ERISA NOTICES

HIPAA SPECIAL ENROLLMENT NOTICE

A federal law called HIPAA requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 your 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).

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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:
Agnes Scott College
Belinda B. Reese
Director of People and Culture
141 E. College Ave.
Decatur, GA 30030
404.471.6221

NOTICE OF PRIVACY PRACTICES

Plan Administrator
Agnes Scott College
Belinda B. Reese
Director of People and Culture
141 E. College Ave.
Decatur, GA 30030
404.471.6221

Your Information. Your Rights. Our Responsibilities.
Agnes Scott College is committed to maintaining and protecting the confidentiality of our employees' personal information.

This Notice of Privacy Practices applies to Agnes Scott College Group Health Plans (collectively, the Plans).
The Plans are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information.
We are required to provide you with this Notice about our policies, safeguards and practices. When the Plans use or disclose your PHI, the Plans are bound by the terms of this Notice, or the revised Notice, if applicable.

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.

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask the Plan to limit the information we share
- Get a list of those with whom the health plan has shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way the health plan uses & shares information as the Plan:

- Answers coverage questions from your family, close
- friends, or others involved in payment for your care
- Provides disaster relief
- Includes you in a hospital directory
- Provides mental health care
- Markets health plan services
- Raises funds

The health plan may use and disclose/share your information as it:

- Helps manage the health care treatment you receive
- Runs our organization
- Pays for your health services
- Administers your health plan
- Helps with public health and safety issues
- Does research
- Complies with the law
- Responds to organ and tissue donation requests and
- work with a medical examiner or funeral director
- Addresses workers' compensation, law enforcement, and other government requests
- Responds to lawsuits and legal actions

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

Get a copy of health and claims records - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct health information about you that you think is incorrect or incomplete.

- Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

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

- Help manage the health care treatment you receive - We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

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

Example: We use health information about you to manage your treatment and services.

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

Example: We give information about you to your health insurance plan so it will pay for your services.

- Administer your plan - We may disclose your health information to your health plan sponsor for plan administration.

Example: Your Company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

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

- Preventing disease
- Helping with product recalls

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

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

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

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

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

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

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

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

Our Responsibilities

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

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

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 Agnes Scott College, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. 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.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *[add if Plan provides retiree health coverage:* 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).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Agnes Scott College
Belinda B. Reese
Director of People and Culture
141 E. College Ave.
Decatur, GA 30030
404.471.6221

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

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

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

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health

Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Plan contact information:

Agnes Scott College
Belinda B. Reese
Director of People and Culture
141 E. College Ave.
Decatur, GA 30030
404.471.6221

SUMMARY OF BENEFITS & COVERAGE (SBC) NOTICE

The SBC is designed to help you better understand and evaluate your health insurance choices. The SBC contains the same standard language used by all insurance companies and group health plans to make it easier for you to compare health plans.

The information contained in an SBC includes:

- A short plain language summary about benefits & coverage
- A uniform glossary of health insurance terms

The SBC also includes details, called 'coverage examples', which are comparison tools that allow you to see what the plan would generally cover in two common medical situations.

You may also request a copy of the glossary of terms from your health Insurance Company or group health plan.

Also, if you don't speak English, you may be entitled to receive the SBC and uniform glossary in your native language upon request to your health Insurance Company or group health plan.

In an effort to comply with Affordable Care Act (Healthcare Reform), a copy of the Summary of Benefits & Coverage (SBC) for the plan is uploaded to Employee Navigator (our benefit enrollment system) and our Agnes Scott College intranet.

The SBC is always available by contacting the (Underlying contract) health plan, the Plan Administrator or Third-Party Administrator.

Agnes Scott College
Belinda B. Reese
Director of People and Culture
141 E. College Ave.
Decatur, GA 30030
404.471.6221

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

ERISA NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) OF 1998

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 this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?
Call your Plan Administrator for more information.

QUALIFIED MEDICAL SUPPORT ORDER (QMSO) PROCEDURE & OBLIGATIONS

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health care coverage to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities.

Generally, a state court or agency may require an ERISA covered health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is "qualified." Such an order is referred to as a Qualified Medical Child Support Order (QMCSO). In addition, a State child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified.

QMSOs Coverage Requirements

The QMCSO provisions apply to "group health plans" subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). For this purpose, a "group health plan" generally is a plan that both:

- Is sponsored by an Employer or employee organization (or both) *and*
- provides "medical care" to employees, former employees, or their families.

"Medical care" means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of a disease; for the purpose of affecting any structure or function of the body; transportation primarily for or essential to such care or services; or for insurance covering such care or services.

As used in this booklet, the term "group health plan" refers to that term as defined in section 607(1) of ERISA and means generally any welfare plan established or maintained by an Employer or employee organization (or both) that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

ERISA does not generally apply to plans maintained by: Federal, State or local governments; churches; and Employers solely for purposes of complying with applicable workers compensation or disability laws. However, provisions of the Child Support Performance and Incentive Act (CSPIA) of 1998 require church plans to comply with QMCSOs and National Medical Support Notices, and State and local government plans to comply with National Medical Support Notices.

[ERISA §§ 4(b), 609(a), and 607(1), Internal Revenue Code § 213(d), CSPIA § 401(f)].

QMSO Procedures

Ordinarily, an Employer may receive a Notice when a child support enforcement agency initially enforces an employee's medical support obligation, or when an employee with a previously established medical support obligation is newly hired.

The Notice is comprised of:

- Part A, Notice to Withhold for Health Care Coverage (which includes an Employer Response), and
- Part B, Medical Support Notice to Plan Administrator (which includes a Plan Administrator Response).

If the employee named in the Notice is not an employee of the Employer, if the Employer does not maintain or contribute to a plan that provides dependent coverage, or if the named employee is among a class of employees (e.g. part-time or non-union) not eligible for enrollment in a plan that provides dependent coverage, the Employer must check the appropriate box on the Employer Response and return it to the issuing agency within 20 business days after the date of the Notice (or sooner if reasonable). Otherwise, the Employer must transfer Part B of the Notice to the group health plan (or plans) for which the child may be eligible for enrollment not later than 20 business days after the date of the Notice.

For these purposes, the "date of the Notice" means the date that is indicated as such on the Notice.

If the Employer offers a number of different types of benefits (e.g., dental, prescription) through separate plans, and the issuing agency has not specified which or all are covered by the Notice, the Employer should assume all plans are covered by the Notice and send copies of Part B of the Notice to each Plan Administrator.

The application of a waiting period (such as one requiring that a new employee must be employed for a certain amount of time or work a certain number of hours) before an employee may enroll in the group health plan does not affect the employer's obligation to transfer Part B to the Plan Administrator(s).

When transferring Part B of the Notice, the Employer retains Part A. An Employer that transfers Part B of the Notice to a Plan administrator(s) may later need to use the Employer Response after it has been notified of the qualification of the Notice and has determined that necessary employee contributions cannot be withheld from wages.
[Social Security Act § 466(a)(19), 45 CFR § 303.32(c)]

Obligations of the Plan
A Plan Administrator who receives a National Medical Support Notice must review the Notice and determine whether it is appropriately completed. The administrator must complete the Plan Administrator Response (included with Part B of the Notice), indicating whether the Notice is a QMCSO, and return it to the State agency that issued the Notice within 40 business days after the date of the Notice.
If the Plan Administrator determines that the Notice is appropriately completed, the administrator is required to treat the Notice as a QMCSO. The Plan Administrator must in that case inform the State agency that issued the Notice when coverage under the plan of the child named in the Notice will begin and must provide the custodial parent of the child (or, in some cases, a named State official) with information about the child's coverage under the plan, such as the plan's summary plan description, any forms or documents necessary to make claims under the plan, etc. If the Participant is not enrolled and there is more than one option available under the plan for coverage of the child, the Plan Administrator must also use the Plan Administrator Response to notify the agency of that fact and inform them of the available options for coverage. If the agency does not then respond within 20 business days and the plan has a "default option," the Plan Administrator may enroll the child in the default option. The Department of Labor has issued a regulation, 29 CFR 2590.609-2, that provides guidance on how administrators of group health plans must deal with Notices they receive.
[ERISA § 609(a)(5)(C), 29 CFR § 2590.609-2]

Additional Information
An "appropriately completed" Notice satisfies the informational requirements of the QMCSO provisions by:

- Providing the name and last known mailing address (if any) of the Participant and the name and mailing address of each child covered by the order;
- Having the child support enforcement agency identify either the specific type of coverage or all available group health coverage;
- Instructing the Plan Administrator that if a Notice does not designate either specific type(s) of coverage or all available coverage, it should assume that all are designated, and further instructing the Plan Administrator that if a group health plan has multiple options and the Participant is not enrolled, the agency will make a selection after the Notice is qualified and, if the agency does not respond within 20 business days, the child will be enrolled under the plan's default option if there is one; and
- Specifying that the period of coverage may end for the named child only when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of events specified in the Notice.

A Notice also requires the plan to provide to a named child *only* those benefits that the plan provides to any dependent of a Participant who is enrolled in the plan, and any other benefits that are necessary to meet the requirements of the State laws relating to medical child support.

The following information about ERISA and other laws may be useful sources of information about obtaining health care coverage and medical care for children:

Two agencies in the Department of Health and Human Services play significant roles in the provision of health care coverage to children. The Office of Child Support Enforcement is responsible for establishing standards and providing guidance for the Child Support Enforcement Program under Title IV-D of the Social Security Act.

- Centers for Medicare and Medicaid Services - The Centers for Medicare and Medicaid Services administers Medicaid and the State Children's Health Insurance Program (also known as SCHIP) and provides additional guidance under HIPAA and other recently enacted health-related laws.

- National Child Support Enforcement Association - The National Child Support Enforcement Association (NCSEA) is a nonprofit membership organization comprised primarily of State and local child support enforcement agencies,

- Eastern Regional Inter State Child Support Association (ERICSA) and the Western Inter State Child Support Enforcement Council (WICSEC) are child support enforcement professional organizations focusing on issues of interstate child support enforcement.

Each State has a child support enforcement agency. Sometimes this agency is located in the State Attorney General's office, but it is frequently found as part of the State's department of social or human services.

Additional Information

- National Medical Support Notice - Notice to Withhold for Health Care Coverage, OMB No. 09700222 - This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income.
- Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998.

- National Medical Support Notice - Medical Support Notice to Plan Administrator, OMB No. 1210-0113 - This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974, and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the Plan Administrator under this Notice are in addition to the existing rights and duties established under such law.

NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

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

MENTAL HEALTH PARITY ACT

Under Health Care Reform, most non-grandfathered small group plans are required to cover mental health and substance use disorder services (as one category of "essential health benefits"), at parity with medical and surgical benefits, for plan years starting in 2014.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") generally applies to Employers that employ 50 or more employees and its health plan provides for mental health and substance abuse benefits. (Thus, if your Plan does not currently offer any mental health or substance abuse benefits, then MHPAEA does not apply.) These group health plans must cover mental health and substance abuse services in a manner equal to their coverage of predominant medical and surgical services.

Financial and treatment limits for mental health/substance abuse, such as deductibles, copayments, co-insurance and out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars, scope, or duration of treatment may not be substantially more limited than for medical/surgical benefits provided. For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

USERRA

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- are a past or present member of the uniformed service;
- have applied for membership in the uniformed service; or
- are obligated to serve in the uniformed service; then an employer may not deny you:
  - initial employment;
  - reemployment;
  - retention in employment;
  - promotion; or
  - any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

THE GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MICHELLE'S LAW NOTICE

Eligibility for Continued Coverage for Dependent Students on Medically Necessary Leave of Absence

Michelle's Law applies to group health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law is effective beginning January 1, 2010). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under Agnes Scott College group health plan as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

- begins while the child is suffering from a serious illness or injury,
- is medically necessary, and
- causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed during this one-year period, the plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination With COBRA Continuation Coverage

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Questions?

If you have any questions regarding the information in this notice or your child's right to Michelle's Law's continued coverage, or if you would like a copy of your Summary Plan Description (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact:

ERISA NOTICES

Agnes Scott College
Belinda B. Reese
Director of People and Culture
141 E. College Ave.
Decatur, GA 30030
404.471.6221