HEALTH INSURANCE NOTICES

October 2021

MAINE MEDIA WORKSHOPS + COLLEGE PO Box 200|Rockport, ME 04856

Contents

It is imperative to properly administer all of the legal documentation requirements under the DOL, PPACA, ERISA, COBRA and HIPAA.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, Maine has a state 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, CHIP or Mainecare at 1-800-321-5557, or go to www.maine.gov/dhhs/oms/

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 Mainecare, 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)**.

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MAINE SMALL BUSINESS HEALTHCARE COST RELIEF PROGRAM

In May 2021, Governor Janet Mills announced the Maine Small Business Healthcare Cost Relief Program. This program is part of Governor Mills' Maine Jobs and Recovery Plan. Supported by $39 million in funds from the Federal American Rescue Plan Act, the program provides small groups a health coverage premium reduction for 18 months from November 1, 2021, through April 30, 2023. As a result, the employees enrolled in your health plan will receive a monthly premium reduction of:

- Employee = $50
- Two adults = $100
- One adult + child = $80
- Two adults + child = $130

(Note: Adult + child plans provide the same reductions per plan, regardless of the number of children. "Child" is a dependent up to age 26.)

This premium reduction will apply to any current and new participants in Maine Media's health plan. The reduction is intended to be split between each covered enrollee/family, based on Maine Media's and the enrollee's contributions to the premium.

Note future premium reduction amounts may be adjusted during the 18 months of this program, depending upon the availability of funding.
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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.
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HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Human Resources|Business Manager, Jane Richardson at jrichardson@mainemedia.edu
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NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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% 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?
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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
Maine Media College		20-5933625
5. Employer address		6. Employer phone number
70 Camden Street		207.236.8581
7. City	8. State	9. ZIP code
Rockport	ME	04856
10. Who can we contact at this job?		
Jane Richardson, Human Resource|Business Manager		

11. Phone number (if different from above)	12. Email address jrichardson@mainemedia.edu

If you are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.
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INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEWS NOTICE

THE HARVARD PILGRIM MAINE'S CHOICE℠ HMO

Appeals and Complaints
This section explains our procedures for processing appeals and complaints and the options available if an appeal is denied.

A. BEFORE YOU FILE AN APPEAL

On occasion, claim denials result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, we recommend that members contact a Member Service Representative before filing an appeal. A Member Service Representative can be reached toll-free at 1–888–333-4742 or call 711 for TTY service. The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

B. OUR MEMBER APPEAL PROCEDURES

If you receive an Adverse Benefit Determination, you may appeal. We have established the following steps to ensure that you receive a timely and fair review of your appeal.

1. Initiating Your Appeal

To initiate your appeal, please mail or fax a letter to us or call us about the coverage you are requesting and why you feel it should be granted. Please be as specific as possible. We need all the important details in order to make a fair decision, including pertinent medical records and itemized bills. We must get this information within one year (365 days) of the denial of coverage, except in cases of extenuating circumstances. Please send your appeal to the following address:

HPHC Member Appeals
HPHC Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509-3085

If you are deaf or hard of hearing or visually impaired, you may request appeal procedure materials in an appropriately accessible format by calling Member Services toll free at **1-888-333-4742 or call 711 for TTY service**.

Appeals concerning mental health and drug and alcohol rehabilitation services should be submitted to:

HPHC Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107
Telephone: 1–888–777-4742
Fax: 1–888–881–7453

When we receive your appeal, we will assign an Appeals Coordinator to manage your appeal throughout the entire appeal process, including the second-level appeal process described below. We will send you a letter identifying your Appeals Coordinator within three business days of receiving your appeal.

That letter will include detailed information on the first and the second level appeal processes described below, as well as your right to independent external review and your right to contact the Maine Bureau of Insurance. Your Appeals Coordinator is available to answer any questions you may have about your appeal and the review process. In addition to the appeals process, we utilize mediation to resolve some coverage disputes. Both the Plan and you must agree to mediation. Your Appeal Coordinator will inform you if we feel that your appeal is appropriate for mediation.

2. First-Level Appeal Process

Standard Review Procedure: Your Appeal Coordinator will investigate your appeal, determine if additional information is required and request any needed information from you. Such information may include statements from your doctors, medical records and bills and receipts for services you have received. If your appeal involves a medical determination, an appropriate clinical peer will review it. After we receive all the information needed to make a decision, your Appeals Coordinator will inform you in writing of whether we have approved or denied your appeal. Most appeals can be resolved within 30 days. If we cannot reasonably meet the 30 day time frame due to an inability to obtain necessary information from non-participating providers, we will inform you in writing of the reason for the delay and that we need more time to make a decision.

Expedited Review Procedure: If your appeal involves services which, if delayed, could seriously jeopardize your health or your ability to regain maximum function, please inform us and we will provide an expedited review. We will grant an expedited review to any appeal for services concerning (1) an inpatient admission, (2) availability of care, or (3) continued health care or services for a Member who has received emergency services and has not been discharged from the hospital where emergency care was provided. You, your representative or your doctor may request an expedited review. We will investigate and decide expedited appeals as quickly as possible, but in all cases we will respond within 72 hours of the receipt of your appeal. Your help in promptly providing all necessary information is essential for us to provide you with an expedited review. For expedited appeals involving (1) continued emergency services to screen or stabilize a Member, or (2) continued care under an authorized admission or course of treatment, coverage will be continued without liability to the Member until the Member has been notified of the expedited appeal decision. To ensure a timely response, we may inform you of our decision on your expedited appeal by telephone. Following telephone notice, we also will provide you with a written decision within two working days after this phone call.

Adverse Determination of Appeal: If we deny your first-level appeal (standard or expedited) in whole or in part, we will provide you with a written decision that includes: (1) the names, titles and credentials of the reviewers who decided your appeal; (2) a statement of the reviewers' understanding of the issues and all the relevant facts; (3) reference to the specific Plan provisions and evidence or documents upon which the decision is based, including the clinical review criteria used to make the determination; (4) the reviewers' decision and the basis for that decision, including the clinical rationale, if any; (5) a reference to the evidence or documentation used as the basis for the decision; (6) notice of your right to contact the Maine Bureau of Insurance by telephone at 1–800–300-5000 (within Maine) or 1–207–624-8475 (outside Maine) or by

mail at 34 State House Station, Augusta, ME 04333 as required by Maine law; (7) a description of the process to obtain a second-level review; and (8) notice of your right to contact the ombudsman, Consumers for Affordable Health Care by telephone at 1–800–965–7476 or by mail at P.O. Box 2490, Augusta, ME 04338–2490.

3. **Second-Level Appeal Process**

If you are dissatisfied with the decision of the first level appeal process, you may ask that your appeal be reviewed by our review committee. You have a right to attend the meeting to discuss your case with the review committee. Just let your Appeals Coordinator know if you wish to attend. You may also participate in the meeting by telephone if you wish. We will hold a review meeting within 45 days after receiving your request for a second-level appeal. You will be notified in writing at least 15 days in advance of the review meeting. You may submit supporting materials before and at the review meeting. You also may be represented by someone at the review meeting. You may also obtain your medical file and information relevant to the appeal free of charge upon request. The decision of the review committee will be sent to you in writing within 5 working days of the meeting. The decision of the review committee is the final decision. If you elect not to attend the review committee meeting in person or participate by telephone, you will be provided with a written response to your appeal within 30 calendar days of your request for a second level appeal. If we deny your second-level appeal in whole or in part, we will provide you with a written decision that includes: (1) the names, titles credentials of the reviewers who decided your appeal; (2) a statement of the reviewers' understanding of the issues and all the relevant facts; (3) reference to the specific Plan provisions and evidence or documents upon which the decision is based, including the clinical review criteria used to make the determination; (4) the reviewers' decision and the basis for that decision, including the clinical rationale, if any; (5) a reference to the evidence or documentation used as the basis for the decision; (6) notice of your right to contact the Maine Bureau of Insurance by telephone at 1–800–300–5000 (within Maine) or 1–207–624–8475 (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333 as required by Maine law; (7) a description of the process to obtain a second-level review; and (8) notice of your right to contact the ombudsman, Consumers for Affordable Health Care by telephone at 1–800–965–7476 or by mail at P.O. Box 2490, Augusta, ME 04338–2490. You may waive your right to a second level appeal. You have the right to instead request an external review after the first level appeal decision.

C. INDEPENDENT EXTERNAL REVIEW OF APPEALS

Appeal decisions involving an Adverse Health Care Treatment Decision by the Plan are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. In most cases you are required to complete our first and second-level appeals process to be eligible for external review. However, this requirement does not apply if (1) Harvard Pilgrim has failed to make a decision on your first or second level appeal in the time frames noted above; (2) you and the Plan mutually agree to bypass the member appeals process; (3) your life or health is in jeopardy; (4) the Member for whom external review is requested has died; or (5) the Adverse Health Care Treatment Decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the Member has received emergency services but has not been discharged from the facility that provided the emergency services. Requests for external review must be in writing to the Maine Bureau of Insurance at 34 State House Station, Augusta, ME 04333 and must be made within 12 months of our final denial of Covered Benefits prior to the initiation of the appeals process. You also may name someone you trust to file an appeal for you. However, you must give that person written permission to do so. The review organization designated by the Maine Bureau of Insurance will consider all relevant clinical information submitted by you and us. In addition, the review organization will consider

any concerns you express about your health status. You have the right to attend the external review meeting at which time you may ask questions of our representative present at the meeting. You also are entitled to obtain information relating to the adverse decision under review. You may use outside assistance for the external review process. This assistance is your own financial responsibility. The external review decision will be made as quickly as required by the medical condition at issue. If the appeal relates to a serious medical condition and delay would jeopardize the Member's life health or ability to regain maximum function, the external review decision will be made within 72 hours of receipt of completed request. All other decisions will be made within at least 30 days of a completed request for external review. You will receive a written decision from the review organization. We will pay the fees of the independent review organization for conducting the review. If the independent review organization decides in your favor, we will cover the services approved.

D. MEMBER COMPLAINTS

If you have any complaints about your care under the Plan or about our service, we want to know about it. We are here to help. For all complaints, except mental health and drug and alcohol rehabilitation complaints, please call or write to us at:

HPHC Member Appeals
HPHC Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509-3085
www.harvardpilgrim.org

Appeals concerning mental health and drug and alcohol rehabilitation services should be submitted to:

HPHC Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107
Telephone: 1–888–777-4742
Fax: 1–888–881–7453

We will respond to you as quickly as we can. Most complaints can be investigated and responded to within thirty (30) days. You may also contact the Maine Bureau of Insurance Superintendent's office at:

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
Telephone: 1–800–300-5000 (within Maine) or
1–207–624–8475 (outside Maine)
Fax: 1–207–624-8599
TTY: 1–888–577–6690

E. INCONTESTABILITY

Any statement made by the Employer Group or a Member in applying for insurance under this Plan, other than a fraudulent misstatement, will be considered a representation and not a warranty. No such statement will be used to contest a claim for benefits under this Plan unless the statement is in writing and a copy is or has been furnished to the Member.

No such statement will be used in contesting the validity of a Member's coverage under this Plan once such coverage has been in effect for two years during the Member's lifetime.

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MEDICARE PART D CREDITABLE COVERAGE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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. Maine Media Workshops + College has determined that the prescription drug coverage offered by Harvard Pilgrim Maine's Choice Plus HMO HSA 4000 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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 coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back.

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 Maine Media and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary

premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
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 the coverage through Maine Media changes. You also may request a copy of this notice at any time.

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).

Date: 11/25/2021
Maine Media College
Jane Richardson
Human Resources|Business Manager
PO Box 200
Rockport, ME 04856
207.236.8581 x308
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COBRA RIGHTS NOTICE FOR EMPLOYEES, SPOUSES AND DEPENDENTS

Introduction
You are receiving this notice because you have recently become or may become covered under the Maine Media College Group Health Care Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's 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 coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

- 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 dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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 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;

- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events
For the 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: Maine Media College, Human Resources|Business Manager, Jane Richardson – 207.236.8581x308

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage. In order to determine if you or a covered member of your family qualify for the disability extension, you must send documentation received from SSA verifying the disability determination to: Maine Media College, Human Resources|Business Manager, Jane Richardson – 207.236.8581x308.

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, you should keep the Plan Administrator informed of 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
Maine Media College, Human Resources|Business Manager, Jane Richardson – 207.236.8581x308 – jrichardson@mainemedia.edu
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HIPPA PRIVACY NOTICE

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.

If you have any questions about this notice, please contact: Jane Richardson, Human Resources| Business Manager, jrichardson@mainemedia.edu.

WHO WILL FOLLOW THIS NOTICE.
During the course of providing you with health coverage, Maine Media College "Employer" Medical & Benefit Plans will have access to information about you that is deemed to be "protected health information", or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. The procedures outlined in this section have been added to the Plan to ensure that your PHI is treated with the level of protection required by HIPAA. This notice describes the medical information practices of your Medical Flexible Spending Account Plan (the "Plan") and that of any third party that assists in the administration of Plan claims.

OUR PLEDGE REGARDING MEDICAL INFORMATION
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.
We are required by law to:

- make sure that medical information that identifies you is kept private;

- give you this notice of our legal duties and privacy practices with respect to medical information about you;
- notify affected individuals following a "breach" of unsecured PHI; and
- follow the terms of the notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer. These employees are Business Office personnel. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action.

The Employer has certified that it will comply with the privacy procedures set forth herein. Employer may not use or disclose your PHI other than as provided herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein. The plan will not use or disclose "genetic information" (as defined in 45 C.F.R.160.103) for purposes of underwriting.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information for purposes of health plan administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment (as described in applicable regulations). If needed, we may use medical information about you to facilitate medical treatment or services.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan maintained by Maine Media College for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Maine Media College personnel solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks. We may disclose medical information about you for public health activities (e.g., to prevent or control disease, injury or disability).
Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.
Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.
National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU
You have the following rights regarding medical information we maintain about you:
Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Jane Richardson, Human Resources & Business Manager. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding. Employer will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to medical information, you may request that the denial be reviewed.
Authorization is required in the following instances: (i) any use or disclosure of psychotherapy notes except as otherwise permitted in 45 C.F.R. 164.508(a)(2); (ii) any use or disclosure for “marketing” except as otherwise permitted in 45 C.F.R. 164.508(a)(3); (iii) any disclosure which constitutes a sale of PHI.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to Jane Richardson, Human Resources & Business Manager. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. Employer may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to Jane Richardson, Human Resources & Business Manager. Your request must state a time period which may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. Employer will not include in your accounting any of the disclosures for which there is an exception under HIPAA. Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Notification of Breach of Your Unsecured Health Information: You have a right to notification of any breach of your unsecured protected health information. That means you are entitled to receive notice of any access, use, or disclosure of your unsecured protected health information that is not permitted under applicable law and which poses a significant risk of financial, or other harm to you. Following discovery of a breach of your unsecured protected health information, we will notify you of the breach by sending written notice to you by first class mail at your last known address. We will notify you following our investigation of the circumstances surrounding the breach, but in no event later than 60 calendar days after the date we discover the breach. We will notify you by telephone or other expedited means, in addition to written notice, in any situation we believe is urgent because of a possible imminent misuse of your unsecured protected health information. When required by applicable law, we will also provide notification of a breach to the media and/or to the Secretary of the U.S. Department of Health & Human Services.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask

us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, contact: Jane Richardson, Human Resources & Business Manager.
Employer must make its internal practices, books and records related to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with these privacy protections.
When Employer no longer needs PHI disclosed to it by the Plan, for the purposes for which the PHI was disclosed, Employer must, if feasible, return or destroy the PHI that is no longer needed. If it is not feasible to return or destroy the PHI, Employer must limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Plan website. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Plan official listed on page 1 of this notice. All complaints must be submitted in writing.
You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.
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WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

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

- 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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the current plan. If you would like more information on WHCRA benefits, call the plan administrator, Human Resources|Business Manager, Jane Richardson, at 207.236.8581 x308.
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NOTICE OF PATIENT PROTECTION AND SELECTION OF PROVIDERS

Harvard Pilgrim generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider and for a list of the participating primary care providers,

https://www.harvardpilgrim.org/public/find-a-provider?_ga=2.168582690.227169831.1635191939-800702805.1621604881

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

You do not need authorization from Harvard Pilgrim 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 the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, **contact Harvard Pilgrim at (888) 333-4742**

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