Appendix O

Notice of Health Insurance Portability and Accountability Act of 1997 (HIPPA)

You are eligible to participate in a group health plan offered to Whitman County Library employees (to actually participate, you must complete an enrollment form and may need to pay part of the premium through payroll deduction).

Federal law (called HIPAA) requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or you or an eligible dependent decline coverage under this plan because of alternative coverage and later lose such coverage due to certain qualifying reasons. Second, this notice advises you of the plan's preexisting condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or your family may have.

Special Enrollment Provisions

1. Rule #1: Loss of Coverage: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, and that coverage terminates due to certain qualifying reasons (i.e., exhaustion of COBRA or state law continuation rights; loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment or reduction in hours; or because employer contributions for the other coverage ceases) you "may" in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, and that you meet certain other important conditions described in the plan SPD (Summary Plan Description).

2. Rule #2: Marriage, Birth, or Adoption: In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you "may" be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, and that you meet certain other important conditions described in the SPD.

3. Important Warning: If you decline enrollment for you or your dependents, you must complete the attached "Form for Employee to Decline Coverage." On the form, you are required to state that coverage under another group health plan or other health insurance coverage is the reason for declining enrollment, and you are asked to identify that coverage. If you fail to complete the form, neither you nor your dependents will be entitled to the special enrollment rights described in Rule #1 above, but you will still have the special enrollment rights described in Rule #2. Without the special enrollment rights described in Rule #1, you must wait until the plan's annual enrollment period to enroll, except in cases of marriage, birth, adoption or placement for adoption. Further, when you eventually do enroll during annual open enrollment, you will be treated as a "late enrollee."

Pre-Existing Condition Provisions

1. **Pre-Existing Condition Defined.** A pre-existing condition is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received with the 3-month period ending on your enrollment date

or, if earlier, the first day of the waiting period for such enrollment. (For new hires who are hired into a benefits eligible job, the 3-month period starts on the date of hire.)

2. **For How Long is Coverage for Pre-Existing Conditions Excluded?** Our plan excludes coverage for your or your dependents' pre-existing condition for 3 months, starting on your enrollment date, or, if earlier, the first day of the waiting period for such enrollment. (For new hires who are hired into a benefits eligible job, the 3-month period starts on the date of hire.)

3. **Prior Periods of Coverage May Shorten or Even Eliminate our Plan's 3-Month PCE Period.** In general, you will be given "credit" for all days on which you had qualifying health care coverage *prior* to joining our plan. Days of prior coverage are "credited" by reducing, day-for-day, the 3-month pre-existing condition exclusion period you otherwise would face under the plan. More specifically, our plan's 3-month PCE period will be shortened one day for each day that you had **"creditable coverage"** under another health plan, provided that you do not have a 63-day lapse in coverage after your creditable coverage ended. A waiting period to get into a plan generally does not count as a lapse in coverage. (Some people elect COBRA coverage under their prior plan just to ensure they don't experience a 63-day lapse in coverage.) Creditable coverage includes coverage under a group health plan, health insurance coverage, a State health benefits risk pool, Medicare, Medicaid, and certain other coverages. Coverage you may have as a dependent—e.g., under your spouse's plan—will count for this purpose.

4. Our plan uses the **"Alternative Method"** of crediting prior group health coverage. Under this method, the plan first will determine your creditable coverage under the Standard Method discussed in the preceding paragraph (under that method, the plan determines how much creditable medical coverage you had in general, without regard to the specific type of coverage). Then, the plan will count the number of days during that time on which you had coverage in each of the five following categories: (1) dental; (2) vision; (3) prescription drugs; (4) substance abuse treatment; (5) mental health. Your 3-month PCE period for coverage in each of these five categories of benefits will be reduced by the number of days or prior creditable coverage you show in each of the categories. A 63-day or greater lapse in coverage with respect to a specified category will not result in a loss of credit for prior coverage for that category, provided that you didn't have a lapse in coverage of your overall creditable medical coverage.

5. **How to Show Us That You Had Creditable Coverage Before Joining our Plan.** In order for the 3-month PCE period to be shortened as described above, you must show us that you had prior creditable coverage under another group health plan, a health insurance policy, a State health benefits risk pool, Medicare, Medicaid, etc. To demonstrate to us that you had other creditable coverage, you should provide us with a **"Certificate of creditable coverage"** from your prior plan. Other evidence of coverage will also be accepted. Most group health plans, health insurers and HMOs automatically furnish these certificates to individuals when coverage is lost. In addition, all plans, insurers and HMOs are required to provide these certificates upon request. The certificate will tell us how long you had coverage under your prior plan, and when it ended. Following the receipt of the certificate, we will ask the entity that issued the certificate to disclose additional information so we can determine your creditable coverage with respect to the five categories described under the alternative method, unless the original certificate contains that information.

6. You have the right to request a certificate from a prior plan, insurer, HMO, or other entity through which you had creditable coverage. If, after making reasonable efforts, you have difficulty getting

a certificate from your prior plan, insurer, HMO, or other entity through which you had creditable coverage, please contact us at the address or phone number above, and we will attempt to assist you.

7. After we receive your certificate(s) or other evidence of coverage, we will determine whether, and for how long, our plans PCE period will apply to you. If we determine that our plan's PCE period will apply to you, we will advise you of this.