South Florida Hotel and Culinary Employees Welfare Fund

c/o National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028
1 (833) 304-0380 | Fax (954) 266-2079

Welcome to the South Florida Hotel and Culinary Employees Welfare Fund (referred to in this document as the "Plan")! The Plan provides health care and other benefits to eligible employees (and their dependents) working under a Collective Bargaining Agreement ("CBA") between your Employer and UNITE HERE Local 355, Local 23, Local 737 or Local 362 (or any other local or union accepted for participation in the Plan). In order to become eligible for benefits under this Plan you must first satisfy any requirements described in your Collective Bargaining Agreement. Most CBAs require that Employees work at least a certain number of hours or meet other conditions before your Employer is required to make contributions to the Plan on your behalf. Please consult your CBA, or talk to your Employer or Union, to find out your specific requirements. Your employer will be required to make contributions to the Plan on your behalf after you've met the requirements in your CBA, and you will become eligible to enroll in the Plan and receive health care benefits.

Let's get to know you! Once you're eligible, you must enroll in the Plan in order to receive benefits. **Please complete and return the enclosed enrollment materials promptly in order to become enrolled in the Plan and receive benefits.** Please also check with your Union or Employer to find out if there are any additional administrative requirements needed to complete your enrollment.

You may also have "special enrollment rights" under certain circumstances, such as if you are otherwise eligible for coverage under this Plan and you acquire a new dependent or lose other coverage. Please see the notice included in these materials for detailed information about your special enrollment rights.

There are several ways to return your enrollment documents.

- Visit **https://www.nebainc.com/SendFile.aspx** and use the Secure File Upload. If you visit the site on your mobile device, you can use your device camera to upload photos of the documents. Photos must be clear enough to read and you must include a photo of all pages of the form(s).

- Mail them to NEBA at 2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028.
- Fax them to NEBA at (954) 266-2079.

Enclosed with your enrollment kit are a few items to help you understand your new plan:

- ✓ **Summary of Benefits and Coverage (SBC)**
- ✓ **Women's Health and Cancer Rights Act Notice**
- ✓ **Notice of Creditable Coverage**
- ✓ **General Notice of COBRA Rights**
- ✓ **Special Enrollment Rights Notice**
- ✓ **Notice of Privacy Practices**

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Enrollment Form

1. First, tell us about yourself.

Please complete all boxes.

First Name		Middle Initial		Last Name	
Gender	☐ Male ☐ Female	Birthdate	/ /	SSN	
Address					
City, State Zip		Marital Status			
Employer Name					

2. How can we get in touch with you?

Email Address:			
Phone Number:	Home: ( ) -	Cell: ( ) -	Work: ( ) -

3. Do you want to enroll for coverage under the Plan?

Please choose one of the options below.

☐	YES, enroll me for employee only coverage.	I request coverage under the South Florida Hotel and Culinary Employees Welfare Fund (the Plan). If I am enrolling dependents I understand that I will be required to submit supporting documents which demonstrate that my dependents are eligible for coverage, such as my children's birth certificates or my marriage certificate. Signature: _____ Date: _____
☐	YES, enroll me & my eligible dependents.	
☐	NO, do not enroll me. I have other health plan coverage.	I understand that by declining coverage, I am waiving rights to all benefits to which I would otherwise be entitled. I understand that if I do not have health insurance I may have to pay a penalty tax to the federal government under the Affordable Care Act. Signature: _____ Date: _____
☐	NO, do not enroll me. I do not have other health plan coverage.	

4. What is the name of the doctor who will provide your primary care?

If you don't currently have an in network Primary Care Physician (PCP), one will be assigned to you. It's important to establish a relationship with a PCP before you get sick! If you don't, it can be difficult to get an appointment when you need one. To add a PCP, please call NHP (South Florida) at (844) 651-3833 or UHC (all others) at (855) 828-7715.

Physician Name:	Physician Address:
Physician Phone Number:	

5. Are you enrolling dependents? If so, please complete the section below.

The Plan offers coverage for your spouse or Domestic Partner and your children up to age 26. Adult children may be covered up to age 30 if certain conditions are met. To enroll your dependents you will need to provide copies of their Social Security cards (if available), birth certificates (required for children), and a marriage certificate (required for spouses and for stepchildren). Other documents may be required and can be requested with NEBA. To add dependents, please fill out their information below and submit copies of the required documents to NEBA via fax, secure email, website upload, or mail within 15 days. In order to enroll your Domestic Partner as a dependent or enroll your dependent child over the age of 26 you must complete additional documents. ***Dependents will not be enrolled in the Plan if the documentation is not submitted timely.*** ***Please contact NEBA at 1(833)304-0380 to request these additional documents.***

Complete the following section if you are enrolling your spouse, Domestic Partner, and/or your dependent children.			
Dependent 1:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	
Dependent 2:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	
Dependent 3:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	
Dependent 4:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	
Dependent 5:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	

6. Authorize us to share your enrollment information with your Employer and your Union

In order to enroll in the Plan, you're required to authorize the Plan to share information about your enrollment with your Employer and with your Union. You become eligible to receive benefits under the Plan based on your Union's Collective Bargaining Agreement (CBA) with your Employer. The benefits, however, are provided through this Plan, which is independent of both your Employer and your Union. Your authorization to share enrollment information is necessary to efficiently operate the Plan. Please also sign and keep the duplicate authorization form contained in this enrollment packet.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ (print name), authorize the use and disclosure of protected health information as described below.

I understand that my enrollment and eligibility for benefits under the Plan is conditioned on providing this authorization in connection with my application for enrollment. I understand that if I do not provide this authorization, neither I nor my dependents will be allowed to enroll in the Plan, and neither I nor my dependents will be eligible for benefits under the Plan.

I authorize NEBA and the Plan to disclose to my Employer and to my Union that I have applied for enrollment in the Plan; that I am enrolled in the Plan; and, if I have enrolled my dependents, the type of dependent enrollment I have selected. I understand that NEBA, my Employer and my Union will use information about my enrollment to administer the Plan and to determine eligibility for benefits. This authorization is limited, and does not include authorization to share any medical information, any information to or about any medical professionals, or any information about my dependents beyond reporting that I enrolled my dependents.

My current Employer is _____ (print name) ("Employer").

I am a member of UNITE HERE Local _____ ("Union").

I have read and understand the following statements about my rights:

- ***I understand that once information is disclosed to my Employer and to my Union it will no longer be subject to protections under federal privacy regulations and may be used and re-disclosed by my Employer or my Union.***
- ***I understand that I may revoke this authorization at any time by sending a written notification to NEBA at 2010 N. W. 150th Avenue, Suite 200, Pembroke Pines, Florida 33028, or by email to uhenrollment@nebainc.com. A revocation will be effective for future uses or disclosures of protected information but will not be effective for any information that has already been disclosed.***
- ***I understand that I am entitled to receive a signed copy of this authorization.***
- ***This authorization does not extend to psychotherapy notes or other health information not described here.***
- ***This authorization will remain in effect as long as I am eligible for benefits under the Plan, or as long as I am employed by an employer required to make contributions to the Plan on my behalf, whichever is longer. If my employment with the employer identified above terminates, and I am subsequently employed by another employer required to make contributions to the Plan on my behalf, this authorization remains in effect and all references to Employer will instead refer to my then current employer.***

I have read and understood the above information. I represent that the signature below is my own and I am legally authorized to sign this document. My signature authorizes the disclosure of the information described above.

_____	_____	_____
Signature	***Print name***	***Date***

That's it! ***Thank you for completing your enrollment form.***

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Please sign and retain this page for your records

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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I understand that my enrollment and eligibility for benefits under the Plan is conditioned on providing this authorization in connection with my application for enrollment. I understand that if I do not provide this authorization, neither I nor my dependents will be allowed to enroll in the Plan, and neither I nor my dependents will be eligible for benefits under the Plan.

I authorize NEBA and the Plan to disclose to my Employer and to my Union that I have applied for enrollment in the Plan; that I am enrolled in the Plan; and, if I have enrolled my dependents, the type of dependent enrollment I have selected. I understand that NEBA, my Employer and my Union will use information about my enrollment to administer the Plan and to determine eligibility for benefits. This authorization is limited, and does not include authorization to share any medical information, any information to or about any medical professionals, or any information about my dependents beyond reporting that I enrolled my dependents.

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I am a member of UNITE HERE Local _____ ("Union").

I have read and understand the following statements about my rights:

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- *I understand that I may revoke this authorization at any time by sending a written notification to NEBA at 2010 N. W. 150th Avenue, Suite 200, Pembroke Pines, Florida 33028, or by email to uhenrollment@nebainc.com. A revocation will be effective for future uses or disclosures of protected information but will not be effective for any information that has already been disclosed.*
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- *This authorization does not extend to psychotherapy notes or other health information not described here.*
- *This authorization will remain in effect as long as I am eligible for benefits under the Plan, or as long as I am employed by an employer required to make contributions to the Plan on my behalf, whichever is longer. If my employment with the employer identified above terminates, and I am subsequently employed by another employer required to make contributions to the Plan on my behalf, this authorization remains in effect and all references to Employer will instead refer to my then current employer.*

I have read and understood the above information. I represent that the signature below is my own and I am legally authorized to sign this document. My signature authorizes the disclosure of the information described above.

_____	_____	_____
Signature	*Print name*	*Date*

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To: All Participants and Beneficiaries
From: Board of Trustees
Subject: The Women's Health and Cancer Rights Act of 1998

This Plan is subject to the Women's Health and Cancer Rights Act of 1998 (WHCRA). Accordingly, the following coverage shall be provided, as required by WHCRA, to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy:

(a) All stages of reconstruction of the breast on which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses; and

(d) Treatment of physical complications of mastectomy, including lymphedema.

Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as set forth herein, and as are consistent with those established for other benefits provided hereunder.

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Important Notice from South Florida Hotel and Culinary Employees Welfare Fund 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 South Florida Hotel and Culinary Employees Welfare Fund 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. South Florida Hotel and Culinary Employees Welfare Fund has determined that the prescription drug coverage offered by the South Florida Hotel and Culinary Employees Welfare Fund 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 it will be in addition to the coverage you have under the South Florida Hotel and Culinary Employees Welfare Fund. Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare 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 South Florida Hotel and Culinary Employees Welfare Fund and don't join a Medicare drug plan within sixty-three (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 sixty-three (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 (19) 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…
Contact National Employee Benefits Administrators, Inc. at (800) 842-5899. 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 South Florida Hotel and Culinary Employees Welfare Fund 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.

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

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

Name of Entity/Sender:	South Florida Hotel and Culinary Employees Welfare Fund
Contact--Position/Office:	National Employee Benefits Administrators, Inc.
Address:	2010 N.W. 150th Avenue, Suite 200 Pembroke Pines, FL 33028
Phone Number:	(833) 304-0380

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IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

This notice has important information about your right to continue your health care coverage in the South Florida Hotel & Culinary Employees Welfare Fund (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1800-318-2596.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision.

What is COBRA continuation coverage? Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan. COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries? Each person ("qualified beneficiary") that was covered under the Plan in the categories below can elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no *longer a dependent under the Plan.*

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last? If elected, COBRA continuation coverage will begin on the first day of the month following your loss of coverage under the Plan and can last up to 18 months.

Continuation coverage may end before the expiration of the time period noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage? If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify NEBA of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit:
http://www.dol.gov/ebsa/publications/cobraemployee.html.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace? The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage? You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage? If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan? You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options? When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact NEBA at the following address and phone numbers:

National Employee Benefits Administrators, Inc.
1-833-304-0380 (Toll Free) • 954-266-6322 • 954-266-2079 (Fax)
2010 N.W. 150th Avenue, Suite 200
Pembroke Pines, FL 33028

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate a navigator in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

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FEDERAL LAW RIGHTS FOR ENROLLMENT AND COVERAGE

Special Enrollment Rights under HIPAA
"Special Enrollment" rights are sometimes allowed under Federal law (HIPAA) to allow employees or dependents to enroll outside of the open enrollment period or after initial eligibility. This section describes when you may have special enrollment rights.

New Dependents: If you enroll in the Plan at the time you are first eligible and you remain eligible for coverage you can enroll a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship by submitting a request for enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Limited "Special Enrollment" rights are also allowed under Federal law (HIPAA) if you decline or waive enrollment in the Plan and do not have other health insurance. Under these special enrollment rights you may request enrollment for yourself and/or your dependents outside of open enrollment if:

- You have a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship and
- You request enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Loss of Other Coverage: If you decline or waive enrollment in the Plan because you have other health insurance coverage, you may be allowed "special enrollment" rights in the future if:

- You are covered under another group health plan or health insurance program at the time you waive coverage under the Plan;
- You lose eligibility for the health care coverage you had at the time of waiver, or the employer sponsoring the other coverage stops contributing towards such other coverage; and
- You make application for enrollment in the Plan within 30 days after your other coverage ends.

Loss of Medicaid or State Child Health Insurance Program: There are special rules for employees and dependents of employees who are eligible for Medicaid or a State Child Health Insurance Program. If an employee (or eligible dependent of such employee) experiences a loss of eligibility for Medicaid or a State Child Health Insurance Program, they have a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days after the loss of eligibility.

Premium Assistance: If an employee (or eligible dependent of such employee) is determined to be eligible for premium assistance by Medicaid or a State Child Health Insurance Program (including under any waiver or demonstration project conducted under or in relation to such a program), such person has a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days of the determination of assistance.

Employees who enroll in the Plan under these special circumstances will be offered the same benefit packages and payment options as those offered to similarly situated employees who enroll when first eligible.

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Your Information. Your Rights. Our Responsibilities.

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

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 a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records 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 and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are 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 consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

continued on next page

Your Rights *continued*

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.
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 payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *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

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.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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 and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • 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.

We never market or sell personal information.

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, on our web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Administrative Manager at:

National Employee Bene its Administrators, Inc.
2010 N.W. 150th Avenue, Suite 200, Pembroke Pines, FL 33028
1-833-304-0380.