Lucent Health

2024 Annual Notice Requirements

Your Annual Notice Requirements

To assist our clients, we are summarizing certain disclosure responsibilities imposed on Plan Sponsors of health plans, including your self-funded plan. For a complete list of requirements, visit the Department of Labor - https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/reporting-and-disclosure-guide-for-employee-benefit-plans.pdf. Please contact your Account Executive with any additional questions.

Contents

Health Plan Notices

ERISA requires plan sponsors of health plans to provide certain notices, including those that describe a member's rights regarding; enrollment, treatment, and care and privacy. Not all notices may pertain to your health plan and are therefore not required to be provided. Because we do not provide legal advice, you should review the disclosure requirements and notices with your counsel.

- **Required Every 3rd Year**
  - HIPAA Privacy Notice

- **Required Annually**
  - Michelle's Law – because of the Affordable Care Act, o*nly plans that provide coverage to dependents beyond age 26, are required to supply this notice.*
  - Women's Health and Cancer Rights Act Notice
  - CHIP Premium Assistance Notice
  - Consolidated Appropriations Act Disclosure for Plan Members

- **Required As Part of Open Enrollment, Plan Change & New Enrollee Benefit Communications**
  - Notice Regarding Grandfathered Plan Status – *If applicable, include in plan materials provided to plan participants.*
  - Summary of Benefits Coverage – *Updated versions need to be supplied when there are material modifications (60 days before the changes are effective). The current SBC should be supplied as part of the Open Enrollment materials when allowing plan election changes and/or as a way of notifying members there are plan changes that need to be considered while making open enrollment decisions (generally, 30 days before the new plan year).*

- **Required Annually to Medicare Eligible Plan Participants & When a Medicare Eligible Employee Becomes Eligible for Coverage**
  - Medicare Part D Creditable/Non-Creditable Coverage Notice – *Since most employers cannot determine with 100% accuracy the Medicare eligibility of all their participants, it is acceptable to send a notice to all plan participants annually. This notice separately is required to be provided to those Medicare-eligible participants before* ***October 15th*** *of each year.*

HIPAA Notice of Privacy Practices

Participants must be notified at least once every three years that of the plan's HIPAA privacy practices. An easy way to comply with this requirement is to notify participants annually, at open enrollment or include the communication with other Annual Notices supplied to participants (as reflected below, the notice should have been updated for the 2013 HHS regulations).

Sample HIPAA Notice:

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Instructions for Notice

- Raymond Ritchie, COO, Nye County School District. Email: rritchie@nyeschools.org. Tel: (775) 727-7743

- Nye County School District does not create or manage a provider directory. The provider directory is managed by Anthem Blue Cross Blue Shield.
- The privacy rules are subject to the laws of the State of Nevada for all disclosures. Nye County School District will never share any medical information without your written permission.

Women's Health and Cancer Rights Act (WHCRA)

Each year participants must receive a description of a health plan's coverage for mastectomies and breast reconstructive services. If the SPD is reissued each year, the notice can be included in the SPD. Otherwise, a separate notice should be included in the plan's annual enrollment materials.

Sample WHCRA Notice:
Do 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? Call your plan administrator at (775) 727-7743 for more information.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Since 2009, special enrollment rights to immediately enroll in an employer's health plan arise if an individual becomes eligible for a state premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP). The subsidy helps low income individuals pay for employer coverage, transferring them from government-sponsored health programs to employer health plans. While most states offer premium assistance subsidies, some states do not. CHIPRA imposes a notice requirement on employers who maintain health plans with participants residing in one or more states providing a premium assistance subsidy. The notice must be provided annually to all employees residing in each premium assistance subsidy state, including employees not enrolled in the plan.

CHIPRA Model Notice:

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	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
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
CALIFORNIA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**

Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a_-to-z/hipp HIPP Phone: 1-888-346-9562
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**NEW HAMPSHIRE – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 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	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. 5218
KANSAS – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	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
KENTUCKY – Medicaid	**NEW YORK – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:	Website: https://www.health.ny.gov/health_care/medicaid/

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	Phone: 1-800-541-2831
LOUISIANA – Medicaid	**NORTH CAROLINA – 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)	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MAINE – Medicaid	**NORTH DAKOTA – 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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MASSACHUSETTS – Medicaid and CHIP	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840 TTY: (617) 886-8102	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MINNESOTA – Medicaid	**OREGON – Medicaid**
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	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MISSOURI – Medicaid	**PENNSYLVANIA – Medicaid**

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
MONTANA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEBRASKA – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid	
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Websites: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**

Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
VIRGINIA – Medicaid and CHIP	
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924	

To see if any other states have added a premium assistance program since July 31, 2021, 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 1/31/2024)

Consolidated Appropriations Act Disclosure for Plan Members

The Consolidated Appropriations Act (CAA) is a comprehensive set of laws that include the No Surprises Act (NSA) and transparency provisions. Plan Sponsors are required to post an NSA Notice in a prominent location in the workplace and/or post a link to the NSA Notice on the searchable home page of their websites. The Department of Labor (DOL) has provided a model notice, which should be used for plan years beginning on or after January 1, 2022.

CAA DOL Model Notice Language:

OMB Control Number: 1210-0150
Expiration Date: 12/31/2024

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

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

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

The State of Nevada conforms to all balance billing laws or requirements imposed by the Consolidated Appropriations Act.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Consolidated Appropriations Act Benefits and Costs Reporting

The Consolidated Appropriations Act (CAA) requires health plans, including self-funded plans, to submit information to CMS about prescription drug and health care spending (referred to as “RxDC”). These reports are expected to enhance transparency and shed light on how prescription drugs contribute to the growth of health care spending and the cost of health coverage. The Frequently Asked Questions (FAQs) below address how Lucent Health will assist plan sponsors to comply with this requirement.

What does RxDC stand for?

The data submission that insurance companies and self-funded health plans must submit about prescriptions drugs and health care spending is called the RxDC report. The Rx stands for prescription drug and the DC stands for data collection.

How often are the RxDC files to be provided?

The files are required each calendar year, starting with 2020. The federal agencies delayed the reporting, so the first reports for 2020 and 2021 are due December 27, 2022. Going forward, subsequent years will be due June 1st.

What are the key RxDC reporting components?

Under the CMS regulations, the following must be reported:

1. P1-3: Plan List (Plan demographic details based on the Market Segment)
2. D1: Premium and Life Years (premiums paid and enrollments)
3. D2: Spending by Category (total healthcare costs by category – hospital. Primary care, prescription drugs etc.)
4. D3: Top 50 Most Frequent Brand Drugs by plan, state, and market segment
5. D4: Top 50 Most Costly Drugs by plan, state, and market segment
6. D5: Top 50 Drugs by Spending Increase by plan, state, and market segment
7. D6: Rx Totals, including prescriptions covered outside of the Rx benefit, by plan, state, and market segment
8. D7: Rebates by Therapeutic Class by plan, state, and market segment
9. D8: Rx Rebates for the Top 25 Drugs by plan, state, and market segment
10. Narrative Response

Note these requirements are subject to change. CMS provides RxDC templates, which are the most up to data file requirements. These can be found on the CMS.gov website under RxDC templates (ZIP): CMS Website Sec 204 Prescription Drug Data Collection Documentation.

What PBM support will be offered to plan sponsors?

As plan sponsor of a self-funded plan, the employer has the obligation to file the report. CMS allows employers to enter into agreements to have one or more third parties file the report.

We expect that a plan sponsor’s pharmacy benefit manager (PBM) will complete and file with CMS the D3 – D8 PBM Rx data files, along with the appropriate Narrative responses and other required data. However, we are finding that each PBM is different. Some are charging a fee to submit, others are not submitting and sending the information to the TPA. If you are not sure how your PBM is submitting files, please contact your PBM.

If your PBM has decided not to submit the files to CMS, then Lucent Health will submit on your behalf as long as we have timely received the files from your PBM. Please coordinate with your Lucent Health account executive and PBM. We must receive the PBM files by December 1st.

Will Lucent Health be submitting files to CMS on behalf of the Plan Sponsor?

Lucent will be submitting P2, D1, D2 and the appropriate Narrative responses on behalf of our active plan sponsors at no additional charge at this time. A fee will be reevaluated next year for the June submission. In order to submit the necessary files to CMS, there is some information needed within the D1 and D2 that we do not have.

Where do I find my 5500 Number?

You can locate your 5500 Number a few different ways –

- on your recent filing,
- by visiting https://www.efast.dol.gov/5500search/, or
- in your SPD

If you have multiple 5500 Numbers, please list all relevant numbers and separate using a semicolon. If you do not have a 5500 Number, please input N/A.

For the average premium, should I report on Medical, Dental, Vision?

You should just include premium for medical.

How do I calculate the average premiums?

$$\text{Average monthly premium paid by employers} = \frac{\text{Total premium paid by employers}}{\text{Total member months}}$$

$$\text{Average monthly premium paid by members} = \frac{\text{Total premium paid by members}}{\text{Total member months}}$$

Monthly premiums are paid by employees not members, can I report on employees?

CMS uses the term members. You can calculate based on the employee average of the total premium equivalent.

How will I know Lucent submitted files to CMS on our behalf?

Lucent will supply the submission ID once the files have been submitted.

Notice Regarding Grandfathered Plan Status

Plans that were in effect prior to the enactment of the Affordable Care Act are exempt from some of the requirements under the ACA if they retain "grandfathered plan" status. One of the requirements to retain grandfathered plan status is including certain disclosures in SPDs and other plan materials (such as annual open enrollment materials) provided to participants describing the plan's benefits. The disclosure must state that the plan is grandfathered and must provide contact information for questions and complaints.

Grandfathered Status Model Notice Language:

Patient Protection and Affordable Care Act: This group health plan believes this plan is a “Grandfathered Health Plan”, under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

Nye County School District Health Benefit Plan
484 S. West Street
Pahrump NV 89084

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

Summary of Benefits and Coverage

The ACA Reform added a new participant notice requirement known as the Summary of Benefits and Coverage ("SBC"). A copy of the SBC should be provided to participants when information about the benefit program is communicated, as well as in other prescribed circumstances. Group health plans are specifically required to provide an SBC to a participant or beneficiary with respect to each “benefit package” offered for which the participant or beneficiary is eligible.

The SBC must be distributed at various times, as outlined below.

- At Open Enrollment (Renewal)
  - If a plan requires participants to actively elect to maintain coverage or provides them with the opportunity to change coverage options during open enrollment, the SBC must be provided at the same time the open enrollment materials are distributed.
  - If there is no requirement to maintain coverage, and no opportunity to change coverage options, renewal is considered to be automatic, and the SBC must be provided no later than 30 days prior to the first day of the new plan year.

- At Initial Enrollment
  - The SBC for each benefit package offered, for which the participant is eligible, must be provided as part of any written application materials that are distributed by the plan.
  - If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage.

- At Special Enrollment
  - The plan must provide the SBC to special enrollees (employees and dependents with the right to enroll in coverage midyear upon specified circumstances) within 90 days after enrollment pursuant to a special enrollment right.

- Benefit Changes (when implemented at a time other than the Plan Renewal)
  - The plan must provide the SBC to participants no later than 60 days prior to the date the change takes effect.

- Upon Request
  - The plan must provide the SBC to a participant upon request, as soon as practicable, but in no event later than seven business days following the request.

The SBC must be provided to all persons covered under the plan, but one copy sent to the employee’s address is sufficient for all family members residing at that address. Plan sponsors may provide SBCs electronically as part of online enrollment as long as participants also have the option to receive a paper copy upon request. ERISA plans required to distribute the SBC must also follow the DOL's electronic distribution requirements by using "measures reasonably calculated to ensure actual receipt" of the SBC.

Lucent Health can assist with the development of the Summary of Benefits and Coverage document if ample notice is requested. A development and/or revision fee does apply.

Medicare Part D Notice of Creditable or Non-Creditable Coverage

This annual notice must be provided ONLY to any participant (employee or dependent) eligible for coverage under Medicare Part A or coverage under Medicare Part B and who lives in the service area of a Medicare Part D prescription drug plan. While employers usually know whether an employee is eligible for Medicare, employers often do not have this information regarding dependents. As a result, providing the notice to all participants ensures compliance. **Notice to Medicare eligible participants should be provided by October 15th each year.** Again, if the SPD is reissued each year, the notice can be included in the SPD. Otherwise, a separate notice can be included in the plan's annual enrollment materials or the notice can accompany the other Annual Notices supplied to participants.

In addition to distributing the Certificate of Creditable Coverage or Certificate of Non-Creditable Coverage to your plan participants, you are also required to complete an online disclosure to CMS within 60 days of the beginning of your plan year. This disclosure notifies CMS if your prescription drug plan is creditable or not. This Disclosure Form can by found on the CMS.gov website - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.

Medicare Part D CREDITABLE Model Notice:

Important Notice from Nye County School District 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 Kroger 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. **Nye County School District has determined that the prescription drug coverage offered by the Nye County School District Health Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Nye County School District Health Benefit Plan coverage will not be affected. The prescription drug plan coverage under Nye County School District Health Benefit Plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D can elect Part D and the health benefit plan will coordinate with Part D coverage.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Nye County School District Health Benefit Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Nye County School District Health Benefit Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information Teresa Erickson at (775) 727-7743. **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 Nye County School District Health Benefit Plan changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

NOTE: 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.

Medicare Part D NON-CREDITABLE Model Notice:

Important Notice From Nye County School District 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 Nye County School District Health Benefit Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. 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. **Nye County School District has determined that the prescription drug coverage offered by the Nye County School District Health Benefit Plan is, on average for all plan participants credible coverage.**

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.

Since you are losing creditable prescription drug coverage under the Nye County School District Health Benefit Plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.]

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

Since the coverage under [Insert Name of Plan], is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Nye County School District Health Benefit Plan coverage will not be affected as long as you remain an active employee

If you do decide to join a Medicare drug plan and drop your current Nye County School District Health Benefit Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Nye County School District changes. You also may request a copy of this notice at any time.

Teresa Erickson
(775) 727-7743

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).

NOTE: 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.

ACA Shared Responsibility Mandate

Although the individual mandate penalty has been eliminated, the employer requirements and penalties remain.

Action Required:

- **January 31, 2024** – Furnish employee statements
  - **Note**: The IRS has permanently extended the furnishing deadline by 30 days. The permanent 30-day extension to the typical January 31 deadline means employers will now have until on or about **March 2nd** each year to furnish the 1095 forms.
- **February 28, 2024** – If compiling data and filing the IRS Forms on your own via paper
- **March 31, 2024** – If compiling data and filing the IRS Forms on your own electronically

Employers subject to the ACA "shared responsibility" mandate—sometimes referred to as "play or pay"—will be required to file a report with the IRS in order to show that the health coverage they offer to their employees is compliant with ACA requirements.

Note: The IRS is eliminating its "good faith effort" standard for ACA-related filings for the 2021 and later calendar years, a standard that insulated insurers and employers from penalties for their errors and omissions on their ACA filings as long as the insurer or employer acted in good faith. The elimination of the good faith standard underscores the importance of the employer double- and triple-checking its Forms 1095-C provided to individuals, and its Forms 1095-C and Form 1094-C filed with the IRS.

Under tax code sections 6055 and 6056, employers must compile monthly and report annually numerous data points to the IRS and their own employees (on Forms 1094-C and 1095-C). This data will be used to verify the individual and employer mandates under the law. Reporting under sections 6055 and 6056 is required in January 2021 to employees and either February or March 2021 to the IRS depending upon filing method.

Many Employers are concerned with how they will manage the IRS Employer and Individual/Employee filing requirements. Therefore, Lucent Health has developed reporting to assist clients who will be managing the filing on their own.

Lucent Health will provide the following at no charge to current clients who were clients in 2022 and will remain contracted with Lucent Health for TPA services effective in 2024:

- A census report, in Excel format, including all members covered under the Plan during 2022. This report will provide the member name, date of birth, social security number, elected plan name and effective dates of coverage by month. We will run the full reporting showing coverage for all of 2022 and post it to each client's secure reporting location by January 17, 2024.

- If reporting is needed in the interim, we are able to produce, upon request, an eligibility report showing activity through the date of request.

Please Note: Again, the reporting noted above will be accessible in the secure reporting location by January 17, 2024.

Section 111 Group Health Plan

The purpose of the Section 111 Group Health Plan (GHP) reporting process is to enable CMS to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility. Responsible Reporting entities (RRE) are required to electronically exchange health insurance benefit entitlement information. In regards to your plan, we are working closely with your PBM providers that the required reporting is being completed.

5500s

Lucent Health does not complete 5500s for Plan Sponsors. However, if needed, Lucent will provide data to assist Plan Sponsors complete the 5500 form.

The above information is for your reference, but please note that Lucent Health Solutions, LLC does not provide legal or accounting advice. You should refer the above with your accountant and/or lawyer to determine how your company may best comply. By providing this information, Lucent Health Solutions, LLC does not assume any responsibility for reporting or disclosing the above information, or any report not described above.