

INDEPENDENT COLLEGES & UNIVERSITIES BENEFITS ASSOCIATION

2023 HEALTH PLAN NOTICES



Dear ICUBA Members:

In this packet, you will find notices required by federal laws and provides important information:

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Sincerely,

ICUBA Member Employers

- | | |
|---------------------------------|--------------------------------------|
| Barry University | The Poynter Institute |
| Beacon College | Rollins College |
| The Bolles School | Saint Edward’s School |
| Central Florida AHEC | Saint Leo University |
| Corbett Preparatory School | Saint Paul’s School |
| Edward Waters University | Saint Stephen’s Episcopal Day School |
| Everglades AHEC | San Jose Episcopal Day School |
| Florida Institute of Technology | St. Thomas University |
| Good Shepherd Episcopal School | Tampa Preparatory School |
| Grace Episcopal Day School | The Unity School |
| Jacksonville Country Day School | The University of Tampa |
| Nova Southeastern University | Warner University |
| Palm Beach Atlantic University | Westminster Christian School |

IMPORTANT NOTICE FROM ICUBA 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 ICUBA and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents. However, you should still keep a copy of this notice in the event you or a dependent qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede 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. ICUBA has determined that the prescription drug coverage offered by the ICUBA Employee Health Care Plan ("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" prescription drug coverage. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information, you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 each year. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

If you are considering joining a Medicare drug plan, 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. See the ICUBA Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting the Human Resources office at your institution.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the ICUBA Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the ICUBA Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description, or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your ICUBA prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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

Contact the Human Resources office at your institution for further information.

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

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

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

Date:	October 1, 2023
Name of Entity/Sender:	ICUBA Medical, Behavioral Health and Prescription Drug Plan
Contact—Position/Office:	HIPAA Privacy Officer
Address:	P.O. Box 616927 Orlando, Florida 32861
Email:	benefitsadministration@icuba.org

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA IMPORTANT NOTICE COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

ICUBA Medical, Behavioral Health, and Prescription Drug Plan Document *

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by ICUBA that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization, or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to provide treatment more effectively to you.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health Care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
 - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as ICUBA) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollment, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
 - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements or when otherwise required by applicable law.
- **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or prisons, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired, or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice, please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or *breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

ICUBA Medical, Behavioral Health and Prescription Drug Plan
Attn: HIPAA Privacy Officer
P.O. Box 616927
Orlando, FL 32861
Email: benefitsadministration@icuba.org

EMPLOYEE HEALTH CARE PLAN 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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within **30 days** after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 your HR Department.

GENERAL COBRA NOTICE

October 1, 2023

Re: CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this Notice of COBRA healthcare coverage continuation rights because you have recently become covered under one or more group health plans. The plan (or plans) under which you have gained coverage are listed at the end of this Form, and are referred to collectively as “the plan” except where otherwise indicated.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare coverage under the plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and/or to other members of your family who are covered under the plan when you and/or they would otherwise lose the group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. ***This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.*** For more information about your rights and obligations under the plan and under federal law, you should either review the plan’s Summary Plan Description or contact the Plan Administrator. In some cases the plan document also serves as the Summary Plan Description, in such case you should review the plan document.

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

COBRA Continuation Coverage and “Qualifying Events”

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Certain newborns, newly-adopted children and alternate recipients under qualified medical child support orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for this continuation coverage.

If you are a covered ***employee***, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

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

If you are the ***spouse of a covered employee***, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in any part of Medicare benefits; or
- You become divorced or legally separated from your spouse.

Your covered ***eligible children*** will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

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

Notice Requirements

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee

has been notified within the 30 day period following a qualifying event that a qualifying event has occurred. The employer must notify the Plan Administrator when the qualifying event is:

- the end of employment or reduction of hours of employment,
- death of the employee, or
- the employee's becoming entitled to Medicare benefits.

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or eligible child who loses coverage will not be offered the option to elect continuation coverage.

COBRA Continuation coverage provided?

Once the Plan Administrator or its designee receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event. ***If you or your spouse or eligible children do not elect continuation coverage within the 60-day election period described above, you will lose your right to elect continuation coverage.***

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event is the death of the employee, enrollment of the employee in any part of Medicare, your divorce or legal separation, or an eligible child losing eligibility as an eligible child, or when a second qualifying event occurs during the initial period of coverage, COBRA continuation coverage lasts for up to **36 months**.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to **18 months**.

There are three ways in which the period of COBRA continuation coverage can be extended...

1. Disability extension of 18-month period of continuation coverage.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage ***and you notify the Plan Administrator or its designee in writing and in a timely fashion***, you and your entire family can receive up to ***an additional 11 months*** of COBRA continuation coverage, for a total maximum of **29 months**.

You must make sure that the Plan Administrator or its designee is notified in writing of the Social Security Administration's determination within 60 days after (i) of the date of the determination or (ii) the date of the qualifying event or (iii) the date coverage is lost due to the qualifying event, whichever occurs last. But in any event the notice must be provided before the end of the 18-month period of COBRA continuation coverage. The plan requires you to follow specific procedures. In addition, your notice must include:

- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. ***If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required period, then there will be no disability extension of COBRA continuation coverage.***

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

If your family experiences ***another qualifying event*** while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, up to a maximum of **36 months (including the initial period of COBRA coverage)**.

This extension is available to ***the spouse*** and ***eligible children*** if, while they and the covered former employee are purchasing COBRA coverage, the former employee:

- dies,

- becomes entitled to Medicare benefits, or
- gets divorced or legally separated.

The extension is also available to an *eligible child* when that child stops being eligible under the plan as an eligible child.

In all of these cases, you must make sure that the Plan Administrator or its designee is notified in writing of the second qualifying event within 60 days after (i) the date of the second qualifying event or (ii) the date coverage is lost, whichever occurs last. Your notice must also ***name the second qualifying event and the date it happened.*** If the second qualifying event is a divorce or legal separation, your notice must include ***a copy of the divorce decree or legal separation agreement.***

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required 60-day period, then there will be no extension of COBRA continuation coverage due to the second qualifying event.

3. Medicare Extension for Spouse and Eligible Children.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and eligible children is **36 months** from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

OTHER RULES AND REQUIREMENTS

Same Rights as Active Employees to Add New Dependents. A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, "*Children Born or Placed for Adoption with the Covered Employee During COBRA Period,*" for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change (adding or dropping dependents, for example).***

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period. A child born to, adopted by, or placed for adoption with a covered employee or former employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee or former employee is a qualified beneficiary, the employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements).

Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.

Alternate Recipients Under Qualified Medical Child Support Orders. A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the employee's period of employment with the employer is entitled the same rights under COBRA as an eligible child of the covered employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.***

Are there other coverage options besides COBRA Continuation Coverage?

Yes, other coverage options not sponsored by your employer may be available. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator or its designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Plan Contact Information.

ICUBA's Cobra Administrator:
Ameriflex COBRA Department
7 Carnegie Plaza
Cherry Hill, NJ 08003
Telephone: 1-866-377-5102, Option 1
Fax: 1-609-257-0136
Email: COBRA@myameriflex.com

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

ICUBA Employee Health Care Plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. ICUBA encourages members to use Total Care or EMBOLD PCP's when available. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Cross Blue Shield at 1-855-258-9029 or www.myhealthtoolkitfl.com.

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

You do not need prior authorization from ICUBA Employee Health Care Plan 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 our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please refer to BCBS of Florida provider list at www.myhealthtoolkitfl.com.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

ICUBA Employee Health Care Plan is required by law to provide you with the following notice:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits. The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The ICUBA Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at benefitsadministration@icuba.org.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

ICUBA Wellness Program is a voluntary wellness program available to all ICUBA medical plan members and covered spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

ICUBA is committed to helping you achieve your best health. Rewards for participating in the wellness program are available to all medical plan members. Details about the wellness program, including criteria and incentives, can be found in the ICUBA WellBeing Operating Plan.

If you believe you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting BCBS Blue Rewards Program at 1-855-258-9029. BCBS Blue Rewards Program will work with you (and, if you wish, with your physician) to find a reasonable accommodation or alternative standard with the same reward that is right for you in light of your health status.

The information from the Biometric Screening and the Health Risk Assessment will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as education or coaching. You also are encouraged to share your results or concerns with your own doctor.

Employees who choose to participate in the wellbeing program will receive an incentive of credits, redeemable for gift cards for wellness activities. Although you are not required to complete the Wellbeing Survey, only employees who do so will receive all benefits of participating.

HEALTH INSURANCE MARKETPLACE COVERAGE

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12%¹ of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act,² you may be eligible for a tax credit.²

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

How Can I Get More Information?

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

¹As that percentage is adjusted by inflation from time to time.

²An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/

<p>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</p> <p>Phone: 678-564-1162, Press 2</p>	<p>Phone: 1-877-438-4479</p> <p>All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</p>
<p>IOWA – Medicaid and CHIP (Hawki)</p>	<p>KANSAS – Medicaid</p>
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p>KENTUCKY – Medicaid</p>	<p>LOUISIANA – Medicaid</p>
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p>MAINE – Medicaid</p>	<p>MASSACHUSETTS – Medicaid and CHIP</p>
<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p>MINNESOTA – Medicaid</p>	<p>MISSOURI – Medicaid</p>
<p>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</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>MONTANA – Medicaid</p>	<p>NEBRASKA – Medicaid</p>
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</p>	<p>Website: http://www.ACCESSNebraska.ne.gov</p>

Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services (https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program) Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access (https://dvha.vermont.gov/members/medicaid/hipp-program) Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

	Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

To see if any other states have added a premium assistance program since July 31, 2023, 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

1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn’t be charged more than your plan’s copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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” means providers and facilities that haven’t signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan’s deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You’re 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 they can bill you is your plan’s in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

In general, under Florida law you cannot be balanced billed in emergency situations. Florida law states that insurance companies are not allowed to bill you for amounts beyond your plan's in-network cost-sharing amount in certain situations. This protection applies for emergency services by out-of-network providers and facilities. In addition, the protection applies when you are unknowingly treated by out-of-network physicians for covered services. Hospitals must post on their websites the health plans with whom they are in-network and provide you notice if you may be seen by out of network practitioners.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Centers for Medicare & Medicare Services (CMS) at 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit FloridaHealthFinder (quality.healthfinder.fl.gov) for more information about your rights under Florida law.

ICUBA Medical, Behavioral Health and Prescription Drug Plan
Attn: HIPAA Privacy Officer
P.O. Box 616927
Orlando, Florida 32861

