



# MEMBER NOTICES

Regarding Your Benefit Plan Offered Through  
School Employees' Benefit Trust

**Required Distribution**

October 1, 2024

# MEDICARE PART D CREDITABLE COVERAGE NOTICE

## Important Notice 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 School Employees' Benefit Trust ("Plan") prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15<sup>th</sup> through December 7<sup>th</sup>.

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

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

If you decide to join a Medicare drug plan, your current Plan coverage will not be affected. The Plan has determined that the prescription drug coverage offered through the Plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. Contact your Plan administrator for more details on your prescription benefits.

If you decide to join a Medicare drug plan and drop your current medical coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a qualifying event or sign up during Open Enrollment.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you want more information, contact Express Scripts [www.express-scripts.com](http://www.express-scripts.com) for more details on your prescription benefits. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your current Plan drug coverage 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](http://www.medicare.gov).
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

## **WOMEN'S CANCER RIGHTS NOTIFICATION**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. all stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prosthesis; and
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you have any questions about the School Employees' Benefit Trust's provisions relating to the Women's Health and Breast Cancer Rights Act of 1998, contact your Claim Administrator at 1-800 288-2078.

## 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](http://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](http://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](http://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, 2024. Contact your State for more information on eligibility –**

ALABAMA – Medicaid	ALASKA – Medicaid
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a> HIBI Customer Service: 1-855-692-6442	Website: <a href="https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268

<b>GEORGIA – Medicaid</b>	<b>INDIANA – Medicaid</b>
<p>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a>  Phone: 678-564-1162, Press 1  GA CHIPRA Website:  <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>  Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program  All other Medicaid  Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>  <a href="http://www.in.gov/fssa/dfr/">http://www.in.gov/fssa/dfr/</a>  Family and Social Services Administration  Phone: 1-800-403-0864  Member Services Phone: 1-800-457-4584</p>
<b>IOWA – Medicaid and CHIP (Hawki)</b>	<b>KANSAS – Medicaid</b>
<p>Medicaid Website:  <a href="http://iowa.gov/health-human-services">Iowa Medicaid   Health &amp; Human Services</a>  Medicaid Phone: 1-800-338-8366  Hawki Website:  <a href="http://iowa.gov/healthy-well-kids">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a>  Hawki Phone: 1-800-257-8563  HIPP Website: <a href="http://iowa.gov/health-insurance-premium-payment">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a>  HIPP Phone: 1-888-346-9562</p>	<p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>  Phone: 1-800-792-4884  HIPP Phone: 1-800-967-4660</p>
<b>KENTUCKY – Medicaid</b>	<b>LOUISIANA – Medicaid</b>
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a>  KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a>  Phone: 1-877-524-4718  Kentucky Medicaid Website:  <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p>	<p>Website: <a href="http://www.medicicaid.la.gov">www.medicicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<b>MAINE – Medicaid</b>	<b>MASSACHUSETTS – Medicaid and CHIP</b>
<p>Enrollment Website:  <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>  Phone: 1-800-442-6003  TTY: Maine relay 711  Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: 1-800-977-6740  TTY: Maine relay 711</p>	<p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>  Phone: 1-800-862-4840  TTY: 711  Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></p>
<b>MINNESOTA – Medicaid</b>	<b>MISSOURI – Medicaid</b>
<p>Website:  <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a>  Phone: 1-800-657-3672</p>	<p>Website:  <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>

<b>MONTANA – Medicaid</b>	<b>NEBRASKA – Medicaid</b>
Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084 Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a>	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
<b>NEVADA – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Medicaid Website: <a href="http://dhcfnv.gov">http://dhcfnv.gov</a> Medicaid Phone: 1-800-992-0900	Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a>
<b>NEW JERSEY – Medicaid and CHIP</b>	<b>NEW YORK – Medicaid</b>
Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
<b>NORTH CAROLINA – Medicaid</b>	<b>NORTH DAKOTA – Medicaid</b>
Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100	Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a> Phone: 1-844-854-4825
<b>OKLAHOMA – Medicaid and CHIP</b>	<b>OREGON – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> Phone: 1-800-699-9075
<b>PENNSYLVANIA – Medicaid and CHIP</b>	<b>RHODE ISLAND – Medicaid and CHIP</b>
Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a> Phone: 1-800-692-7462 CHIP Website: <a href="http://www.pa.gov/childrens-health-insurance-program">Children's Health Insurance Program (CHIP) (pa.gov)</a> CHIP Phone: 1-800-986-KIDS (5437)	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
<b>SOUTH CAROLINA – Medicaid</b>	<b>SOUTH DAKOTA - Medicaid</b>
Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a> Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a> Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a> Phone: 1-888-222-2542 Adult Expansion Website: <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a> Utah Medicaid Buyout Program Website: <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a> CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a>
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a> Phone: 1-800-250-8427	Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a> Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022	Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a> <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
 Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)  
 1-877-267-2323, Menu Option 4, Ext. 61565

### Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

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



## NOTICE OF PRIVACY PRACTICES

***THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

This Notice provides information about the use and disclosure of protected health information by the School Employees' Benefit Trust ("SEBT"). SEBT is required by law to maintain the privacy of protected health information. Protected health information, or "PHI," is information about you that relates to your health, condition, health care provided to you, and payment for health care services. Your PHI includes any of this information that identifies you or could be used to identify you.

This Notice is provided to you to explain Our legal duties and privacy practices with respect to your PHI. School Employees' Benefit Trust is required to abide by the terms of the Notice currently in effect.

When used in this Notice, the term "We," "Our," and "Us" refers to SEBT and its groups.

**Uses and Disclosures of PHI.** We will use or disclose your PHI as needed and in accordance with the law for purposes of treatment, payment and health care operations. We may use and disclose your PHI for the following purposes without your consent or permission:

***Treatment:*** "Treatment" means the provision, coordination or management of health care by one or more health care providers, including consultations, referrals and coordination with a third party. We are not a health care provider and do not render health care; however, We may disclose your PHI to a health care provider, for example, to assist that provider with respect to your treatment.

***Payment:*** "Payment" includes the activities undertaken by a health care provider to obtain payment and the activities undertaken by a plan to determine eligibility and benefits; to conduct utilization review, precertification, concurrent care and retrospective review activities; to bill and collect premiums; to coordinate benefits and enforce its reimbursement and subrogation rights; and to obtain payment from stop-loss insurance. For example, We may disclose your PHI to Our claims administrator so that We can determine the amount of benefits that may be payable by your health plan.

***Health Care Operations:*** "Health care operations" includes underwriting, premium rating, and other activities relating to the creation or maintenance of a health plan; the acquisition and maintenance of stop-loss insurance; conducting or arranging for medical review, legal services and auditing; business planning and development relating to the management and operation of a health plan; and conducting the general business activities of a plan. For example, We may disclose your PHI in order to obtain or renew stop loss insurance coverage.

***Underwriting Purposes:*** If at any time We intend to use or disclose your PHI for underwriting purposes, please be advised that We are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

***Business Associates:*** The activities and functions listed above may be performed by third parties, called business associates. We may disclose your PHI to a business associate to the extent necessary for it to perform those activities and functions. Our claims administrator is a business associate. We may have other business associates as well. When disclosing information to a business associate, We will appropriately protect your PHI by contract.

***Other Disclosures:*** We may use or disclose your PHI without your consent or authorization to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law. Examples of instances in which We are required to disclose your PHI include: (a) to a person who is authorized by applicable law to make decisions on your behalf regarding your health care and to your executor, administrator or other personal representative following your death; (b) to a member of your family or a close friend who is involved in your health care or payment for your health care to the extent of his or her involvement; however, We will not do so if you tell Us not to; (c) to an authorized public health authority for certain public health activities such as preventing and controlling disease, injury or disability; (d) in response to a court order or other lawful process; (e) to a law enforcement official for law enforcement purposes to the extent permitted under law; (f) to a governmental health oversight agency; (g) to coroners, medical examiners and funeral directors as needed for them to perform their duties; (h) for cadaveric donation of organs, eyes or tissue; (i) to avert a serious threat to the health or safety of any person or to the public; (j) certain military activities; (k) national security and intelligence activities; (l) to a correctional institution where you are an inmate; (m) to permit a Sponsor to comply with laws regarding workers compensation and work-related medical conditions; and (n) to a governmental health oversight agency.

***Disclosures to Plan Sponsors:*** We will disclose your PHI to designated representatives of Our Plan Sponsors for purposes related to treatment, payment and health care operations. For example, We may disclose information to the Plan Sponsors regarding your present or former enrollment information. The Plan Sponsors are also required to protect your PHI.

**Uses and Disclosures Pursuant to Your Authorization.** We will not make any other use or disclosure of your PHI (other than disclosures incidental to a permitted use or disclosure) unless you give Us your written authorization to do so.

We require your written authorization for most uses and disclosures of psychotherapy notes, for marketing (other than a face-to-face communication between you and one of Our workforce members or a promotional gift of nominal value), or before selling your PHI. If you authorize Us to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, We will no longer use or disclose your PHI for the reasons listed in your written authorization. The revocation will not apply to uses or disclosures that have already occurred. Also, We will continue to comply with laws that require certain disclosures.

**Uses and Disclosures that Require an Attestation.** For PHI related to reproductive health care, any disclosure for purposes of health oversight activities, judicial and administrative proceedings, law enforcement, and coroners and medical examiners must be accompanied by an attestation. A valid attestation will verify that the use or disclosure of PHI is not otherwise prohibited by the plan and include the following elements:

- Description of the PHI requested that identifies your name or class of individuals;
- Your name;
- The name or other specific identification to whom you are to make the requested use or disclosure;
- Statement that the use or disclosure is not for a purpose otherwise prohibited by the plan;
- Statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains or discloses your identifiable health information; and
- Your signature and the date signed. If the signed by your representative, a description of the representative's authority to act for the person.

**Additional Protection of Your PHI.** Special state and federal laws apply to certain classes of PHI. For example, additional protections may apply to information about sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records, and HIV/AIDS information. When required by law, We will obtain your authorization before releasing this type of information.

We will not use or disclose PHI to conduct a criminal, civil, or administrative investigation into any person for the act of seeking, obtaining, providing, or facilitating reproductive health care. We will also not impose criminal, civil, or administrative liability upon any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care. We will not identify any person for any of the purposes described in this paragraph.

**Your Rights.** You have certain rights with respect to your PHI.

***Restrictions on Uses and Disclosures:*** You have the right to request restrictions or limits on your PHI We use or disclose about you for treatment, payment or health care operations. We are not required to agree to such other requests. However, if We do agree, We will comply with your request unless the information is needed to provide you with emergency treatment or to make a disclosure that is required under law. Restriction requests must be in writing, and you must tell Us: (1) what information you want to limit; (2) whether you want to limit Our use, disclosure or both; and (3) to whom you want the limits to apply. We may terminate an agreement to a restriction if We inform you of this termination. We will notify you of such termination, if applicable. You may also request to terminate a restriction or limitation on your PHI. To request a restriction or limit on your PHI, write to the contact person listed near the end of this Notice.

***Restrictions on Communications from SEBT:*** You have the right to make a written request that We communicate with you by alternate means or at alternate locations if you clearly state that the disclosure of your PHI through Our ordinary means of communications could endanger you. We will accommodate reasonable requests. Direct your written request to the contact person listed near the end of this Notice.

***Inspection and Copying of PHI:*** You have the right to make a written request that you be allowed to inspect and copy your PHI. All requests for access to your PHI must be in writing and signed by you or your representative. We may charge you a fee, especially if extensive and/or non-recent PHI is requested. We may also charge for postage if you request a mailed copy. If the information you request is maintained electronically, and you request an electronic copy of such information, We will provide you with access to the information in the electronic form and format you request, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as you and We agree. In some limited situations, your request to review or receive a copy may be denied. For example, when a licensed health care professional determines that access may endanger your life/physical safety or the life/physical safety of another. In some denial situations, you have the right to have the denial evaluated by a reviewing official. Based upon the determination of the reviewing official We will then provide or deny access. To request to review and/or receive a copy of your PHI, you or your representative, as applicable, will need to complete a signed release of information authorization form that may be obtained the contact person listed near the end of this Notice.

***Amendment of PHI:*** You have the right to make a written request to amend your PHI. As part of your request, you must explain the reasons why you think the information should be amended. We are not obligated to make all requested amendments but will give each request careful consideration. For example, an amendment request may be denied if the information to be amended was not created by Us or is not part of the PHI kept by Us. If an amendment you request is made by Us, We may also notify others who work with Us and have copies of the

uncorrected record if We believe that such notification is necessary. Direct your written request for amendments to the contact person listed near the end of this Notice.

**Accounting of Disclosures:** You have the right to make a written request for and to receive an accounting of disclosures of your PHI that We have made during the 6 years prior to the date the accounting is requested. However, this does not apply to disclosures made for purposes of treatment, payment or health care operations, disclosures made to you, disclosures made to persons involved in your care, or disclosures made for national security or intelligence purposes as authorized by the National Security Act.

**Paper Copy of Notice:** You may request and receive a paper copy of this Notice, even if you have received an electronic version of this Notice.

**Breach Notification:** In the event of any breach of unsecured PHI, We are required to, and will, fully comply with breach notification requirements mandated by law, which will include notification to you of any impact that breach may have had on you and the actions We have undertaken to minimize any impact the breach may or could have on you.

**Complaints.** If you are concerned that We have violated your privacy, or you disagree with a decision We made about access to your records, you may file a complaint with Our Privacy Officer. If you want to file a complaint, send a written statement describing your complaint to the contact person listed below. No one will retaliate against you for filing a complaint. If you believe that your privacy rights have been violated, you may also contact the Secretary of the Department of Health and Human Services (HHS).

Generally, a complaint must be filed with HHS within 180 days after the act or omission occurred, or within 180 days of when you knew or should have known of the action or omission.

**Privacy Notice Changes.** We reserve the right to change the privacy practices described in this Notice. We reserve the right to make the revised or changed Notice effective for PHI We already have as well as any information We may receive in the future. We will post a copy of the current Notice on Our websites. You may link to each division from <http://www.sebtoptimalhealth.com> Also, if We revise the Notice, We will provide the revised Notice, or information about the revision and how to obtain the revised Notice, in Our next annual communication (newsletter or mailing) to individuals then covered by SEBT's plans.

**Contact.** If you wish to file a complaint or obtain further information about SEBT's privacy policy, please contact:

Privacy Officer  
School Employees Benefit Trust  
113 North Second Street  
Decatur, Indiana 46733

## Continuation Coverage Rights Under COBRA

### INTRODUCTION

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 rights 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.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Benefit Book or contact the Plan Administrator.

**You may have other options available to you when you lose group health 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.

### **What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called 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 must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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); or

- 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:

- 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; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **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, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**For all 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 after the qualifying event occurs. You must send this notice in writing to the Plan Administrator. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.**

### **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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying

events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18 month period of COBRA continuation coverage can be extended.

### ***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 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 total 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.

A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event.

Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

### ***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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), 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.

### ***Are there other coverage options besides COBRA Continuation Coverage?***

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), 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 these options at [www.HealthCare.gov](http://www.HealthCare.gov).

### ***Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?***

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

### **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 applicable law, including COBRA, 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) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa), (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.

### **Plan Contact Information:**

COBRA Administrator  
Allied Benefit Systems  
200 w. Adams Street Suite 500  
Chicago, IL 60606  
1-800-288-2078



## **NEWBORN'S AND MOTHERS HEALTH PROTECTION ACT**

Under the provisions of The Newborn's and Mothers Health Protection Act, 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 Caesarean 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 NOTICE**

If you are declining group health plan enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this group health plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days (or any longer period that applies under the plan) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days (or any longer period that applies under the plan) after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department.

## **WELLNESS PROGRAM DISCLOSURE**

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

## **MULTIPLE EMPLOYER WELFARE ARRANGEMENT STATEMENT**

Your coverage is issued by a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for your multiple employer welfare arrangement.

044475.000003 4882-9304-3694.1