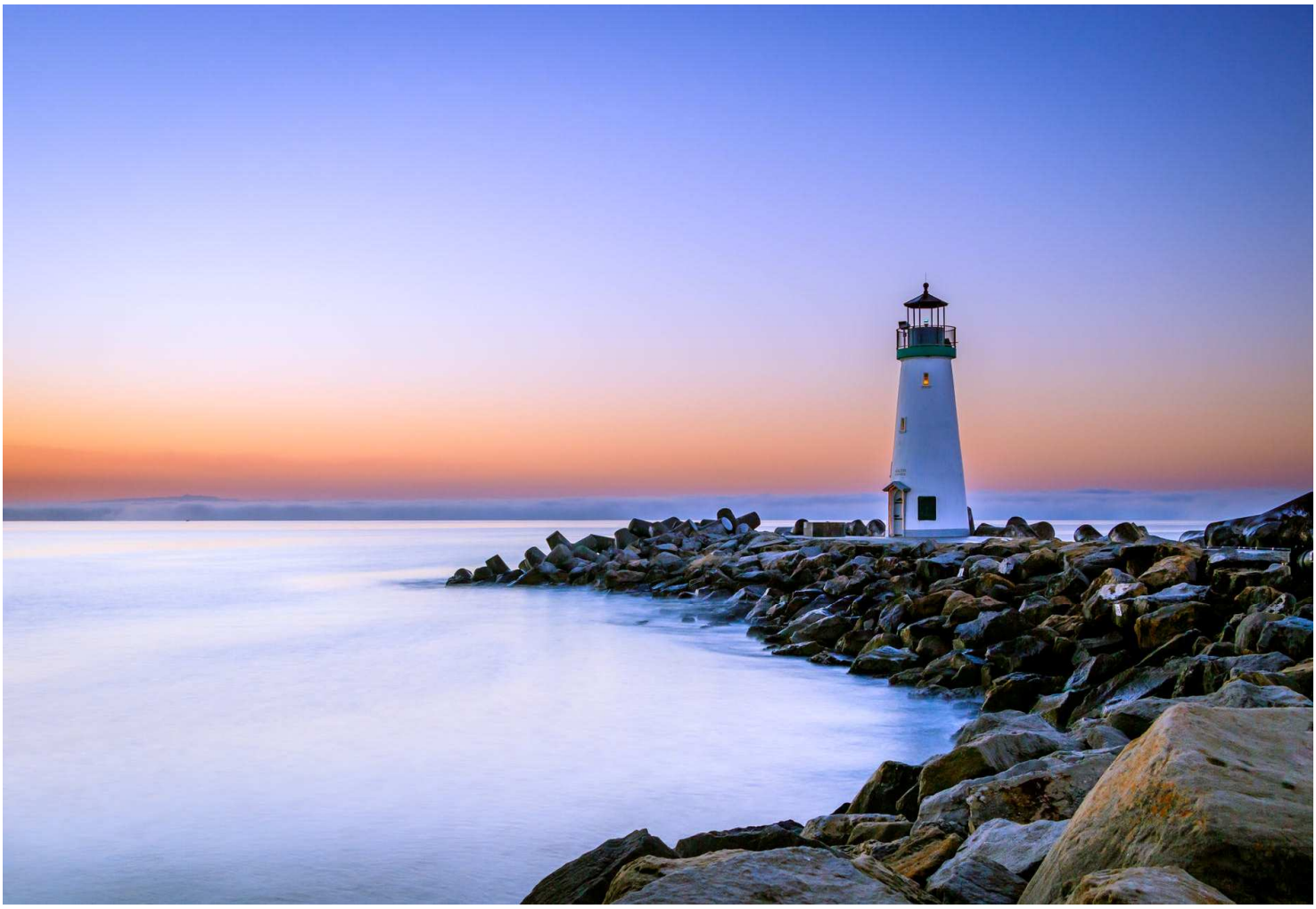


Grand Traverse Metro Emergency Services Authority
Employee Benefit Guide
January 1, 2022-December 31, 2022

Peterson McGregor

2022 Employee Benefit Guide

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.

MEDICAL

DENTAL

VISION

LIFE

DISABILITY

Pick the Best Benefits For You and Your Family

Grand Traverse Metro Emergency Services Authority strives to provide a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all of the different benefits offered, so you can identify which offerings are best for you and your family.

The elections you make during open enrollment will become effective on 01/01/2022.

Contents included in this document are as follows:

- Contact Information
- Plan Information
- Payroll Deductions
- Legislative Updates & Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see Important Notice from Grand Traverse Metro Emergency Services Authority About Your Prescription Drug Coverage and Medicare for additional details.

The information in this guide applies to the Grand Traverse Metro Emergency Services Authority Health and Welfare Plan, Plan number 501. This guide meets the requirements for a Summary of Material Modification as required by the Employee Retirement Security Income Act (ERISA). The company reserves the right to amend, modify, or terminate this Plan at any time and in any manner.

WHO IS ELIGIBLE FOR BENEFITS

Full time employees working a minimum of 40 hours per week, and their eligible dependents.

Eligible Dependents are defined as follows:

- **Lawful spouse:** The individual to whom you are legally married and who is not legally separated or divorced from you.
- **Dependent Child:** Child related to you or your spouse by birth, marriage, legal adoption, or legal guardianship

For Medical: Dependents who are less than 26 years old may be enrolled for coverage until the end of the month in which they turn 26 (married or unmarried).
For Dental & Vision: Dependents who are less than 26 may be enrolled until the end of the month they turn 26.

For New Hires: Coverage will begin on the 1st of the month following 60 days of employment.

STEPS OF OPEN ENROLLMENT

Review the benefit materials provided in your Enrollment packet.

After you have determined your benefit elections, you will need to complete your enrollment through the Employee Navigator portal.

OPEN ENROLLMENT PERIOD – 11/23-12/6
EMPLOYEE MEETINGS: 11/29 2pm @ Metro Admin 11/30 9 am @ station 11
EFFECTIVE DATE – 1/1/2022

Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change (see below).

MAKING CHANGES OUTSIDE OF OPEN ENROLLMENT

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period.

Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence due to an employment transfer for you or your spouse
- Commencement or termination of adoption proceedings
- Change in your spouse's employment status or a change in coverage under another employer-sponsored plan

You have 30 days from the date of the qualifying event to notify HR of any changes that need to be made to your coverage.

We are committed to a comprehensive Employee Benefit Program that helps our employees stay healthy, feel secure, and maintain a work/life balance. We are excited about the benefit package available to our employees and we hope you are pleased with the plans available to you and your family!

Contact List for when you have questions or need assistance!

MEDICAL

Carrier:	Priority Health
Phone:	1-800-942-0954
Website:	www.priorityhealth.com
Network List:	HMO
Group #:	790147-S001
ID Card:	Yes

DENTAL

Carrier:	Delta
Phone:	1-800-524-0149
Website:	www.deltadentalmi.com
Network List:	PPO
Group #:	2875-0001
ID Card:	No

VISION

Carrier:	VSP
Phone:	1-800-877-7195
Website:	www.vsp.com
Network List:	VSP Choice
Group #:	30052957
ID Card:	No

GROUP LIFE AD&D, STD & LTD

Carrier:	The Hartford
Phone:	1-860-547-5000
Website:	www.thehartford.com
Network List:	N/A
Group #:	TBD

VOLUNTARY LIFE

Carrier:	The Hartford
Phone:	1-860-547-5000
Website:	www.thehartford.com
Network List:	N/A
Group #:	TBD

General Benefits Questions & Claims Assistance

PETERSON MCGREGOR INSURANCE

Ryanne Ockert, Benefit Account Manager -Claims Assistance
(231)944-7032
rockert@team-pma.com

Raquel Paulus, Employee Benefits Specialist-Sales
(231) 944-7030
rpaulus@team-pma.com

Payroll Deductions Chart

MEDICAL

Priority Health is our group medical plan provider. Please see benefit summary for plan details.

Grand Traverse Metro Emergency Services Authority will continue to contribute the full $1,500 single and $3,000 2 person/family deductible to your HSA account. <u>This year in addition to the full deductible contribution, GTMESA will contribute an additional $200 for single enrollees and $400 for 2 person/ family enrollees to your HSA account.</u> If you are a new hire your employer contribution amount will be pro-rated for the first year.

Grand Traverse Metro Emergency Services Authority pays 96% of your monthly single, double or family premiums, you are responsible for the remaining 4%. Rates are based on age; please see rate chart on page 6 to calculate your contribution amount.

DENTAL

Delta is our group dental plan provider. Please see benefit summary for plan details.

Grand Traverse Metro Emergency Services Authority pays 96% of your monthly single, double or family premiums, you are responsible for the remaining 4%.

Monthly Premiums:
Single: $37.18 Your 4% $1.49
Double: $74.65 Your 4% $2.87
Family: $149.18 Your 4% $5.81

VISION

VSP is our group vision plan provider. Please see benefit summary for plan details.

Grand Traverse Metro Emergency Services Authority Pays for 96% of the monthly single, double or family premium. You are responsible for the remaining 4%.

Monthly Premiums:
Single: $8.74 Your 4% $0.36
Double: $13.37 Your 4% $0.54
Family: $23.98 Your 4% $0.96

LIFE AD&D, STD & LTD

The Hartford is our group Life AD&D, STD and LTD plan provider. Please see benefit summaries for plan details.

These benefits are 100% paid for by Grand Traverse Metro Emergency Services Authority. There is no cost to you.

VOLUNTARY LIFE

The Hartford is our Voluntary Life plan provider. Please see benefit summary for plan details.

This benefit is based on age banded rates. Please see Employee Navigator for pricing.

Rate grid for: PriorityHSA HMO 1500

PriorityHealth

Zip code: 49686
County: GRAND TRAVERSE
Effective Date: 01/01/2022

Generated on: 10/01/2021

Age	Member rate (with taxes and fees)
0 - 14	$201.33
15	$219.22
16	$226.06
17	$232.91
18	$240.27
19	$247.64
20	$255.27
21	$263.17
22	$263.17
23	$263.17
24	$263.17
25	$264.22
26	$269.49
27	$275.80
28	$286.07
29	$294.49
30	$298.70

Age	Member rate (with taxes and fees)
31	$305.01
32	$311.33
33	$315.28
34	$319.49
35	$321.59
36	$323.70
37	$325.80
38	$327.91
39	$332.12
40	$336.33
41	$342.65
42	$348.70
43	$357.12
44	$367.65
45	$380.02
46	$394.76
47	$411.33

Age	Member rate (with taxes and fees)
48	$430.28
49	$448.97
50	$470.02
51	$490.81
52	$513.71
53	$536.87
54	$561.87
55	$586.87
56	$613.98
57	$641.35
58	$670.56
59	$685.03
60	$714.24
61	$739.51
62	$756.09
63	$776.88
64+	$789.51

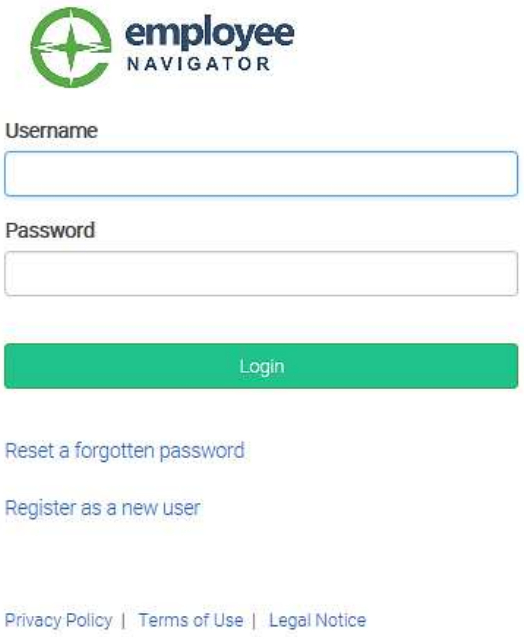
EMPLOYEE NAVIGATOR
ENROLLMENT STEP-BY-STEP GUIDE

Step 1: Log In

Go to www.employeenavigator.com and click **Login**

- **First time users:** Click on your Registration Link in the email sent to you by your admin or **Register as a new user**. Create an account, and create your own username and password.

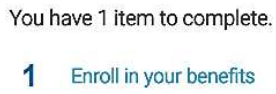
- Returning users: Log in with the username and password you selected.
  If you forgot your password, click **Reset a forgotten password.**



****Please use Google Chrome or Firefox to complete your enrollment. If you use Safari or Internet Explorer you may receive errors and not be able to complete the process.****

Step 2: Welcome!

After you login click **Start Enrollment** to complete your required tasks.
After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

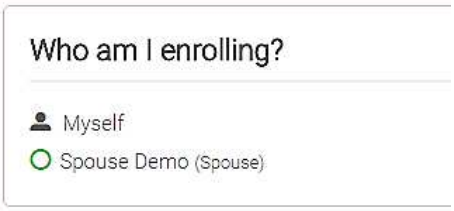


Good Afternoon, Demo!
You have 6 days left to complete your benefit enrollment.

Step 3: Verify and Enter Required Information

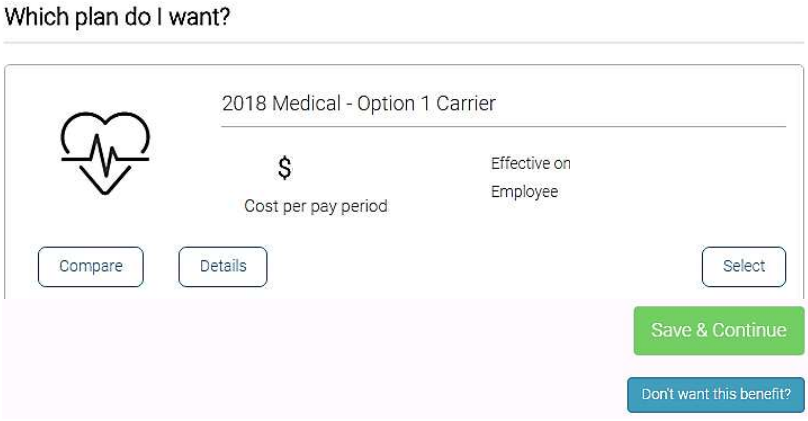
Please ensure to fill out required information for you and your dependents.

Step 4: Benefit Elections



To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.



Click **Save & Continue** at the bottom of each screen to save your elections.

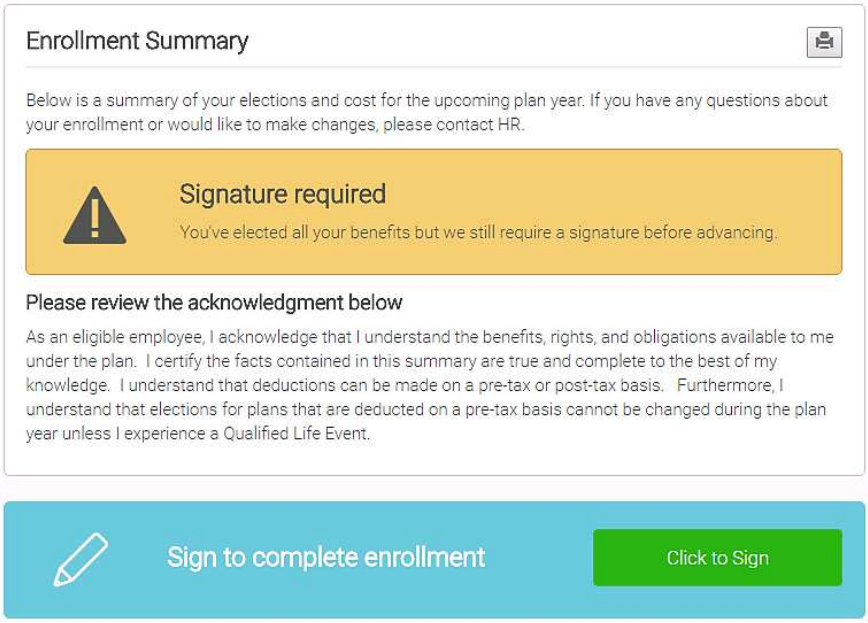
If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 5: Review & Confirm Elections

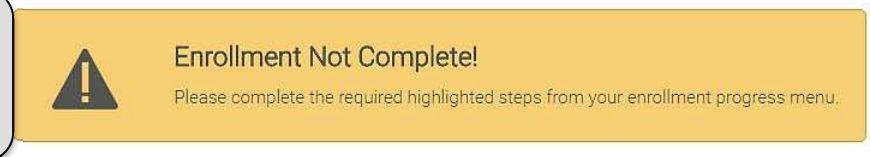
Review the benefits you selected on the enrollment summary page to make sure they are correct.

Click to Sign to complete your enrollment.

You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

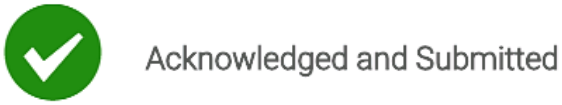


TIP - If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 6: You're All Done!

Depending on your employer policy, you may have time to change elections if needed within the enrollment period. Otherwise, any other changes may be needed a proof of qualifying event to request.



Grand Traverse Metro Fire Dept

Health Plan Analysis

January 1, 2022 Renewal

	Current	Renewal **Priority Health** *Gold* HMO HSA
Benefits	In-Network	In-Network
Annual Deductible Embedded or Aggregate Individual Family	 $1,400 $2,800	 Aggregate Deductible **$1,500** **$3,000**
Coinsurance	90% | 10%	**85% | 15%**
Out-of-Pocket Maximum Individual Family	 $3,500 $7,000	 **$4,000** **$8,000**
Hospitalization	90% after deductible	**85% after deductible**
Primary Care Office Visits	90% after deductible	**85% after deductible**
Online/Virtual Visits	$45 copay (100% after deductible)	**Allowed Amount** **($10 copay after deductible)**
Specialist Office Visits	90% after deductible	**85% after deductible**
Urgent Care	90% after deductible	**85% after deductible**
Preventive Care	100%	**100%**
Emergency Room	90% after deductible	**85% after deductible**
Ambulance	90% after deductible	**85% after deductible**
Digital Imaging (CT, MRI, MRA, PET)	90% after deductible	**85% after deductible**
Prescription Drugs Generic Preferred Brand Non-Preferred Brand Preferred Specialty Non-Preferred Specialty	*All copays after deductible* T1A $5/T1B $25	*All copays after deductible* **T1A $5/T1B $30** T2 $65 T3 $85 T4 20% ($250 max) T5 20% ($450 max)
Vision Coverage		Pediatric Vision
	Current	Renewal

***Aggregate deductible means that one family member could potentially satisfy the entire family deductible.**

HEALTH SAVINGS ACCOUNTS

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

WHAT ARE THE BENEFITS OF AN HSA?

It saves you money. HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.

It is portable. The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.

It is a tax-saver—HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

The maximum amount that you can contribute to an HSA in 2022, is $3,650 for individual coverage and $7,300 for family coverage.

Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

INFORMATION ABOUT HEALTH SAVINGS ACCOUNTS (HSA)

The HSA plan is a qualified High Deductible Health Plan and requires it to be combined with a Health Savings Account (HSA). The HSA is a tax exempt account in which you may set aside money pre-tax and accumulate savings to help pay eligible medical, dental and vision care expenses.

To be an eligible individual and qualify for an HSA, you must meet the following requirements:

You must be covered under a high deductible health plan (HDHP) on the first day of the month.
You have no other health coverage except what is permitted under IRS guidelines
You are not enrolled in Medicare.
You cannot be claimed as a dependent on someone else's tax return.

You may contribute additional dollars to your HSA up to the following maximums:

Contribution limits include any employer contributions to your account	2022
Single Contribution Limit	$3,650
Family Contribution Limit	$7,300
Catch-up contribution (over age 55)	$1,000

You may use the money in your HSA account to pay for expenses for yourself, your spouse, and your dependent children, even if they are not covered under the HSA medical plan.

Any amount used for purposes other than to pay for "qualified medical expenses" is taxable as income and subject to an additional 20% tax penalty.

If you are enrolling in the HSA for the first time, please make certain to open your Health Savings Account at the banking institution of your choice prior to the effective date, and provide HR with your account information so deposits to your account can be completed.

DENTAL

Your dental insurance will be provided through Delta. You may see any provider you like, but staying in Network saves you money. To find participating providers, visit: www.deltadentalmi.com. The chart below provides a general summary of your plan benefits. For details and full benefit summary please see the Employee Navigator portal.

	DELTA DENTAL PPO
Deductible (per calendar year)	In-Network
Individual	$0
Family	$0
Benefit Maximum (all services combined)	
Individual (per person, per year)	$1,500
Covered Services	
Preventive Care (exams, cleanings, bitewing x-rays)	100% (Deductible waived)
Basic Services (fillings, root canals, extractions)	75%
Major Services (crowns, bridges, dentures)	50%
Orthodontia (Up to age 19)	50% / $1,500 Lifetime max

Claims paid to out of network providers are subject to balance billing and other out of pocket costs.

Common Terms

Annual Maximum: The maximum dollar amount a plan will pay out for care in a 12 month period.

Balance Billing: When a provider bills a person for the difference between the provider's charge and the allowed amount.

Benefit: The amount a plan pays for a dental procedure or service.

Co-Insurance: The percentage of costs of a coverage service a person pays (20% for example) after they've paid their deductible.

Co-Pay: A fixed amount ($20, for example) a person must pay for a covered service after they've paid their deductible.

Deductible: The amount a person pays for covered services before their insurance plan starts to pay.

Exclusions: Services that a person's insurance or plan doesn't pay for or cover.

Maximum Allowable Charge: The maximum dollar amount a dental program will pay toward the cost of a dental service as specified in the program's contract provisions.

Maximum Benefit: The maximum dollar amount a dental plan will pay toward the cost of dental care in a given period.

Pretreatment Estimate: A written estimate of benefits available as of a specific date and time, given to an employee or treating dentist in advance of proposed treatment.

Preventive and Diagnostic Services: Dental procedures concerned with preventing dental diseases through protective and educational measures

(e.g. exams, cleanings, x-rays and flouride).

Waiting Period: The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage.

VISION

Your voluntary vision insurance will be provided through VSP using the VSP choice network. The chart below provides a general summary of your plan benefits. For details and a full benefit summary please see the Employee Navigator portal.

Vision Benefits	Frequency	In-Network
Exam	12 months	$10 copay
Contact Lens Fit & Follow Up	12 months	$60 max copay
Lenses	12 months	$10 copay
Frames	12 months	$130 allowance
Contact Lenses (instead of glasses)	12 months	$130 allowance

Claims paid to out of network providers are subject to balance billing and other out of pocket costs.

Benefit eligibility is based on last date of service. For example, if you get an eye exam on 09/24/21 you won't be eligible for another one until 09/24/22.

LIFE INSURANCE

Your Life AD&D and voluntary life insurance is provided through The Hartford.

Employer Paid Life

- GTMESA is pleased to provide basic life insurance for you at no cost. If you would like additional coverage you can purchase additional voluntary life coverage for you, your spouse and dependent children.
- It is important to designate a beneficiary for this coverage. If you don't your loved ones will have a difficult time collecting the benefit if you die.
- For complete coverage information please see the benefit summaries posted in the Employee Navigator Portal.

Basic Life AD&D Summary	
For you	$100,000
For Your Spouse	$5,000
For Your Child(ren)	$500 Live birth to 6 months, $2,000 (6 months to age 19)
Your benefit will reduce by 35% at age 65, and 50% of original amount at age 70	

Voluntary Life AD&D

Voluntary Life AD&D Summary	
If you want additional coverage for you	$10,000 increments not to exceed 3x your annual income up to a max of $500,000
If you want additional coverage for your spouse	$5,000 increments to $25,000 not to exceed 50% of the employee approved amount
If you want additional coverage for your dependent children	15 days to 6 months $500, 6 months to age 19 or 25 if a full time student $10,000

- Guarantee issue is $100,000 for employees, $25,000 for spouses and $10,000 for children.
- If you elect an amount over the guarantee issue for yourself or your spouse you will need to answer medical questions. These questions are often called evidence of insurability or EOI.
- Your benefit will reduce by 35% at age 65 and 50% of the original amount at age 70.
- Please see Employee Navigator for cost information.

Since this is a new carrier we must have at least 8 employees sign up for voluntary life insurance in order to be able to offer the benefit. If we don't get at least 8 employees we will not be able to offer this benefit for 2022.

DISABILITY INSURANCE

Your short term and long term disability insurance is also provided through The Hartford. The chart below provides a general summary of your plan benefits. For details and a complete benefit summary please see the Employee Navigator portal.

	SHORT TERM DISABILITY	LONG TERM DISABILITY
Elimination Period		
Accident	1st day	90 days
Sickness	8th day	90 days
Benefit		
	66 2/3% of your weekly earnings	60% of your monthly earnings
Maximum Benefit		
	$1,000 per week	$6,000 per month
Benefit Duration		
	13 weeks	SSNRA*

***Social Security Normal Retirement Age**

Legislative Updates

The Women's Health and Cancer Rights Act
The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:
- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and co-pays consistent with other coverage provided by the Plan.

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting the mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

Mental Health Parity Act

According to the Mental Health Parity Act of 1996, the lifetime maximum and annual maximum dollar limits for mental health benefits under the Grand Traverse Metro Emergency Services Authority Medical Plans are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan. However, mental health benefits may be limited to a maximum number of treatment days per year or series per lifetime.

Health Insurance Portability and Accountability Act

We, in accordance with HIPAA, protects your Protected Health Information (PHI). We will only discuss your PHI with medical providers and third party administrators when necessary to administer the plan that provides your medical and dental benefits or as mandated by law.

Continuation Required By Federal Law for You and Your Dependents

Federal law enables your or your dependents to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your dependent(s) to continue health insurance if their coverage ceases due to your death, divorce, legal separation, or with respect to dependent children, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your employer's group health plan(s) and is subject to federal law, regulations and interpretations. For additional information, contact Human Resources.

HIPAA Special Enrollment Rights

Loss of Other Coverage – If you are declining enrollment for yourself and/or dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents other coverage. To be eligible for this special enrollment opportunity, you must request enrollment within **30 days** after your other coverage ends or after the employer stops contributing toward the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption – If you have a new dependent as a result of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself and/or your dependents. To be eligible for this special enrollment opportunity, you must request enrollment within **30 days** after the marriage, birth, adoption or placement for adoption. Contact Human Resources to request a special enrollment.

Medicaid or CHIP
If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

For More Information or Assistance
To request special enrollment or obtain more information, please contact Human Resources.

REMEMBER: The Affordable Care Act requires most individuals to obtain health coverage or pay a penalty. Due to the passage of the Tax Cuts and Jobs Act in 2017 the penalty starting in 2019 going forward will be $0.

NOTICE OF PATIENT PROTECTIONS

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

Priority Health generally requires 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. Until you make this designation, Priority Health designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Priority Health at 1-800-942-0954.

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

You do not need prior authorization from Priority Health 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, contact Priority Health at 1-800-942-0954.

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

Important Notice from Grand Traverse Metro Emergency Services Authority (GTMESA) 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 GTMESA 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. GTMESA. has determined that the prescription drug coverage offered by GTMESA Medical Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current GTMESA medical plan coverage will be affected.

You cannot be enrolled in a Medicare Part D drug plan and an employer sponsored group health plan at the same time. If you enroll in a Medicare Part D drug plan your medical coverage under the GTMESA group health plan will be terminated for you and all of your enrolled dependents.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the GTMESA medical plan during the open enrollment period under the Medical Plan after you terminate your Medicare Part D drug plan.

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

You should also know that if you drop or lose your current coverage with GTMESA 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 November to join.

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

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

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

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

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

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).

Date: 01/01/2022

Name of Entity: Grand Traverse Metro Emergency Services Authority	Contact: Stacey Bird Phone: 231-947-3000 Ext. 1221	Office Address: 897 Parsons Road, Traverse City, MI 49686

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get 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 Summary Plan Description 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 it 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'll 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 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."

When is COBRA continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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 provide this notice to: Stacey Bird.

How is COBRA continuation 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 COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get 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 COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

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

If your family experiences another qualifying event during the 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 getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying 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, Medicare, 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 many of these options at **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[1] 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 the Employee Retirement Income Security Act (ERISA), 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 **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**.

Keep your Plan informed of address changes

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 send to the Plan Administrator.

Plan contact information

Grand Traverse Metro Emergency Services Authority 897 Parsons Road, Traverse City, MI 49686 Stacey Bird 231-947-3000 Ext. 1221

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

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

Get an electronic or paper copy of your medical record

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

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
- In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Your Information. Your Rights. Our Responsibilities.

This privacy 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.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

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

Run our organization -We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services -We can use and share your health information to bill and get payment from health plans or other entities.

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

Help with public health and safety issues -We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research -We can use or share your information for health research.

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

Respond to organ and tissue donation requests -We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director -We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests -We can use or share health information about you:

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

Respond to lawsuits and legal actions -We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

Changes to the Terms of this Notice

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

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.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 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 9.5 percent (as adjusted each year after 2014) 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, you may be eligible for a tax credit. (An 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.)

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 payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Stacey Bird 231-947-3000 Ext. 1221.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Peterson McGregor