



WESTERN MICHIGAN UNIVERSITY
Human Resources

Notice of Special Enrollment Rights

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

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

To request special enrollment or obtain more information, contact Human Resources at (269) 387-3620 or hr-hris@wmich.edu.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in the Western Wellness program are available to employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at (269) 387-3620 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice of Patient Protection

The University's Healthy Blue Living HMO Plan through Blue Care Network (BCN) requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the BCN network and who is available to accept you or your family members. Until you make this designation, BCN designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCN at 1-800-662-6667.

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

You do not need prior authorization from BCN or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the 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 BCN at 1-800-662-6667.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA) 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.

Women's Health and Cancer Rights Act (WHCRA) of 1998 Annual Notice

Did you know that 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? Contact Blue Cross Blue Shield of Michigan or Blue Care Network for more information.

Michelle's Law

Under the Affordable Care Act, group health plans (i.e., large, small, self-funded, fully insured and governmental group health plans) and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. If your plan provides dependent coverage beyond age 26 for a covered dependent who is enrolled in a post-secondary education, Michelle's Law is still applicable.

What does Michelle's Law require?

Plan sponsors and insurers are prohibited from terminating group health plan coverage if a covered dependent child takes a medically necessary leave of absence and the plan provides dependent coverage beyond age 26 for a covered dependent child who is enrolled in a post-secondary educational institution.

"Medically necessary leave of absence" means with respect to a dependent child in connection with a group health plan or health insurance coverage offered in connection with a group health plan, a leave of absence from or other change in enrollment status in a postsecondary educational institution that begins while the child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the plan or coverage.

A "dependent child" is a beneficiary who is a dependent child under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage, and who was enrolled in the plan or coverage on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence involved.

If your health plan provides coverage beyond age 26 for a covered dependent child who is enrolled in a postsecondary educational institution, it must continue plan coverage for the dependent child upon written certification by the dependent's treating physician that states the dependent is suffering from a serious illness or injury and that a leave of absence (or reduction in student hours) is medically necessary until the earlier of: one year after the first day of the medically necessary leave of absence; or the date on which the coverage under the plan would otherwise terminate.

In the event that any dependent child is covered under the above circumstances and the dependent child has a change in their health coverage that results in a loss of plan coverage under the plan, but new coverage is provided under another plan, the new plan must honor the remaining period of leave. For example, if a covered dependent has been on a medically necessary leave of absence for six months and the individual's health coverage changes from Insurer A to Insurer B, the dependent child will still be eligible for the remaining six months of leave under Insurer B.

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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalh Hipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarh Hipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: h Hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mychohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	ILLINOIS - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	IOWA – Medicaid and CHIP (Hawki)
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	KENTUCKY – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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: KIHIPPI.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	MINNESOTA – Medicaid
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	MONTANA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPProgram@mt.gov
NEBRASKA – Medicaid	NEVADA – Medicaid
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	NORTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	PENNSYLVANIA – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	SOUTH CAROLINA – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RlTe Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	TEXAS – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	VERMONT– Medicaid
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
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, 2026, 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

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 5/31/2029)



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2027)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

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

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **Human Resources Service Center at 269-387-3620.**

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name WESTERN MICHIGAN UNIVERSITY		4. Employer Identification Number (EIN) 38-6007327	
5. Employer address 1903 W MICHIGAN AVE		6. Employer phone number (269) 387-3620	
7. City KALAMAZOO	8. State MICHIGAN	9. ZIP code 49008-5217	
10. Who can we contact about employee health coverage at this job? Human Resources Service Center			
11. Phone number (if different from above)		12. Email address HR-HRIS@wmich.edu	

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

- As your employer, we offer a health plan to:
 - ☐ All employees. Eligible employees are:
 - ☒ **Some employees. Eligible employees are:**

- Faculty (AAUP) eligible for benefits per the terms of their collective bargaining agreement
- Dining Services, Facility Management and Other (AFSCME) staff eligible for benefits per the terms of their collective bargaining agreement
- Police Officers (POA) eligible for benefits per the terms of their collective bargaining agreement
- Power Plan (MSEA) staff eligible for benefits per the terms of their collective bargaining agreement
- Staff Compensation System: Non-Bargaining Exempt staff with employment appointments of at least 0.50 FTE
- Staff Compensation System: Non-Bargaining Nonexempt staff with employment appointments of at least 0.50 FTE
- Temporary Employees who qualify as full-time under the Affordable Care Act (regularly scheduled for 30 hours or more per week or a variable work schedule that averages 30 hours or more per week during the most recent 12-month look-back period (generally mid-October of the current year to mid-October of the previous year))

- With respect to dependents:
 - ☒ **We do offer coverage. Eligible dependents are:**

- Eligible employee's legal spouse
- Eligible employee's birth child or legally adopted child under the age of 26
- A child under the age of 26 placed with an eligible employee for adoption
- Child of eligible employee's legal spouse by birth; by legal adoption; by legal foster care; or by legal guardianship for whom the employee is legally obligated by court order to provide health insurance and is under age 26
- A child under age 18 for whom the eligible employee is recognized as the legal guardian and legally obligated by court order to provide health insurance
- Eligible employee's child who is age 26 or older and is totally and permanently disabled
- A child of an eligible employee named as an alternate recipient under a medical child support order
- Adult designated by eligible employee who resides in the same residence with the employee and has done so for at least the previous 18 consecutive months and the employee does not have a spouse enrolled (does not include IRS dependents of employee, relatives or tenants)
- Dependent child of individual designated by eligible employee who is under the age 26

☐ **We do not offer coverage.**

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

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process.

Important Notice from Western Michigan University About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Western Michigan University has determined that the prescription drug coverage offered by the University is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Western Michigan University coverage will be affected. Medicare eligible individuals enrolled in health insurance through Western Michigan University are covered by the University's prescription drug plan. A summary of benefits is available at www.wmich.edu/hr or by contacting Human Resources. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current Western Michigan University prescription drug coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Western Michigan University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may

consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact Human Resources for further information at (269) 387-3620. **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 Western Michigan University changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date	October 2026
Name of Entity/ Sender	Western Michigan University
Contact Position/Office	Human Resources
Address:	1903 W. Michigan Avenue, Kalamazoo, MI 49008-5217
Phone Number:	(269) 387-3620

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

Western Michigan University

Notice of Privacy Practices

Section 1: Purpose of this notice and effective date

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.

Effective Date: This Notice, originally effective April 14, 2003, and updated effective September 23, 2013, has been further updated to be effective as of February 16, 2026.

This Notice is required by a federal law called the Health Insurance Portability and Accountability Act, commonly known as HIPAA.

This Notice applies to all group health plans maintained by Western Michigan University that are subject to HIPAA, collectively referred to herein as the “Plan.”

The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan’s uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Plan’s duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Plan’s privacy practices.

This Notice applies to your PHI used or disclosed by the Plan as well as entities designated as “business associates” of the Plan.

You will receive a separate Privacy Notice from the insurer or HMO that you have selected for your health coverage.

Please share these Notices with your covered family members, as their PHI is also protected under federal law.

Section 2: Your protected health information

Protected Health Information (PHI) defined

The term “Protected Health Information” (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form.

Section 3: Use or disclosure for which your authorization or consent is not required

When the Plan may use or disclose your PHI

Under the law, the Plan may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- At your request. If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect and/or copy it.
- As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- For treatment, payment or health care operations. The Plan and its business associates will use PHI in order to carry out treatment, payment, or health care operations.

Treatment is the provision, coordination, or management of health care and related services. For example, the Plan may disclose PHI to a physician who is treating you.

Payment includes but is not limited to actions to make coverage determinations and payment. For example, the Plan may use PHI to pay claims from your health care provider. If we contract with third parties to help us with payment operations, such as a third-party claims administrator, we will also disclose information to them and they may conduct these activities on our behalf. These third parties are known as “business associates.”

Health care operations includes but is not limited to quality assessment and improvement, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan or its third-party administrators may use information about your claims to refer you to a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its health care payments.

The Plan will not use your genetic information for underwriting purposes.

Disclosure to the Plan sponsor

The Plan will also disclose PHI to certain individuals who work for the Plan Sponsor for purposes related to treatment, payment, and health care operations, and has amended the Plan Documents to permit this use and disclosure as required by federal law. For example, we may disclose information to certain individuals to allow them to decide appeals of eligibility determinations, negotiate renewals of insurance contracts or audit the accuracy of health care payments.

In addition, the Plan may use or disclose “summary health information” for the purpose of obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan has provided health benefits.

Other use or disclosure of your PHI for which consent, authorization or opportunity to object is not required

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. When required by applicable law.
2. Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. Domestic violence or abuse situations. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
4. Health oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of benefit programs (for example, to the Department of Labor).
5. Legal proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
6. Law enforcement health purposes. When required for law enforcement purposes (for example, to report certain types of wounds).
7. Law enforcement emergency purposes. For certain law enforcement purposes, including identifying or locating a suspect, fugitive, material witness or missing person, and disclosing information about an individual who is or is suspected to be a victim of a crime.
8. Determining cause of death and organ donation. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other

authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9. Funeral purposes. When required to be given to funeral directors to carry out their duties with respect to the decedent.
10. Research. For research, subject to certain conditions.
11. Health or safety threats. When consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person who is reasonably able to prevent or lessen the threat, including the target of the threat.
12. Workers' compensation programs. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
13. Specialized Government Functions. When required, to military authorities under certain circumstances, or to authorized federal officials for lawful intelligence, counterintelligence and other national security activities.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, which you have the right to revoke.

Other uses or disclosures

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Additional restrictions on use and disclosure

Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information such as alcohol and substance use disorder, (including Part 2 Programs); biometric information; child or adult abuse or neglect, including sexual assault; communicable diseases; genetic information; HIV/AIDS; mental health; minors' information; prescriptions; reproductive health; and sexually transmitted diseases. In such case, the Plan will follow the more stringent or protective law, to the extent that it applies.

Note, information that is disclosed by the Plan in accordance with HIPAA's Privacy Rule is subject to redisclosure by the recipient and may no longer be protected by the Privacy Rule.

Section 4: Use or disclosure for which your authorization or consent is required

When the Plan obtains or receives a valid authorization for its use or disclosure of PHI, such use or disclosure will be consistent with such authorization. If you have authorized us to use or disclose your PHI for a purpose that requires authorization, you may revoke your authorization in writing at any time. If you revoke your authorization, the Plan will no longer be able to use or disclose PHI about you for the reasons covered by your written authorization. However, the Plan will be unable to take back any disclosures it has already made with your permission. Requests

to revoke a prior authorization must be submitted in writing to the Privacy Official identified in Section 7. The following situations require your authorization:

Use of psychotherapy notes

The Plan does not routinely obtain psychotherapy notes. However, if it is necessary to use or disclose them, it must obtain your written authorization. The Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Marketing of PHI

The Plan does not engage in the marketing of your PHI. In any event, before the Plan could market your PHI, it would have to obtain your authorization for any use or disclosure of PHI for marketing purposes and disclose whether remuneration will be received. Note face-to-face communications made by the Plan to you and promotional gifts of nominal value provided by the Plan are not considered as marketing.

Sale of PHI

The Plan does not sell your PHI. In any event, before the Plan could sell your PHI, it would have to obtain your authorization. For this purpose, sale of PHI generally means a disclosure of PHI by the Plan where the Plan directly or indirectly receives remuneration from or on behalf of the recipient of the PHI in exchange for the PHI, but does not include a disclosure of PHI otherwise permitted by HIPAA.

Substance use disorder treatment records

Substance use disorder treatment records (SUD Records) received from a program covered by 42 CFR Part 2 (a “Part 2 Program”), or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, as provided under law. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested SUD Record is used or disclosed.

If the Plan receives SUD Records about you from a Part 2 Program pursuant to a consent you provided to the Part 2 Program to use and disclose your SUD records for all future purposes of treatment, payment or health care operations, the Plan may use and disclose your SUD records for the purposes of treatment, payment or health care operations, as described above, consistent with such consent until the Plan receives notification that you have revoked such consent in writing. When disclosed to the Plan for treatment, payment, and health care operations activities, the Plan may further disclose those SUD records in accordance with HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.

Fundraising

The Plan will not use or disclose your PHI (including, but not limited to, SUD Records) for any fundraising activities whether for the benefit of the Plan, or for or on behalf of others. In any event, before the Plan could use your PHI for fundraising, it would have to obtain your written authorization for such use or disclosure, and with respect to SUD Records, give you the opportunity to elect not to receive any fundraising communications.

Section 5: Your individual privacy rights

All requests under this section with respect to information about the Plan should be addressed to the Privacy Official identified in Section 7 below. If a form is required, it will be available from the Privacy Official.

Requests with respect to PHI held by your insurer or HMO should be directed to them at the address indicated on their Privacy Notice.

You may request restrictions on PHI uses and disclosures

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Official determines it to be unreasonable.

You may request confidential communications

You have the right to ask us to communicate with you using an alternative means or at an alternative location. The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to request restrictions on use and disclosures of your PHI in writing to the Privacy Official listed below.

You may inspect and copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to request access to the PHI in your designated record set in writing to the Privacy Official listed below. A reasonable fee may be charged.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and HHS.

Designated Record Set: includes enrollment, payment, claims adjudication and other information used to make decisions about payment for care. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You have the right to amend your PHI

You have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You or your personal representative will be required to request amendment of the PHI in writing to the Privacy Official listed below.

You have the right to receive an accounting of the Plan’s PHI disclosures

At your request, the Plan will also provide you with an accounting of certain disclosures by the Plan of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations; disclosures made to you or authorized by you in writing, to your friends or family in your presence or because of an emergency; for national security purposes; or incidental to otherwise permissible disclosures. The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

Your request for an accounting must be submitted in writing to the Privacy Official listed below. You may request an accounting of disclosures made within the last six years. You may

request one accounting free of charge within a 12-month period. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Receive a paper copy of this notice

You have the right to obtain a paper copy of this Notice upon request.

Your personal representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form or other form acceptable under state or federal law.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse, violence, or neglect.

Use or disclosure of your PHI to family members

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Section 6: The Plan's duties

The Plan is required by law to maintain the privacy of your PHI and to maintain the privacy of Protected Health Information, to provide individuals with notice of its legal duties and privacy practices, and to notify affected individuals following a breach of unsecured protected health information.

The Plan is required to abide by the terms of the Notice currently in effect.

The Plan reserves the right to change the terms of the Notice and to apply the changes to any PHI received or maintained by the Plan prior to that date. If this Notice is changed, a revised version of this Notice will be provided to you.

Section 7: Your right to file a complaint with the Plan or the HHS secretary

Complaint to the Plan

If you believe that your privacy rights have been violated, you may obtain additional information or file a complaint with the Plan in care of the following person:

PJ Capelli [CISSP, MBA]
Security & Privacy Officer
Western Michigan University
1903 W. Michigan Ave.
Kalamazoo, MI 49008-5217
Phone (269) 387-0091
Peter.capelli@wmich.edu

Complaint to HHS

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services (“HHS”). Please contact the nearest office of the Department of Health and Human Services, listed in your telephone directory, visit the HHS website at www.hhs.gov, or contact the Privacy Official for more information about how to file a complaint.

The Plan will not retaliate against you for filing a complaint.

Section 8: If you need more information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official listed in Section 7.

Section 9: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede this Notice if there is any discrepancy between the information in this notice and the regulations.

Compliance Bulletin

Creditable Coverage Determination Method Comparison Chart

Starting in 2027, plan sponsors will no longer be permitted to use the original simplified determination method to determine whether their coverage is creditable. Only the revised simplified determination method or an actuarial determination will remain available. For 2026 only, plan sponsors may still choose between the original and revised simplified methods (or an actuarial determination), but should begin preparing now for the 2027 transition. Employers applying for the retiree drug subsidy are not eligible to use either simplified method and must instead use an actuarial determination. The chart below compares the original and revised simplified determination methods, including the criteria that plans must meet under each.

Criteria	Original Simplified Method	Revised Simplified Method
Minimum drug expense	Plans must be designed to pay, on average, at least 60% of participants' drug expenses	Plans must be designed to pay, on average, at least 72% of participants' drug expenses for 2026 and at least 73% of participants' drug expenses for 2027
Brand-name drug coverage	Reasonable coverage required	Reasonable coverage required (retained)
Generic drug coverage	Reasonable coverage required	Reasonable coverage required (retained)
Biological products	Not addressed	Explicitly included in the criteria
Retail pharmacies	Reasonable access required	Reasonable access required (retained)
Annual/lifetime limits	Minimum limit standards required, though largely prohibited under the Affordable Care Act	Eliminated as an outdated criterion
Annual deductible	Specific deductible-related standards applied	Removed (reflects that most employer plans integrate medical and drug coverage)
Effect on high deductible health plans (HDHPs)	Deductible rules could make qualification harder	While higher-deductible plans (including HDHPs) may seem less likely to meet the higher drug expense threshold, the risk can be mitigated by other plan design features (e.g., not applying a deductible to preventive medications, a reasonable and supportable allocation of the deductible attributable to prescription drug expenses, or offering lower cost sharing than standard Part D coverage once the deductible is met)

Provided by **Segal**

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Compliance Bulletin

Key Compliance Reminders

- ✓ **Separate testing:** For plans with multiple benefit options (e.g., PPO, HMO, and HDHP), the creditable coverage test must be applied separately for each option.
- ✓ **Notice deadlines:** Employers must provide notices to Medicare-eligible individuals before Oct. 15 each year.
- ✓ **CMS reporting:** The online disclosure form must be submitted to the Centers for Medicare and Medicaid Services (CMS) within 60 days of the start of the plan year (e.g., March 1 for calendar year plans).
- ✓ **Account-based plans:** HRAs, HSAs, and FSAs are exempt from the creditable coverage disclosure requirements for coverage beginning on or after Jan. 1, 2027.