TO: Bay Path University
Employees Eligible for Group Health Benefits

RE: 2019-2020 ANNUAL NOTICES FOR GROUP HEALTH PLAN BENEFITS

To make sure that you have all the information you need to make informed decisions for you and your family, the law requires Bay Path University to provide you with notice of certain legal rights that you may have and legal obligations that apply to the Health New England (Plan). These rights and obligations are described in more detail in the enclosed notices.

The notices include:

- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Prescription Drug Coverage and Medicare
- Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)
- Mental Health Parity Act (MHPA)
- Michelle’s Law
- Newborns' and Mothers' Health Protection Act
- Patient Protection Act
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  Privacy and Security Rules
  Special Enrollment Rights
- Uniformed Services Employment and Reemployment Act of 1994 (USERRA)
- Women’s Health and Cancer Rights Act of 1998 (WHCRA)

You should review these notices closely and keep them with other materials that you receive about benefits available under the Plan. If you have any questions about any of the legal rights and obligations described below or the Plan, you should write or call the Plan Administrator:

Bay Path University
588 Longmeadow Street
Longmeadow, MA 01106
413.565.1180

The following notices are not intended to be a description of the benefits offered under the Plan. For more information about specific benefits, refer to the Summary Plan Description, which is available in your open enrollment and/or new hire package or from your employer.
Introduction
This notice has important information about your right to COBRA continuation coverage (if enrolled in the Plan), 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 30 days after the qualifying event occurs. You must provide this notice to: Bay Path University.

**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 and notice must be provided to the Plan Administrator within 30 days after the qualifying event occurs:

**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

**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, 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 can learn more about many of these options at www.healthcare.gov.

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.

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 Health New England 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 a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. Bay Path University has determined that the prescription drug coverage offered by HNE 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 enroll in a Medicare prescription drug plan.
When Can You Join A Medicare Drug Plan?
You can join a Medicare prescription 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 coverage 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 prescription drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?
If you decide to join a Medicare prescription drug plan and drop your coverage through Medical carrier, you and your dependents may not be able to get this coverage back. Contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
If you drop or lose your current coverage with Bay Path University and do not join a Medicare prescription drug coverage 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 days or longer without creditable prescription drug coverage, your monthly premium may go up 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 coverage, your premium will always be at least 19% higher than what many other people pay. You’ll have to pay this higher premium 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 BFP Associates, Inc. at 413.739.2352. NOTE: You will get this notice each year and you will also get it before the next period you can join a Medicare Drug Plan, and if the coverage through Bay Path University changes. You may also request a copy of this notice.

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 if you are eligible. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug plans:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) at www.socialsecurity.gov, or 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).
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 August 10, 2017. Contact your State for more information on eligibility –

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<tr>
<th>MAINE – Medicaid</th>
<th>RHODE ISLAND – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a></td>
<td>Website: <a href="http://www.eohhs.ri.gov/">www.eohhs.ri.gov/</a></td>
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<tr>
<td>Phone: 1-800-442-6003</td>
<td>Phone: 855-697-4347</td>
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<td>TTY Maine relay 711</td>
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<th>MASSACHUSETTS – Medicaid and CHIP</th>
<th>VERMONT – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealthMassHealth">http://www.mass.gov/eohhs/gov/departments/masshealthMassHealth</a></td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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<tr>
<td>Phone: 1-800-862-4840</td>
<td>Phone: 1-800-250-8427</td>
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<tr>
<th>NEW HAMPSHIRE – Medicaid</th>
<th>NEW YORK – Medicaid</th>
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<tr>
<td>Phone: 603-271-5218</td>
<td>Phone: 1-800-541-2831</td>
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To see other states premium assistance program since August 10, 2017, 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
Mental Health Parity Act

The Mental Health Parity Act (MHPA), signed into law on 9/26/1996 and updated October 2008, requires insurers who offer mental health benefits to cover the diagnosis and treatment of certain mental disorders to the same extent that they cover the diagnosis and treatment of physical disorders. The law makes it illegal to place stricter annual or lifetime dollar or unit of service limitations on coverage of qualifying mental disorders that differ from the limitations on coverage of physical conditions. The law also provides for minimum outpatient and inpatient benefits for those disorders not required to be treated the same as physical ailments.

MHPA and the new provisions are effective to group health plan years beginning on or after 7/1/2009. The law provides parity for the following disorders:

- Schizophrenia and schizoaffective disorder
- Bipolar disorder, major depressive disorder, paranoia and other psychotic disorders
- Obsessive-compulsive disorder, panic disorder
- Delirium and dementia
- Affective disorders, eating disorder, post traumatic stress disorder
- Autism
- Any other “biologically-based” mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the “DSM”) that are scientifically recognized and approved by the Commissioner of Mental Health in consultation with the Commissioner of Insurance
- Provides parity for rape-related mental or emotional disorders to the extent the costs of diagnosis and treatment exceed the maximum compensation awarded to victim(s).
- Requires the member to provide proof of “medical necessity” even when the disorder or treatment is covered by the parity law.
- Provides children under the age of 19 parity of coverage for non-biologically based mental, behavioral or emotional disorders that substantially interfere with or substantially limit functioning and social interactions.
- Provides parity for the treatment of substance abuse, including alcoholism, when treatment for these problems occurs in conjunction with treatment for mental disorders.

Michelle’s Law

Federal Law P.L. 110-381, known as Michelle’s Law, became effective 10/9/2009. Michelle’s Law provides for continuation of coverage for dependents that are on a medically necessary leave of absence from a college or university, when they would otherwise lose eligibility because they are not enrolled as a full-time student. The following requirements and provisions are contained in Michelle’s Law:

- The leave of absence must be medically necessary and must begin while the dependent is suffering from a serious illness or injury and otherwise will lose coverage under the plan.
- The dependent must be enrolled in our group medical plan prior to the 1st day of the leave.
- There must be written certification by the dependent’s physician stating the dependent is suffering from a serious illness/injury that requires the leave/change in enrollment status.
Newborns and Mothers Health Protection Act

“Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)”. This act does not amend or change any of the terms of your group health plan.

Patient Protection Disclosure

Your medical plan generally requires the designation of a primary care provider (PCP). You have the right to select any primary care provider who participates in the Health New England provider network and who is available to accept you/your family members. For dependent children, you may select a participating pediatrician as the primary care provider.

You do not need prior authorization from Health New England or from your Primary Care Provider in order to obtain access to obstetrical/gynecological care from a health care professional within the 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 information on how to select a primary care provider or for a list of participating health care professionals who specialize in obstetrics or gynecology, contact Health New England
800.842.4464
www.healthnewengland.org

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PRIVACY AND SECURITY RULES

This summarizes how medical information about you may be used and disclosed by Bay Path University or others in the administration of your claims, and certain rights you have.

Our Pledge Regarding Medical Information
We are committed to protecting your personal health information. We are required by law to (1) make sure that any medical information that identifies you is kept private; (2) provide you with certain rights with respect to your medical information; (3) give you a notice of our legal duties and privacy practices; and (4) follow all privacy practices and procedures currently in effect.

How We May Use and Disclose Medical Information
We may use and disclose your personal health information without your permission to facilitate your medical treatment, for payment of any medical treatments, and for any other health care operation.
We will disclose your medical information for plan administration functions; but those employees who have access may not share your information for employment-related purposes. We may also use and disclose your personal health information without your permission as allowed or required by law. Otherwise, we must obtain your written authorization for any other use and disclosure of your medical information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given.

**Your Rights Regarding Your Medical Information**

You have a right to inspect and copy your medical information to request corrections of your medical information and to obtain an accounting of certain disclosures of your medical information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your medical information, or that communications about your medical information be made in different ways or at different locations.

**How To File A Complaint**

If you believe your privacy rights have been violated, you have a right to file a complaint with us or with the Office for Civil Rights. We will not retaliate against you for making a complaint.

**SPECIAL ENROLLMENT RIGHTS**

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this plan. You must provide your request and required documentation within 30 days of your other coverage ending. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment and provide required documentation within 30 days of the marriage, birth, adoption, or placement for adoption.

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**Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) established requirements that employers must meet for certain employees who are involved in the Uniformed Services. In addition to the rights that you have under COBRA, you are entitled under USERRA to continue the coverage you had under your employer’s medical plan.

**I. Definitions**

a. “Uniformed Services” means the US Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty for training, or full-time National Guard duty), and the commissioned corps of the Public Health Service. Moreover, the President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

b. “Service in the Uniformed Services” or “Service” means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, inactive duty training, full-time National Guard duty, and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.
II. **Duration of USERRA Coverage**

General Rule: 24 month maximum. When a covered employee takes a leave for Service in the Uniformed Services, USERRA coverage for the employee (and covered dependents for whom coverage is elected) begins the day after the employee (and covered dependents) lose coverage under the Plan, and it continues for up to 24 months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.

a. A premium payment is not made within the required time;
b. You fail to return to work within the time required under USERRA following your completion of your service in the uniformed services; or
c. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Returning to Work: Your right to continue coverage under USERRA will end if you do not notify us of your intent to return to work within the time required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service.

*COBRA and USERRA coverage are concurrent.* This means that both COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to 18 months (it may continue for a longer period and it is subject to early termination, for certain events). In contrast, USERRA coverage can continue for up to 24 months.

III. **Premium Payments for USERRA Continuation Coverage**

If you elect to continue your health coverage pursuant to USERRA, you will be required to pay 102% of the full premium for the coverage elected. However, if your Uniformed Service leave of absence is less than 31 days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

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

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedemas

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

If you would like more information on WHCRA benefits, contact Bay Path University.