Care (40 visits per plan year)	Covered in full
Skilled Nursing Facility (365 days per plan year)	$1,500 Copayment
Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)	$50 Copayment
Prosthetic Appliances and Durable Medical Equipment	50% Coinsurance
Hearing Aids	$399 or $699 Copayment through Hearing Care Solutions
Diabetic Services	
Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to $100 out of pocket per 30 day supply.	$50 Copayment
Vision Services	
Routine Adult Vision Exam (One exam per plan year)	$50 Copayment
Adult Glasses/Contacts	Coverage is for standard lenses and frames or contact lenses, up to a $75 reimbursement
Routine Pediatric Vision Exam (One exam per plan year)	$50 Copayment
Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)	50% Coinsurance
Laser Eye Surgery	Up to a maximum of $750 reimbursement for eligible eye surgeries and consultations per lifetime
Wellness Care	
Weight Management	Up to a $100 reimbursement available for participation in a weight loss program
Fitness Reimbursement	Up to $200 reimbursement per 50 visits for subscriber (max $400 reimbursement per year) and $100 reimbursement per 50 visits for covered dependent (max $200 reimbursement per year)
Child Birthing Classes	Up to $75 reimbursement available for completion of child birthing class
CaféWell Participation	Participating (Up to $180 Life Points per contract per calendar year)
Acupuncture (10 visit limit per plan year for acupuncture services)	$50 Copayment
Nutritional Counseling	$50 Copayment
Chiropractic Benefits	$50 Copayment

CDPHP® HMO Plan Benefit Summary

Marketing Plan ID: 224
Plan Code: SHGF5120
Group ID: PROSPECT
Presented For: PROSPECT
Date Prepared:
Effective Date: 20220101
Metal Tier: GOLD

This Summary of Benefits is intended to provide a general outline of coverage. In the event of any conflict between this document and the member's Certificate and any applicable Rider(s) issued by CDPHP, the Certificate and Rider(s) will be the controlling documents.

CDPHP gives you access to more than 12,000 participating practitioners and providers, including most of the local hospitals, and a variety of value-added services to help you and your family stay healthy. If you have a question or wish to receive additional information, please contact the CDPHP marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at www.cdphp.com.

*Please Note. All non-emergency services must be provided by a Capital District Physician's Health Plan, Inc. ® (CDPHP) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP.**Please Note. All non-emergency services must be provided by a Capital District Physician's Health Plan, Inc. ® (CDPHP) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP.*

CDPHP® HMO Plan Benefit Summary

Marketing Plan ID: 224
Plan Code: SHGF5120
Group ID: PROSPECT
Presented For: PROSPECT
Date Prepared:
Effective Date: 20220101
Metal Tier: GOLD

CDPHP® EPO Copay First Plan Benefit Summary

Marketing Plan ID: 425
Plan Code: SUSF4560
Presented For: PROSPECT
Group ID: PROSPECT
Date Prepared:
Effective Date: 20220101
Metal Tier: SILVER

	Phase 1 Cost-Share	Phase 2 Cost-Share
Outpatient Surgery * Cost share may be reduced at a preferred ambulatory surgery center.	$75 Copayment	Deductible then Covered in full
Maternity Services*		
Maternity - Routine Prenatal Care and Postnatal Care	Covered in Full*	Deductible then Covered in full
Maternity - Inpatient Hospital Services	$500 Copayment	Deductible then Covered in full
Newborn Nursery	Covered in full	Deductible then Covered in full
*(Non-routine services may result in an additional cost share)		
Emergency Care		
Worldwide Emergency Room Care (waived if admitted inpatient)	$75 Copayment	Deductible then Covered in full
Ambulance	$75 Copayment	Deductible then Covered in full
Urgent Care		
Nonparticipating urgent care facility services within the CDPHP UBI service area are not covered	$60 Copayment	Deductible then Covered in full
Diagnostic Testing*		
Outpatient Hospital or Office Based Laboratory Services * Copayment waived if provider is a preferred laboratory.	$50 Copayment	Deductible then Covered in full
Outpatient Hospital or Office Based Radiology Services * Copayment waived if provider is a preferred center.	$50 Copayment	Deductible then Covered in full
Prescription Drugs Administered in Office or Outpatient Facilities*		
PCP Office	20% Coinsurance	Deductible then Covered in full
Specialist Office	20% Coinsurance	Deductible then Covered in full
Outpatient Facility	20% Coinsurance	Deductible then Covered in full
*the cost share applies to the drug only, there is no separate cost share for the administration of the drug		
Behavioral Health Services		
Mental Health/Substance Use Inpatient Services	$500 Copayment	Deductible then Covered in full
Mental Health/Substance Use Outpatient Services	$30 Copayment	Deductible then Covered in full
*(Up to 20 visits per plan year may be used for substance use family counseling.)		
Condition Support Services		
Outpatient Rehabilitation/ Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) *(60 visits per condition per plan year combined therapies for OT, PT, ST)	$50 Copayment	Deductible then Covered in full
Home Health Care (40 visits per plan year)	Covered in full	Deductible then Covered in full
Skilled Nursing Facility (365 days per plan year)	$500 Copayment	Deductible then Covered in full
Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)	$30 Copayment	Deductible then Covered in full
Prosthetic Appliances and Durable Medical Equipment	50% Coinsurance	Deductible then Covered in full
Hearing Aids	$399 or $699 Copayment through Hearing Care Solutions	$399 or $699 Copayment through Hearing Care Solutions
Diabetic Services		
Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to $100 out of pocket per 30 day supply.	$30 Copayment	Deductible then Covered in full
Vision Services		
Routine Adult Vision Exam (One exam per plan year)	$50 Copayment	Deductible then Covered in full

CDPHP® EPO Copay First Plan Benefit Summary

Marketing Plan ID: 425
Plan Code: SUSF4560
Presented For: PROSPECT
Group ID: PROSPECT
Date Prepared:
Effective Date: 20220101
Metal Tier: SILVER

	Phase 1 Cost-Share	Phase 2 Cost-Share
Adult Glasses/Contacts	Coverage is for standard lenses and frames or contact lenses, up to a $75 reimbursement	Deductible then See Phase 1
Routine Pediatric Vision Exam (One exam per plan year)	$30 Copayment	Deductible then Covered in full
Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)	50% Coinsurance	Deductible then Covered in full
Laser Eye Surgery	Up to a maximum of $750 reimbursement for eligible eye surgeries and consultations per lifetime	See Phase 1
Wellness Care		
Weight Management	Up to a $100 reimbursement available for participation in a weight loss program	See Phase 1
Fitness Reimbursement	Up to $200 reimbursement per 50 visits for subscriber (max $400 reimbursement per year) and $100 reimbursement per 50 visits for covered dependent (max $200 reimbursement per year)	See Phase 1
Child Birthing Classes	Up to $75 reimbursement available for completion of child birthing class	See Phase 1
CaféWell Participation	Participating (Up to $180 Life Points per contract per calendar year)	See Phase 1
Acupuncture (10 visit limit per plan year for acupuncture services)	$50 Copayment	Deductible then Covered in full
Nutritional Counseling	$50 Copayment	Deductible then Covered in full
Chiropractic Benefits	$50 Copayment	Deductible then Covered in full

This Summary of Benefits is intended to provide a general outline of coverage. In the event of any conflict between this document and the member's Certificate and any applicable Rider(s) issued by CDPHP, the Certificate and Rider(s) will be the controlling documents.

All benefits of this plan are subject to coordination of benefits. This summary is designed to highlight benefits of the plan being offered and does not detail all benefits, limitations, or exclusions. It is not a contract and may be subject to change. For more detailed information, a membership Certificate is available for your review upon request.

CDPHP UBI gives you access to more than 825,000 participating practitioners and providers nationwide, including many of the major hospitals, and a variety of value-added services to help you and your family stay healthy. If you have a question or wish to receive additional information, please contact the CDPHP marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at www.cdphp.com.

Please Note. All non-emergency services must be provided by a CDPHP Universal Benefits, Inc. ® (CDPHP UBI) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP UBI.Please Note. All non-emergency services must be provided by a CDPHP Universal Benefits, Inc. ® (CDPHP UBI) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP UBI.

CDPHP® EPO Copay First Plan Benefit Summary

Marketing Plan ID: 425
Plan Code: SUSF4560
Presented For: PROSPECT
Group ID: PROSPECT
Date Prepared:
Effective Date: 20220101
Metal Tier: SILVER

Summary of Benefits

Dental Benefit Summary

Group ID:	00779713	Coverage Type:	Contributory
Group Name:	SHARI KLINE, INC. DBA TL AT HOME	Class:	0001 ALL ELIGIBLE EMPLOYEES
Waiting Period:	3 month(s)	As of Date:	08/12/2022

Plan Information

Your dental networks is: Dental - DentalGuard Pref - Syracuse

Coverage Information

	Dental - DentalGuard Pref - Syracuse	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref - Syracuse** network will be most cost effective.	
	In Network	Out of Network
Calendar year deductible	$50, Once the annual deductible is met by each of three family members, no further deductibles apply.	$50, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive	Waived	Waived
Basic	Not Waived	Not Waived
Major	Not Waived	Not Waived
Calendar Year Maximum Benefit	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	$1,000
Lifetime Orthodontia Maximum	The amount shown in the out of network field is your combined Lifetime Orthodontia Maximum for both in and out of network services	$1,000
Maximum rollover	Yes	Yes
Monthly Switch	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?(as a percentage of fee schedule.)

	Dental - DentalGuard Pref - Syracuse	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref - Syracuse** network will be most cost effective.	
	In Network	Out of Network
Office Visit Co-pay (one office visit may cover multiple services)	None	None
Preventive Care:	100%	100%
Bitewing X-Rays	100%	100%
Full Mouth X-Rays	100%	100%
Cleaning	100%	100%
Oral Exams	100%	100%
Sealants (per tooth)	100%	100%
Basic Care:	80%	80%
Fillings (one surface)	80%	80%
General Anesthesia[1]	80%	80%
Scaling & Root Planing (per quadrant)	80%	80%
Simple Extractions	80%	80%
Major Care:	50%	50%
Dentures	50%	50%
Single Crowns	50%	50%
Orthodontia	50%	50%

General Exclusions

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans:

This policy provides dental insurance only. Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury.

Deductibles apply.

The plan does not pay for:

- Oral hygiene services (except as covered under preventive services),
- Orthodontia (unless expressly provided for),
- Cosmetic or experimental treatments (unless they are expressly provided for).

- Any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment.

The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DEN -16 et al.

Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

Pediatric Essential Health Benefit Coverage Information

	Dental - DentalGuard Pref - Syracuse - Low	
	In Network	Out of Network
Calendar year deductible	$150, Each family member must satisfy their individual deductible amount.	$150, Each family member must satisfy their individual deductible amount.
Preventive	Waived	Not Waived
Basic	Not Waived	Not Waived
Major	Not Waived	Not Waived
Orthodontia	Not Waived	Not Waived
Individual Out of Pocket Maximum	$350	N/A
Family Out of Pocket Maximum	$700	N/A
Office Visit Co-pay (one office visit may cover multiple services)	None	None
Diagnostic & Preventive Care:	70%	70%
Oral Exam	70%	70%
Cleaning	70%	70%
X-Rays	70%	70%
Sealants	70%	70%
Fluoride	70%	70%
Basic Care:	50%	50%
Anesthesia	50%	50%

	Dental - DentalGuard Pref - Syracuse - Low	
	In Network	Out of Network
Fillings	50%	50%
Oral Surgery	50%	50%
Major Care:	50%	50%
Periodontal Maintenance	50%	50%
Periodontal Services	50%	50%
Endodontics/Root Canal Treatment	50%	50%
Dentures	50%	50%
Single Crowns	50%	50%
Implants	50%	50%
Medically Necessary Orthodontia	50%	50%

General Exclusions

- Reasonable,member out-of-pocket max as determined by each state. This means that once the member has reached his or her out-of-pocket max, the pediatric dental essential health benefits will be paid at 100% for the remainder of the benefit year.

- No annual or lifetime maximums may be applied to the pediatric dental essential health benefits.

- Limitation on orthodontia, where covered, to medically necessary only.

- Medically necessary orthodontics includes, but may not be limited to, orthodontic treatment of skeletal, dental and/or occlusal conditions due to cleft palate and resulting in severe or handicapping malocclusion. Medically necessary orthodontics does not include orthodontic treatment performed solely for crowded dentitions (crooked teeth), excessive spacing between teeth, and/or having horizontal/vertical (overjet/overbite) discrepancies.

1 Restrictions apply and may be subject to medical necessity.

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

Definitions shown on this site are in summary form and are for general informational purposes. The terms of the insurance contract prevails.

PLEASE PRINT. *For address and/or primary care physician changes call (518) 641-3700, 1-800-777-2273, or visit www.cdphp.com* USE BLACK INK ONLY.

Enrollment Application/Change Form

500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3700
or
1-800-777-2273

EMPLOYER USE ONLY

Date Hired (MM/DD/YY) *(required)* ________ ◯ Full-time ◯ Part-time (20 hours or less/week)

Date coverage is effective ________ ◯ Actively Working ◯ COBRA

◯ Retiree 65 or older ◯ Retiree 55–65 ◯ Retiree Under 55

Date of status change ________ Employer Name ________

◯ Part- to full-time ◯ Union to non-union ◯ Other ________

Group/Subgroup #: ________ Class #: ________

Chamber Assoc: ________ **Grp Admin Initials *(required)*** ________

A. EXPLANATION *(CHECK ALL THAT APPLY)*

◯ New Hire ◯ Open Enrollment ◯ Loss of Coverage ◯ Marriage ◯ Birth ◯ Change in Student Status ◯ Dependent through 29

◯ Name/Address Change ◯ Court Order

◯ **COBRA**—*Reason:* ◯ Left Employ/Retirement ◯ Divorce/Legal Separation ◯ Death of Spouse ◯ Dependent Reached Max Age ◯ Loss of Student Status

◯ **Termination**—*Reason:* ◯ Employment Terminated ◯ Remove Dependents Only ◯ Deceased ◯ Other ________

B. COVERAGE INFORMATION *(CHECK ALL THAT APPLY)*

Product Type: ◯ HMO ◯ EPO ◯ HDEPO ◯ PPO ◯ HDPPO ◯ HNY

PCP Copay Amt: $ ______ Specialist Copay Amt: $ ______ % Coins: ____ Deduct. Amt: $ ______ ◯ **Delta Dental of New York Coverage**

C. FUNDING ACCOUNT *(CHECK ALL THAT APPLY)*

I am participating in a CDPHN-administered:

◯ Flexible Spending Account (FSA) ◯ Health Reimbursement Arrangement (HRA) ◯ Health Savings Account (HSA) ◯ Not Applicable

D. SUBSCRIBER INFO *(CHECK ALL THAT APPLY)*

For **HMOs only,** you and each dependent **MUST** select a Primary Care Physician (PCP). Member may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. **For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.**

1. Last Name ________ First Name ________ M.I. ____
4. Telephone: Home ________ Work ________ Mobile ________

2. Street Address ________ Apt. # ____
5. E-mail Address ________

3. City ________ State ____ ZIP ________
6. Employer Name ________

7. Social Security Number ***(Required)*** ________ Date of Birth ________

Medical Add *or* Delete ◯ ◯

Sex: ◯ *M* ◯ *F* ◯ *Non-Binary* ◯ Living with a Disabling Condition ◯ End-Stage Renal Disease

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional)*: Spoken: ________ Written: ________

Race *(optional, check all that apply)*: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Other Pacific Islander ◯ White

Ethnicity *(optional)*: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Medicare number: ________ Part A effective date: ________ Part B effective date: ________

Delta Dental Add *or* Delete ◯ ◯

For enrollees in small group (100 or fewer full time equivalent employees): Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. ________

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for rate information.

Previous coverage: ◯ *Yes* Previous carrier: ________ Effective from: ________ To: ________

HMO only—Physician (PCP) Last ________ First ________ Phys # ________ Current Patient? ◯

OB/GYN Last ________ First ________ Phys # ________ Current Patient? ◯

21-17442

Continued on page 2

E. DEPENDENT INFO

For **HMOs only,** you and each dependent **MUST** select a Primary Care Physician (PCP). Females may also choose one OB/GYN. Also indicate if a member is a current patient and get the Physician # and Office Location from the provider directory or at www.cdphp.com. **For all other products, include copy of your HIPAA certificate. If you have Medicare Parts A and B, include a copy of your Medicare card.**

8a. Last ______ First ______ M.I. ______ SSN *(Required)* ______ Date of Birth ______ **Medical Add *or* Delete** ◯ ◯

Rel: ◯ *Spouse* ◯ *Other* Sex: ◯ *M* ◯ *F* ◯ *Non-Binary* ◯ Living with a Disabling Condition ◯ End-Stage Renal Disease

Telephone: Home ______ Work ______ Mobile ______ E-mail Address ______

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional)*: Spoken: ______ Written: ______

Race *(optional, check all that apply)*: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Other Pacific Islander ◯ White

Ethnicity *(optional)*: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Medicare number: ______ Part A effective date: ______ Part B effective date: ______

For enrollees in small group (100 or fewer full time equivalent employees): Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No **Delta Dental Add *or* Delete** ◯ ◯

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. ______

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for rate information.

Previous coverage: ◯ *Yes* Previous carrier: ______ Effective from: ______ To: ______

HMO only—Physician (PCP) Last ______ First ______ Phys # ______ Current Patient? ◯

OB/GYN Last ______ First ______ Phys # ______ Current Patient? ◯

8b. Last ______ First ______ M.I. ______ SSN *(Required)* ______ Date of Birth ______ **Medical Add *or* Delete** ◯ ◯

Rel: ◯ *Son* ◯ *Daughter* ◯ *Other* ◯ *Full-time student?* ◯ Living with a Disabling Condition ◯ End-Stage Renal Disease

Telephone: Home ______ Work ______ Mobile ______ E-mail Address ______

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional)*: Spoken: ______ Written: ______

Race *(optional, check all that apply)*: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Other Pacific Islander ◯ White

Ethnicity *(optional)*: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Medicare number: ______ Part A effective date: ______ Part B effective date: ______

For enrollees in small group (100 or fewer full time equivalent employees): Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No **Delta Dental Add *or* Delete** ◯ ◯

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. ______

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for rate information.

Previous coverage: ◯ *Yes* Previous carrier: ______ Effective from: ______ To: ______

HMO only—Physician (PCP) Last ______ First ______ Phys # ______ Current Patient? ◯

OB/GYN Last ______ First ______ Phys # ______ Current Patient? ◯

8c. Last ______ First ______ M.I. ______ SSN *(Required)* ______ Date of Birth ______ **Medical Add *or* Delete** ◯ ◯

Rel: ◯ *Son* ◯ *Daughter* ◯ *Other* ◯ *Full-time student?* ◯ Living with a Disabling Condition ◯ End-Stage Renal Disease

Telephone: Home ______ Work ______ Mobile ______ E-mail Address ______

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional)*: Spoken: ______ Written: ______

Race *(optional, check all that apply)*: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Other Pacific Islander ◯ White

Ethnicity *(optional)*: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Medicare number: ______ Part A effective date: ______ Part B effective date: ______

For enrollees in small group (100 or fewer full time equivalent employees): Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No **Delta Dental Add *or* Delete** ◯ ◯

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. ______

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for rate information.

Previous coverage: ◯ *Yes* Previous carrier: ______ Effective from: ______ To: ______

HMO only—Physician (PCP) Last ______ First ______ Phys # ______ Current Patient? ◯

OB/GYN Last ______ First ______ Phys # ______ Current Patient? ◯

Note: Make sure you sign and date the application on the next page.

Continued on page 3

E. DEPENDENT INFO *Cont'd*

8d. Last ______ First ______ M.I. ______ SSN *(Required)* ______ Date of Birth ______ **Medical Add *or* Delete** ○ ○

Rel: ○ *Son* ○ *Daughter* ○ *Other* ○ *Full-time student?* ○ Living with a Disabling Condition ○ End-Stage Renal Disease

Telephone: Home ______ Work ______ Mobile ______ E-mail Address ______

The following are optional but help us understand the diversity of our membership.

Primary Language *(optional)*: Spoken: ______ Written: ______

Race *(optional, check all that apply)*: ○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ White

Ethnicity *(optional)*: ○ Hispanic or Latino ○ Not Hispanic or Latino

Medicare number: ______ Part A effective date: ______ Part B effective date: ______

Delta Dental Add *or* Delete ○ ○

For enrollees in small group (100 or fewer full time equivalent employees): Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ○ Yes ○ No

If you answered "yes," please provide the name of the company issuing the stand-alone dental coverage. ______

If you answered "no," we will provide you coverage of the pediatric dental essential health benefit. Additional cost may apply. Ask your employer for rate information.

Previous coverage: ○ *Yes* Previous carrier: ______ Effective from: ______ To: ______

HMO only—Physician (PCP) Last ______ First ______ Phys # ______ Current Patient? ○

OB/GYN Last ______ First ______ Phys # ______ Current Patient? ○

F. OTHER INSURANCE

Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? ○ Yes: *If yes, complete below.* ○ No

9. Policyholder name ______ Policy # ______ Insurance carrier ______ Employer name ______

Date of birth: ______ Address: ______

Effective date: ______ Coverage type: ○ Hospital ○ Medical ○ Drug ○ Dental ○ Vision

Covered Individuals—*Check all that apply* ○ Self ○ Spouse ○ Dependents

G. SIGNATURE: AGREEMENT: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the last page of this form.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

10. Applicant's Signature: ______ 11. Date: ______

IMPORTANT INFORMATION

Failure to complete any sections will result in a processing delay of your application, member ID cards and, claims payment. Failure by your employer to complete the employer section will also result in a delay.

If you should have any questions about this Enrollment Application/Change Form, please call the CDPHP® member services department at (518) 641-3700 or 1-800-777-2273. Thank you for choosing CDPHP for your health care coverage.

Your signature on this application hereby affirms the following:

On behalf of myself and any dependents listed, I hereby apply for coverage under the Master Group Contract (health and/or dental, as the case may be) issued to my employer by Capital District Physicians' Health Plan, Inc. (HMO products) and/or CDPHP Universal Benefits,® Inc. (CDPHP UBI) (EPO/PPO/HD products) and/or Delta Dental of New York, Inc.

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any attached riders. I further understand that for HMO benefits provided by Capital District Physicians' Health Plan, Inc., except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in rider) or in a participating hospital (unless otherwise noted in rider) when admitted or referred by a participating physician (unless otherwise noted in rider), and also that certain services may require a copayment (unless otherwise noted in rider) by me (or my dependents) directly to the provider of such services.

I hereby permit my employer to deduct the necessary Health Services Fees, if any, from my wages or salary, with the understanding that the employer acts as my agent in all dealings with CDPHP and/or Delta Dental of New York, Inc., and that all acts performed by the employer and all notices given to the employer in such dealings are binding upon me, as not prohibited by statute or regulation.

I understand that unresolved grievances are subject to the procedure specified in the Master Group Contract.

CDPHP COMPANIES
Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.

Delta Dental Service Plans are underwritten and administered by Delta Dental of New York, Inc.

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

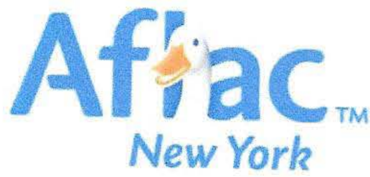
Delta Dental of New York
One Delta Drive
Mechanicsburg, PA 17055
1-800-932-0783
TTY/TDD 1-888-373-3582
www.deltadentalins.com

GUARDIAN

Group Insurance
Enrollment/Change Form

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Fraud Warning Statements



______ I am interested in considering **SHORT TERM DISABILITY**

______ I am interested in considering the **ACCIDENT ADVANTAGE PLAN**

______ I am interested in considering the **CANCER PLAN**

______ I am interested in considering the **HOSPITAL PLAN**

______ I am interested in considering the **LIFE**

______No, I am not interested in participating in the AFLAC NY Programs at this time.
I understand that I may have the opportunity to take advantage of these programs at a later time.

PRINT NAME: ______________________________________ DATE: ___________________

Phone Number: __________________________________ Best Time To Call: ____________

Email: ____