Patient Protection Affordable Care Act March 23, 2013
Timeline of Penalty Benefit Compliance

1. Calendar Year 2012 W-2 Form reporting required to be furnished to employees in **January 2013** for employers that were required to file 250 W-2 Forms. Notice 2012-9 includes information on how to report, what coverage to include and how to determine the cost of coverage.

2. Review and Revise your Notice of Privacy Practices and make necessary revisions by September 23, 2013, the compliance deadline for the new rules. If you maintain your Notic3e of Privacy Practices on your website, you must pose the revised notice to the website as of the effective date of the new notice. Distribution of a paper copy of the revised notice to each covered employee enrollee in the next annual health plan mailing, usually your open enrollment period. **(Exhibit A)**

3. Business Associate Agreements executed on or after January 25, 2013 the compliance date is September 23, 2013. For contracts already in existence prior to January 25, 2013, the earlier of: The date the contract or other arrangement is renewed or modified on or after September 23, 2013 or September 22, 2014. **(Exhibit B)**

4. Patient Centered Outcome Research Trust Fund (PCORI): Self-insured plans, the fee due under Section 4376 is on the "plan sponsored" of an applicable self-insured plan. The "plan sponsor" is the designated employer.2012-2018 plan years (for a total of 7 years. Annual filing on the IRS Form 720. Fees must be paid by July 31 of the calendar year immediately following the last day of the plan year ending October 1, 2013 thereafter. The first fee for the Plan Years ending **after September 30, 2012 updated to state Plan Years on or after October 1, 2012.** The **2012 calendar year initial payment is due by July 31, 2013**. The **IRS** updated **Form 720** to accommodate CER Fees in the near future. Fee is $1.00 per participant for 2012, **$2.00** per participant for 2013 **paid in 2014**, and indexed for the future. HRA and H.S.A. counts will be applicable if integrated with a health plan.

Plan Year	First PCORI Payment Due Date
November 1, 2011 to October 31, 2012	July 2013
December 1, 2011 to November 30, 2012	July 2013
January 1, 2012 to December 31, 2012	July 2013
February 1, 2012 to January 31, 2013	July 2014
March 1, 2012 to February 28, 2013	July 2014
April 1, 2012 to March 31, 2013	July 2014
May 1, 2012 to April 30, 2013	July 2014
June 1, 2012 to May 31, 2013	July 2014
July 1, 2012 to June 30, 2013	July 2014
August 1, 2012 to July 31, 2013	July 2014
September 1, 2012 to August 31, 2013	July 2014
October 1, 2012 to September 30, 2013	July 2014

5. Exchange Notice Requirement: ***(Distribution delayed until October 2013):*** Employers to send employees a written notice not later than March 1, 2013 (sample notice not released yet) telling them about the new health insurance Exchanges. Notice should include information regarding employee purchases coverage through an Exchange then they may no longer be eligible for employer contribution toward health coverage on a pre-tax basis. **(Exhibit D)**

   a. The law also requires the notice to explain that if the employer plan's payment of plan costs is less than 60%, the employee may be eligible for a premium assistance tax credit if he or she purchases coverage in the Exchange. Awaiting Guidance. Starting in 2014, small business with up to 100 employees* (states may apply waiver to insure business with up to 50 employees in their SHOP exchange) and individuals without employer-sponsored coverage will be able to buy insurance on state-administered "exchanges." State-based Exchanges will be administered by a government agency or non-profit organization.

b. A qualified health plan, to be offered through the new American Health Benefit Exchange/Insurance Marketplaces must provide essential health benefits which include cost sharing limits. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed $2,000 for an individual and $4,000 for a family.

6. HITECH Upgrades
   a. 4010 to 5010 June 2012
   b. Health Plan Identification Number: **Application March 29, 2013**
   c. Electronic Fund Transfers: V-Payment/ACH Payment **by January 2014** compliance date, ICD 10 conversion from ICD 9 **October 2014** compliance date. TML IEBP membership Webcast with Finance and TML IEBP should occur no later than close of **September 2013.**
      i. Group health plans must file a certification with the Secretary of HHS that their plan is in compliance with the "administrative simplification" rules for electronic fund transfer, health claim status and health care payment. The penalty for non-compliance is $1.00 per covered life per day of non-compliance, to a maximum of $20.00 per covered life per year. A double penalty applies in the case of a misrepresentation by the employer.
      ii. Hybrid timeline for ICD 9 and ICD 10 October 2014.
      iii. Automatic electronic > 200 enrollment 2014 possible delay.
      iv. TML Intergovernmental Employee Benefits Pool Explanation of Benefit Document Upgrade/HealthX Electronic EOB interface

7. Employer Cost Share Program/Pay or Play Penalty: **Beginning Plan Years January 2014 and thereafter (July 2, 2103 announcement that the IRS penalty will be delayed until January 2015 HB 2667 vote 246-161 individual mandate 251-174 vote)** the pay or play rule will be effective. If employers with at least 50 full-time equivalent employees fails to offer minimum essential major medical health coverage to its full-time employees and their dependents, and at least one full-time employee who works on average 30 hours or more a week/130 hours a month and/or 120 consecutive seasonal days a year obtains a subsidized coverage in a state health insurance Exchange/Insurance marketplaces the 4980H(a) penalty is $2,000 times the total number of full-time employees employed by the employer for employees in excess of the employee deductible of thirty (30).
   a. Measurement Period applies to employers with 50 or more employees: of 12 consecutive months not less than 6/3 months. Begin no later than July 1, 2013 and ends no earlier than 90 days before the first day of the plan year that begins on or after January 1, 2014. Payroll Departments need to review reporting for hours worked, measurement period, high turnover positions, unpaid work hours, employees being paid outside of payroll, unpaid work hours, variable hourly employees, temporary staff, terms and rehires.
      i. Employer Steps to Full Time Equivalent Management
         » Documented Executive Decision regarding Employer's decision regarding measurement period timeline:
            - 12 month
            - 9 month
            - 6 month
         » Measurement Period Activity
            - Review payroll within designated period
            - Identify a documented list of employees who have not been given access to medical healthcare benefits per month during designated measurement period
            - Identify a documented list of the employees during the measurement period that have not been given access to medical healthcare benefits per month during designated measurement period
            - Identify a documented list of the employees during the measurement period that have not been given access to medical healthcare benefits per month during the measurement period that work an average of 30 hours a week, 130 hours a month or 120 seasonal days a year

- Employers have a "three month free pass/grace period" to provide health coverage for regular full time employees or pay the penalty.
- Employers should identify a documented procedure on tracking full time equivalent hours. Options for new hire tracking are
  - » hire date
  - » first day of payroll period
  - » first day of a month
- The documented designated tracking period allows an employer a 90 day "initial administrative period" to identify designated staffing pattern to identify employee's full time equivalency.

b. Hours of service include both hours paid based on performance of duties as well as paid time for vacation, holiday, illness, incapacity (including disability) layoff, jury duty, military duty or leave of absence.

c. Special rules apply to unpaid leave subject to the FMLA of 1993 and the Uniformed Service Employment and Reemployment Rights Act of 1994 that the averaging method exclude if from calculation so that the employee is not disadvantaged by taking these leaves.

d. Rules only apply to employees who are in continuing service, not to those who are terminated and then rehired. Employees rehired with less than a 26 week break in employment may apply "rule of parity" if rehired with a greater than 26 week break, will be treated as new hire.

e. Employees not paid on an hourly based may be calculated on (1) counting actual hours of service; (2) using a days-worked equivalency, which credits the employee with 8 hours of service for each day or (3) using a weeks-worked equivalency of 40 hours of service per week.

f. A large employer will be treated as having offered coverage to its full-time employees and their dependents for a calendar month if, coverage is offered to 95% of its full-time employees as long as dependent coverage was also offered. Failure to offer coverage to 95% of all full-time employees will result in the 4980H (a) penalty being imposed.

g. Affordability Test/Employer Shared Responsibility Penalty

i. "Affordability Test" allow the employers to measure 9.5% of the employee's wages from the employer, as reported in Box 1 of the Form W-2 instead of household income in regards to the most cost effective minimum qualified health plan option actuarially equivalent to the Bronze Plan.

ii. If the coverage does not meet the "affordability test" or the "minimum value test" and at least one full time employee obtains subsidized coverage in a state health insurance Exchange/Marketplaces than the employer would pay a 4980H (b) penalty. $3,000 times each full-time employee who receives subsidized coverage in Exchange/Marketplaces. Penalty (b) impacts the employer who offers health coverage to its full-time employees and their dependents but the coverage does not meet the "affordability test" or the minimum value test and at least one full-time employee obtains subsidized coverage in a state health insurance exchange, then the employer would pay a 4980H (b) penalty.

» The amount would be $3,000 times each full time employee who receives subsidized coverage in Exchange with a maximum of the 4980H (a) penalty amount that would have been due if the employer did not receive coverage.

» Employers should be aware that there are two "play or pay" tests – the **objective test** and the **subjective test**. The objective test asks whether the covered employer provides any level of health care coverage. If the answer is no, the employer penalty is $2,000 per employee (with a 30 person deductible). The subjective test asks if the employer provides health care coverage, is that coverage sufficiently affordable and robust. Coverage is sufficiently affordable if the cost is 9.5% or less of employee's W-2 form compensation for the most cost effective single coverage for an employee's benefit plan.

» The Penalty will be the lesser of the objective and subjective test-the IRS wants to make sure the employers who are providing some level of coverage do not end up paying more in penalties than an employer who is not providing any coverage.

» Employers will be penalized if an employee receives a premium tax credit provided by the Federal Government to Insurance Marketplaces/Exchanges on behalf of individuals whose income is between 100 and 400 percent of the poverty level. The existence of premium tax credit matters to employers because a penalty will apply if one employee receives a premium tax credit.

8. Minimum Essential Major Medical Actuarial Value Calculator: 60% Bronze Plan/Individual Deductible not excess of $2,000 individual/$4,000 family for small employers.
   a. Limit on Out-of-Pocket Expenses: Group health plans must limit Covered Individual Maximum out of Pocket Expenses for major medical plans currently excluding prescription plans.
      i. The 2013 maximum out of pocket is $6,250 for single coverage and $12,500 for family.
      ii. Discussion for 2014 no Mandate: Individual $6,350, Family $12,700.
   b. 7.25.13
      i. There is a transition rule for the first plan year with respect to prescription drug coverage.
      ii. For plan years beginning on or after January 1, 2015, the out of pocket maximum must be applied to both major medical and prescription drugs together. For the first plan year beginning on or after January 1, 2014, if the plan has separate service providers for major medical and prescription drugs, the out of pocket maximum is applied separately to each service provider.
      iii. The out of pocket maximum applies to all non-grandfathered self-insured plans.

9. Model COBRA Continuation Coverage Election Notice
   a. The notice must contain information about individual's right to continue health care coverage in current plan as well as other health coverage alternatives that may be available through the Health Insurance Marketplace with tax credits. Additional note requirement that preexisting condition exclusion and/or limitations will be prohibited **beginning 2014** under the Patient Protection Affordable Care Act. IRS proposed regulations lower and middle–income employees who quit or are laid off, or employees' widowed or divorced spouses who are eligible for COBRA but do not enroll, will be entitled to premium subsidies to buy health insurance in public exchanges that begin operating in 2014. Currently proposed regulations state that the COBRA plan would have to fail the 9.5% affordability test and satisfy the 400% federal poverty level test to access COBRA single-coverage. Comments are being received on this proposed regulation and potential penalty. **(Exhibit C)**

10. Prohibition of Pre-Existing conditions for >19 years of age participants Plan Years Jan 2014 thereafter.

11. Transitional Reinsurance Fund: The program designed to help stabilize premiums in the individual health insurance market for those with pre-existing conditions, will be effective from 2014 through 2016. Fees of $63.00 PPPY (Employee, Dependent, and COBRA, Retirees) to support this transitional reinsurance program will be assessed against both insured and self-funded group health plans. HHs will collect the reinsurance fees on an annual basis. **By Nov 15 of each year, the contributing entity must submit the number of covered lives subject to the fee that calendar year. HHS will notify the contributing entity of the total fee to be paid within 15 days of submission or by December 15. Payment to HHS will be within 30 days of receiving notice of the amounts. Established in each state by January 1, 2014, the program will operate from November 2014 through 2016. November 2014 is projected to be timeframe for first payment**. The total amount of fees to be collected over the three-year period is $25B. Of this amount, $20B will fund the reinsurance program, while the other $5B will be paid to the U.S. Treasury. This program, designed to help stabilize premiums in the individual health insurance market for those with pre-existing conditions, will be effective from 2014 through 2016. Health insurance issuers and third party administrators will pay the assessment to fund state nonprofit reinsurance entities, which will establish high-risk pools for the individual market.

12. Excise Tax on High Cost Employer-Provided Health Coverage: In 2018, plan administrators will pay a 40% tax for any health insurance plan that is above the threshold of $10,200 for singles and $27,500 for families. This excise tax would apply to the amount of the premium that is above these thresholds.

Insurance Marketplaces/Exchange

Steps Involved in the Employer Decision "Pay or Play"

1. Review the terms and cost of current coverage for employees and dependents
2. Estimate the number of employees in 2014 working an average of 30 or more hours a week, 130 hours a month or 120 season days a year.
3. If applicable, estimate the increased cost of amending plans to cover additional employees meeting the definition of a full time equivalent employee. In cost estimation ensure costs reflect actual date of premium/contribution costs after waiting and or administrative stability period.
4. Estimate the cost of partial or full payment of non deductible shared-responsibility payments
5. Review and evaluate the financial and nonfinancial considerations of providing or terminating coverage
6. Calculate the Pay or Play Proposed Penalty.
7. Seasonal employees PPACA definition is an employee working 120 or more seasonal days a year. Proposed implementation of the definition is that seasonal employee working 120 or more seasonal days a year is averaging 30 hours a week or 130 hours a month during the seasonal work period for the full time equivalency to be met.

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Exhibit A

Notice of Privacy Practices

September 23, 2013 Compliance Date

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.

TML IEBP is required by law to keep your health information private and to notify you if TML IEBP, or one of its business associates, breaches the privacy or security of your unsecured, identifiable health information. This notice tells you about TML IEBP's legal duties connected to your health information. It also tells you how TML IEBP protects the privacy of your health information. As your group health plan, TML IEBP must use and share your health information to pay benefits to you and your healthcare providers. TML IEBP has physical, electronic and procedural safeguards that protect your health information from inappropriate or unnecessary use or sharing.

Is all my health information protected?

Your individually identifiable health information that TML IEBP transmits or maintains in writing, electronically, orally or by any other means is protected. This includes information that TML IEBP creates or receives and that identifies you and relates to your participation in the health plan, your physical or mental health, your receipt of healthcare services and payment for your healthcare services.

What steps does TML IEBP take to protect my information?

Because TML IEBP believes that protecting your health information is of the highest priority, TML IEBP takes the following steps to ensure that your health information remains confidential:

Business Associate Agreements - TML IEBP follows the requirements of federal law and makes sure that any TML IEBP business associate who receives your personal health information signs a written agreement to protect your health information.

Encryption of Health Data - TML IEBP encrypts your health information that is sent electronically (for example, over the Internet) so that no one, who is not supposed to, can view your health information. To make sure that only the people who need your health information to administer your health plan benefits are able to see it, TML IEBP reviews the list of people who are allowed to view your personal health information on a regular basis.

Independent Review - TML IEBP periodically employs an independent security company to review and test TML IEBP's security controls to make sure they meet the requirements of federal law. The independent security company provides certified security professionals to conduct the review.

Use of Health Information - TML IEBP's Privacy & Security Officer reviews the use of personal health information by TML IEBP to ensure that it complies with both federal law and with TML IEBP's own privacy policies.

How does TML IEBP use and share my health information?

TML IEBP's most common use of health information is for its own treatment, payment and healthcare operations. TML IEBP also may share your health information with healthcare providers, other health plans and healthcare clearinghouses for their treatment, payment and healthcare operations. (Healthcare clearinghouses are organizations that help with electronic claims.) TML IEBP also may share your health information with a TML IEBP business associate if the business associate needs the information to perform treatment, payment or healthcare operations on TML IEBP's behalf. For example, if your health plan includes a retail and mail order pharmacy network, TML IEBP must share information with the pharmacy network about your eligibility for benefits. Healthcare providers, other health plans, healthcare clearinghouses and TML IEBP business

associates are all required to maintain the privacy of any health information they receive from TML IEBP. TML IEBP uses and shares the smallest amount of your health information that it needs to administer your health plan.

What are treatment, payment and healthcare operations?

Treatment is the provision, coordination or management of healthcare and related services. For example, your health information is shared for treatment when your family doctor refers you to a specialist.

Payment includes TML IEBP activities such as billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and notification of healthcare services. For example, TML IEBP may tell a doctor if you are covered under a TML IEBP health plan and what part of the doctor's bill TML IEBP will pay.

Healthcare operations include quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting and other activities necessary to create or renew health plans. It also includes disease management, case management, conducting or arranging for medical review, legal services, auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, TML IEBP may use information from your claims to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. Please note that while TML IEBP may use and share your health information for underwriting, TML IEBP is prohibited from using or sharing any of your genetic information for underwriting.

How else does TML IEBP share my health information?

TML IEBP may share your health information, when allowed or required by law, as follows:

- Directly with you or your personal representative. A personal representative is a person who has legal authority to make healthcare decisions for you. In the case of a child under 18 years of age, the child's personal representative may be a parent, guardian or conservator. In the case of an adult who cannot make his own medical decisions, a personal representative may be a person who has a medical power of attorney.
- With the Secretary of the U.S. Department of Health and Human Services to investigate or determine TML IEBP's compliance with federal regulations on protecting the privacy and security of health information.
- With your family member, other relative, close personal friend or other person identified by you who is involved directly in your care. TML IEBP will limit the information shared to what is relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the release of your health information.
- For public health activities.
- To report suspected abuse, neglect or domestic violence to public authorities.
- To a public oversight agency.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- With organ procurement organizations or other organizations to facilitate organ, eye or tissue donation or transplantation.
- With a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties required by law.
- With a funeral director when permitted by law and when necessary for the funeral director to carry out his duties with respect to the deceased person.
- To avert a serious threat to health or safety.
- For specialized government functions, as required by law.
- When otherwise required by law.

- Information that has been de-identified. This means that TML IEBP has removed all your identifying information and it is reasonable to believe that the organization receiving the information will not be able to identify you from the information it receives.

Can I keep TML IEBP from using or sharing my health information for any of these purposes?

You have the right to make a written request that TML IEBP not use or share your health information, unless the use or release of information is required by law. However, since TML IEBP uses and shares your health information only as necessary to administer your health plan, TML IEBP does not have to agree to your request.

Are there any other times when TML IEBP may use or share my health information?

TML IEBP may not use or share your health information for any purpose not included in this notice, unless TML IEBP first receives your written authorization. To be valid, your authorization must include: the name of the person or organization releasing your health information; the name of the person or organization receiving your health information; a description of your health information that may be shared; the reason for sharing your health information; and an end date or end event when the authorization will expire. You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before TML IEBP receives your request.

TML IEBP must always have your written authorization to:

- Use or share psychotherapy notes, unless TML IEBP is using or sharing the psychotherapy notes to defend itself in a legal action or other proceeding brought by you.
- Use or share your identifiable health information for marketing, except for: (1) a face-to-face communication from TML IEBP, or one its business associates, to you; or (2) a promotional gift of nominal value given by TML IEBP, or one its business associates, to you.
- Sell your identifiable health information to a third party.

Will TML IEBP share my health information with my employer?

TML IEBP shares summary health information with the employer who sponsors your group health plan. Employers need this information to get bids from other health plans or to make decisions to modify, amend or terminate the TML IEBP group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by the entire group of people covered under a health plan. Summary health information does not include any information that identifies you, such as your name, social security number or date of birth.

Also, TML IEBP shares with the employer who sponsors your group health plan information on whether you are enrolled in TML IEBP's group health plan or if you recently added, changed or dropped coverage.

Can I find out if my health information has been shared with anyone?

You may make a written request to TML IEBP's Privacy and Security Officer for a list of any disclosures of your health information made by TML IEBP during the last six years. The list will not include any disclosures made for treatment, payment or healthcare operations; any disclosures made directly to you; any disclosures made based upon your written authorization; or any disclosures reported on a previous list.

Generally, TML IEBP will send the list within 60 days of the date TML IEBP receives your written request. However, TML IEBP is allowed an additional 30 days if TML IEBP notifies you, in writing, of the reason for the delay and notifies you of the date by which you can expect the list.

If you request more than one list within a 12-month period, TML IEBP may charge you a reasonable, cost-based fee for each additional list.

Can I view my health information maintained by TML IEBP?

You may make a written request to inspect, at TML IEBP's offices, your enrollment, payment, billing, claims and case or medical management records that TML IEBP maintains. You also may request paper copies of your records. If you request paper copies, TML IEBP may charge you a reasonable, cost-based fee for the copies. Requests to view your health information should be made in writing to:

TML IEBP
ATTN: Privacy and Security Officer
1821 Rutherford Lane, Suite 300
Austin, Texas 78754-5151

If I review my health information and find errors, how do I get my records corrected?

You may request that TML IEBP correct any of your health information that it creates and maintains. All requests for correction must be made to TML IEBP's Privacy and Security Officer, must be in writing and must include a reason for the correction.

Please be aware that TML IEBP can correct only the information that it creates. If your request is to correct information that TML IEBP did not create, TML IEBP will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be corrected because the diagnosis is incorrect, TML IEBP will correct the claim if TML IEBP made an error in the data entry of the diagnosis. However, if your healthcare provider submitted the wrong diagnosis to TML IEBP, TML IEBP cannot correct the claim without a statement from your healthcare provider that the diagnosis is incorrect.

TML IEBP has 60 days after it receives your request to respond. If TML IEBP is not able to respond, it is allowed one 30-day extension. If TML IEBP denies your request, either in part or in whole, TML IEBP will send you a written explanation of its denial. You may then submit a written statement disagreeing with TML IEBP's denial and have that statement included in any future disclosures of the disputed information.

I'm covered as a dependent and do not want any of my health information mailed to the covered employee's address. Will you do that?

If mailing communications to the covered employee's address would place you in danger, TML IEBP will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the covered employee's address would place you in danger.

Please be aware that TML IEBP is required to send the employee any payment for a claim that is not assigned to a healthcare provider, except under certain medical child support orders.

If I believe my privacy rights have been violated, how do I make a complaint?

If you believe your privacy rights have been violated, you may make a complaint to TML IEBP.

Write to: TML IEBP
ATTN: Privacy and Security Officer
1821 Rutherford Lane, Suite 300
Austin, Texas 78754-5151

Or call: (800) 282-5385

Also, you may file a complaint with the U.S. Department of Health and Human Services. TML IEBP will not retaliate against you for filing a complaint.

When are the privacy practices described in this notice effective?

This privacy notice has an effective date of September 1, 2013.

Can TML IEBP change its privacy practices?

TML IEBP is required by law to follow the terms of its privacy notice currently in effect. TML IEBP reserves the right to change its privacy practices and to apply the changes to any health information TML IEBP received or maintained before the effective date of the change. TML IEBP will maintain its current privacy notice on its website at: www.tmliebp.org. If a revision is made during your plan year, TML IEBP will post the revised notice to its website on the date the new notice goes into effect. You will receive a paper copy of the revised privacy notice before the start of your next plan year.

What happens to my health information when I leave the plan?

TML IEBP is required to maintain your records for at least six years after you leave TML IEBP's group health plan. However, TML IEBP will continue to maintain the privacy of your health information even after you leave the plan.

How can I get a paper copy of this notice?

To request that TML IEBP mail you a paper copy of this notice, call (800) 282-5385.

Who can I contact for more information on my privacy rights?

Write to: TML IEBP
ATTN: Privacy and Security Officer
1821 Rutherford Lane, Suite 300
Austin, Texas 78754-5151
Or call: (800) 282-5385

Exhibit B

Business Associate Agreement

September 23, 2013 Compliance Date

This agreement is made between TML Intergovernmental Employee Benefits Pool (TML IEBP) and the undersigned Business Associate in consideration of the release of protected health information (PHI) by TML IEBP to the Business Associate. The terms "Business Associate" and "protected health information," or "PHI," as used in this Contract shall have the same meanings as in 45 CFR § 160.103.

In providing health benefits to its Members, TML IEBP maintains PHI on plan participants. TML IEBP also serves as the record keeper for our Administrative Services Only (ASO) Members, and any provisions herein also shall apply to PHI of ASO Members.

In order to fulfill its duties to TML IEBP, the Business Associate requires receipt of certain PHI from TML IEBP. The purpose of this Contract is to ensure that the Business Associate implements administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, security, integrity and availability of PHI it creates, receives, maintains or transmits on behalf of TML IEBP and that such administrative, physical and technical safeguards meet the standards of 45 CFR Parts 160 and 164. Any violation of confidentiality, security, integrity or availability of PHI by the undersigned Business Associate seriously injures TML IEBP's reputation and effectiveness and may result in the violation of state and/or federal law.

The Business Associate understands and agrees that to the extent the Business Associate creates, maintains, receives or transmits PHI on behalf of TML IEBP, the Business Associate is subject to 45 CFR Parts 160 and 164 (HIPAA Rules) including rules on Privacy, Security, Breach Notification and Enforcement.

All information provided to the Business Associate by TML IEBP shall be regarded as confidential and available only to the Business Associate. Use or disclosure of the information without authorization by the plan participant to whom the information pertains may be permitted only in the following circumstances:

- In its capacity as a Business Associate of TML IEBP as necessary to perform the services set forth in the underlying service agreement between TML IEBP and the Business Associate, and in accordance with TML IEBP's minimum necessary policies and procedures.
- For the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate if the use or disclosure is required by law or if the Business Associate obtains reasonable written assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- To provide data aggregation services relating to TML IEBP's plan of benefits.

The terms "use" and "disclosure" as used in this Contract shall have the same meanings as in 45 CFR § 160.103.

The Business Associate will use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as permitted in this Contract or as required by law. To the extent that the Business Associate carries out one or more of TML IEBP's obligation(s) under Subpart E of 45 CFR Part 164, the Business Associate will comply with the requirements of Subpart E that apply to TML IEBP in the performance of such obligation(s).

In regard to any PHI provided to the Business Associate at the direction of a Member, nothing in this agreement shall allow the release of any such information to any other person, including the Member, or its officers or employees, which release is expressly forbidden.

The Business Associate will report to TML IEBP any use or disclosure of PHI not provided for by this Contract of which the Business Associate becomes aware. The Business Associate will report to TML IEBP any security incident of which the Business Associate becomes aware. The term "security incident" as used in this Contract shall have the same meaning as in 45 CFR § 164.304. Following discovery by the Business Associate of any breach of unsecured PHI, the Business Associate agrees to notify TML IEBP of such breach without unreasonable delay and in no case more than thirty (30) calendar days following the Business Associate's discovery of the breach. Such notification shall include, to the extent available, the identity of each individual whose unsecured PHI has been or is reasonably believed by the Business Associate to have been accessed, acquired, used or disclosed during the breach. At the time of notification or promptly thereafter as such information becomes available, the Business Associate shall also provide TML IEBP with such information as is required for TML IEBP to notify an individual of the breach as required by 45 CFR § 164.404(c). Except for notification to the Secretary of the United States Department of Health and Human Services, which must be done by TML IEBP, the Business Associate agrees that to the extent the breach is solely as a result of the Business Associate's failure to implement reasonable and appropriate safeguards as required by this Contract, and not due in whole or in part to the acts or omissions of TML IEBP, the Business Associate shall provide the notifications required under 45 CFR §§ 164.404 and 164.406 subject to any delay required by law enforcement pursuant to 45 CFR § 164.412. The term "breach" as used in this Contract shall have the same meaning as in 45 CFR § 164.402.

The Business Associate will ensure that any agents, including a subcontractor, to whom the Business Associate provides PHI that it creates, receives, maintains or transmits on behalf of TML IEBP agrees, in a written contract, to the same restrictions and conditions that apply to the Business Associate with respect to such information.

The Business Associate will make available PHI to the plan participant to whom the PHI pertains as required by 45 CFR § 164.524.

The Business Associate will make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.

The Business Associate will make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

The Business Associate will make its internal practices, books and records relating to the use, disclosure, security, integrity and availability of PHI that the Business Associate creates, receives, maintains or transmits on behalf of TML IEBP available to the Secretary of the United States Department of Health and Human Services for purposes of determining TML IEBP's compliance with 45 CFR Parts 160 and 164.

The Business Associate, upon termination of its underlying service agreement with TML IEBP will, if feasible, return or destroy all PHI the Business Associate created, received, maintained or transmitted on behalf of TML IEBP that the Business Associate still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of this Contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. The confidentiality, security, integrity and availability obligations of this Contract shall be on a continuing basis, shall survive the termination of the present underlying service agreement or any subsequent underlying service agreement and shall terminate only if and when TML IEBP's legal obligation to maintain the confidentiality, security, integrity and availability of PHI shall no longer exist.

The Business Associate acknowledges and agrees that it will not permit any person to remove from its premises any TML IEBP records, reports or documents, whether or not they contain PHI, without a prior written release from the management of TML IEBP.

The Business Associate acknowledges and agrees that violation of the terms of this Business Associate Contract may result in termination of the Business Associate's underlying service agreement with TML IEBP.

TML IEBP and the Business Associate agree to take action to amend this Contract as is necessary for compliance with the requirements of 45 CFR Parts 160 and 164 and any other applicable law.

This Business Associate Contract is effective on the date the agreement is signed by the Business Associate.

Business Associate:

Business Associate Name	Date
Signature	Printed Name

TML Intergovernmental Employee Benefits Pool:

Susan Smith, Executive Director	Date

Exhibit C

Model COBRA Continuation of Coverage Election Notice

January 2014

Continuation of Coverage Rights under Cobra

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA Continuation of Coverage (COC), which is a temporary extension of coverage under the Plan as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. This notice generally explains COBRA Continuation of Coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

The right to COBRA Continuation of Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation of Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan booklet or contact TML IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

What is COBRA Continuation of Coverage?

COBRA Continuation of 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 of 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 of Coverage may be required to pay depending on the policy of your employer.

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:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

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

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B and/or Part C); or
5. You become divorced or legally separated from your spouse.

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

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (Part A, Part B and/or Part C);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

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

Please note that Continuation of Coverage does not include any life benefits. If you had voluntary life coverage, you may convert it to an individual policy within thirty-one (31) days of your qualifying event. Contact your employer's human resources office for more information and conversion forms.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see that your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA Continuation of Coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request your enrollment within thirty (30) days.

When is COBRA Continuation of Coverage available?

The Plan will offer COBRA Continuation of Coverage to qualified beneficiaries only after TML IEBP (Continuation of Coverage/COBRA Coordinator) has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (under Part A, Part B and/or Part C), the employer must notify TML IEBP of the qualifying event.

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 TML IEBP (Continuation of Coverage/COBRA Coordinator) within 60 days after the qualifying event occurs. Notice must be provided to: TML IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

How is COBRA Continuation of Coverage provided?

Once TML IEBP (Continuation of Coverage/COBRA Coordinator) receives notice that a qualifying event occurred, COBRA Continuation of Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA Continuation of Coverage. Covered employees may elect COBRA Continuation of Coverage on behalf of their spouses, and parents may elect COBRA Continuation of Coverage on behalf of their children.

COBRA Continuation of Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (Part A, Part B and/or Part C), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA Continuation of Coverage lasts for up to a total of thirty-six (36) months. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA Continuation of Coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA Continuation of Coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA Continuation of Coverage generally lasts for only up to a total of eighteen (18) months. There are three (3) ways in which this eighteen (18) month period of COBRA Continuation of Coverage can be extended.

Active Duty Reservists

If covered by the plan as an employee at the time of call to active duty, active duty reservists or guard members and their covered dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which the person's absence begins is the qualifying event for COBRA Continuation of Coverage (COC) to be offered to the reservist or guard member.

If a fire fighter or police officer is called to active duty for any period, the employer must continue to maintain any health, dental, or life coverage received on the date the fire fighter or police officer was called to active military duty until the employer receives written instructions from the fire fighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COC purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, TML IEBP (Continuation of Coverage/COBRA Coordinator), will follow the time guidelines of COBRA Continuation of Coverage under 42 U.S.C.A.300bb-1 *et seq*. To qualify for this coverage, the employee must give written notice to the employer within sixty (60) days of the qualifying event. The employer member must notify TML IEBP (Continuation of Coverage/COBRA Coordinator) that an employee has been called to active duty and submit a copy of the employer member's active reservist policy to TML IEBP (Continuation of Coverage/COBRA Coordinator).

Disability extension of COBRA Continuation of Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify TML IEBP within sixty (60) days of that determination, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA Continuation of Coverage for a total maximum of twenty-nine (29) months. The disability must start at some time before the sixtieth (60th) day of COBRA Continuation of Coverage and must last at least until the end of the eighteen (18) or twenty-four (24) month period of COBRA Continuation of Coverage. You may contact TML IEBP about a disability determination at 1820 Rutherford Lane, Suite #300, Austin, Texas 78754 or by telephone (800) 282-5385.

Second Qualifying Event extension of COBRA Continuation of Coverage

If your family experiences another qualifying event while receiving eighteen (18) or twenty-four (24) months of COBRA Continuation of Coverage, the spouse and dependent children in your family may get up to eighteen (18) additional months of COBRA Continuation of Coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B and/or Part C) or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Adding Dependents

If you are a COBRA Continuation of Coverage participant, you have the same rights to add dependents to your COBRA Continuation of Coverage as an active covered employee. For example, you may add dependents to your COBRA Continuation of Coverage within thirty-one (31) days of marriage or the birth, adoption or placement for adoption of a child. Also, you may add dependents to your COBRA Continuation of Coverage during your employer's open enrollment. However, these dependents who were not covered under the Plan before your qualifying event occurred are not qualified beneficiaries and do not have individual COBRA Continuation of Coverage rights, except for children added within thirty-one (31) days of birth, adoption or placement for adoption. Children added to your COBRA Continuation of Coverage within thirty-one (31) days of birth, adoption or placement for adoption are qualified beneficiaries and have their own COBRA Continuation of Coverage rights.

If you have questions

Questions concerning your Plan or your COBRA Continuation of Coverage rights should be addressed to the contact or contacts identified below. State and local government employees seeking more information about their rights under COBRA Continuation of Coverage, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, can contact the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services at:

- www.cciio.cms.gov/programs/protections/cobra/cobra_fact_sheet.html; or
- www.cciio.cms.gov/programs/protections/cobra/cobra_qna.html.

For more information about health insurance options available through a Health Insurance marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep TML IEBP (Continuation of Coverage/COBRA Coordinator) informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and TML IEBP.

Resource	Contact Information	Accessible Hours
TML Intergovernmental Employee Benefits Pool **1821 Rutherford Lane, Suite 300** **Austin, Texas 78754**		
Customer Care Helpline:	(800) 282-5385	8:30 AM - 5:00 PM Central
Secured Customer Care E-mail:	https://tmliebp.org/ **|** select "Contact Us" **|** click on "Send a secure e-mail to Customer Service"	8:30 AM - 5:00 PM Central
TML IEBP Internet Website:	www.mytmliebp.org	Twenty-four (24) hours
Medical Authorizations:	(800) 847-1213	8:30 AM - 5:00 PM Central
Prescription Authorizations:	(888) 871-4002	
Professional Health Coaches:	(800) 818-2822	
Spanish Line:	(800) 385-9952	
Where to Mail Paper Medical Claims:	TML Intergovernmental Employee Benefits Pool PO Box 149190 Austin, Texas 78714-9190	
Where to Mail Paper Prescription Claims:	Restat **|** Patient Reimbursement 11900 W. Lake Park Drive Milwaukee, WI 53224	
Telemedicine:	1-800-Teladoc **|** Teladoc.com	
After Hours and/or Weekend Medical and Mental Healthcare Emergencies:	Call 911 or immediately go to the emergency department.	

Exhibit D

Exchange Notice Requirement

Distribution Delayed until October 2013

Department of Labor Insurance Marketplace Notification

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

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 and employment-based health coverage offered by your employer.

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 9.6% 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.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

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.

[1] 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.

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)	
5. Employer address	6. Employer phone number	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)