

IMPORTANT NOTICES REGARDING YOUR HEALTH INSURANCE RIGHTS

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For an individual receiving mastectomy-related benefits, coverage will be provided in a manner determined by 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 an asymmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient

The Newborns' and Mothers' Health Protection Act of 1996

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Enrollment

If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll you or your dependents in the plan, provided that your request enrollment within 30 days after your other coverage ends (COBRA or state continuation coverage ends, divorce, legal separation, death, termination of employment or reduction in hours worked; or because the employer contributions cease).

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 you and your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you decline enrollment for yourself or for your dependents (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage

under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

If you have any questions, please contact HR Department at 937-440-5996.

Michelle's Law (2010)

Michelle's Law prohibits the termination of health coverage if the child takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

- Be medically necessary (and certified by a physician as medically necessary)
- Commence while the child is suffering from a serious illness or injury
- Cause the child to lose student status for the purposes of coverage under the plan (either from an absence from school or reducing his/her course load to part time)

To take advantage of the extension, the child must be enrolled in the group health plan by being a student at a post-secondary educational institution immediately before the first day of the leave.

Coverage must extend for one year after the first day of the leave (or, if earlier, the date coverage would otherwise terminate under the plan). The student on leave is entitled to the same benefits as if they had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

Pre-existing Condition Exclusion and Certificate of Creditable Coverage Information

Recent changes in Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. Contact your state insurance department for further information.

You have the right to receive a certificate of prior health coverage. You may need to provide other documentation for earlier periods of health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions, and if you need to provide a certificate of other documentation of your previous coverage.

To obtain a certificate:

UMR will mail a certificate of prior health coverage to your home after employment at Miami County is terminated.

The certificate must be provided to you promptly. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

Genetic Information Nondiscrimination Act (2008)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information.

GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA prevents a plan or issuer from imposing a preexisting condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits or premiums based on any health factor (including genetic information).

GINA provides group health plans and health insurance issuers cannot base premiums for an employer or a group of similarly situated individuals on genetic information. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

GINA also generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although the regulations make clear the plan or issuer may request only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) a participant or beneficiary undergo a genetic test.

GINA also prohibits a plan from collecting genetic information (including family medical history) prior to, or in connection with enrollment, or for underwriting purposes. Thus, under GINA, plans and issuers generally are prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA). The regulations provide several examples illustrating GINA's application to HRAs.

An exception is included for incidental collection, provided the information is not used for underwriting. However, the regulations make clear the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice 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.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information*: must pay *or* are not required to pay] for COBRA continuation coverage.

If you are an 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.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an 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 entitled to Medicare benefits (under Part A, Part B, or both).
- You become divorced or legally separated from your spouse.

Your dependent 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 entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee become entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs.

You must provide this notice to:

HR Department
(937) 440-5996

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee become entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child loses eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. This 18-month period of COBRA continuation coverage can be extended.

First qualifying event 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 and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator 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.

Plan Contact Information

For further information please contact:

HR Department
(937) 440-5996

MEDICAID AND THE CHILDRENS' HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

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 January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	CALIFORNIA – Medicaid Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	COLORADO – Medicaid and CHIP Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	FLORIDA – Medicaid Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
GEORGIA – Medicaid Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	MONTANA – Medicaid

<p>Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588</p>	<p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084</p>
INDIANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://www.in.gov/fssa Phone: 1-800-889-9948</p>	<p>Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092</p>
IOWA – Medicaid	NEVADA – Medicaid and CHIP
<p>Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562</p>	<p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669</p>
KANSAS – Medicaid	
<p>Website: https://www.khpa.ks.gov Phone: 1-800-792-4884</p>	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p>Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238</p>
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
MAINE – Medicaid	
<p>Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557</p>	
MASSACHUSETTS – Medicaid and CHIP	NEW MEXICO – Medicaid and CHIP
<p>Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120</p>	<p>Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure CHIP Phone: 1-888-997-2583</p>
MINNESOTA – Medicaid	
<p>Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (area): 651-431-2670</p>	
NEW YORK – Medicaid	TEXAS – Medicaid
<p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p>Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493</p>
NORTH CAROLINA – Medicaid	UTAH – Medicaid
<p>Website: http://www.nc.gov Phone: 919-855-4100</p>	<p>Website: http://health.utah.gov/upp Phone: 1-866-435-7414</p>
NORTH DAKOTA – Medicaid	VERMONT – Medicaid
<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>	<p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>

OKLAHOMA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	WASHINGTON – Medicaid
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicaidassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	WISCONSIN – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

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