



Dear Benefits Officer,

According to federal legislation, Section 1906 [42 U.S.C. 1396e], all states are required to enact a program to identify cases where enrollment of a Medicaid recipient into an Employer Group Health Plan (EGHP) would be cost effective. As a result of this legislation, Pennsylvania's Health Insurance Premium Payment Program (HIPP) was created to identify and purchase these cost-effective EGHP's for Medicaid recipients.

Administered by Pennsylvania's Department of Public Welfare (DPW), the purpose of HIPP is to save taxpayers money that is associated with Medical Assistance (MA) program expenditures each year. Working with Employers, HIPP staff determines the cost effectiveness of Employers Group Health Plans for individual Medical Assistance households and enrolls cost effective families into the HIPP program. Due to this automated process, Pennsylvania's HIPP program generates the highest savings in the nation.

The HIPP program purchases employment related group health insurance for the employee and/or their dependent children based upon the cost to the employer. The HIPP program reimburses the Employee's share of the premium and not the Employer's share of the work related insurance premium.

The purpose of this packet is to provide Employers with a single reference guide to the HIPP Program. This guide includes explanations of HIPP Program requirements, procedures and practices affecting Employers and Medical Assistance Program savings.

Please review this booklet and our website, www.dpw.state.pa.us/HIPP, and direct questions to your [local regional office](#) (see page 2 of the booklet enclosed) or e-mail ra-hipp@state.pa.us.

Thank you,

A handwritten signature in black ink that reads "Veronica E. Ressler". The signature is written in a cursive style.

Veronica Ressler
HIPP Program Director
Department of Public Welfare
Bureau of Program Integrity

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A. HIPP Regional Offices

The Regional Offices are the main point of contact for employers and HIPP recipients. The employee's county of residence dictates the responsible Regional Office.

Regional Office Locations

Chestnut Ridge Regional Office

| | | | | |
|-------------------------|------------------|-----------|---------|------------|
| HIPP Program | Counties: | Allegheny | Clarion | Jefferson |
| P. O. Box H | | Armstrong | Elk | Washington |
| Torrance, PA 15779-0115 | | Beaver | Greene | |
| (724) 459-3119 | | | | |
| (800) 684-7730 | | | | |

Clark Summit Regional Office

| | | | | |
|-----------------------------------|------------------|------------|--------------|-------------|
| HIPP Program | Counties: | Bucks | Monroe | Pike |
| 1451 Hillside Drive – Newton Hall | | Chester | Montgomery | Susquehanna |
| Clarks Summit, PA 18411 | | Delaware | Northampton | Wayne |
| (570) 587-9661 | | Lackawanna | Philadelphia | Wyoming |
| (888) 819-9206 | | Luzerne | | |

Harrisburg Regional Office

| | | | | |
|---------------------------|------------------|------------|----------------|------------|
| HIPP Program | Counties: | Adams | Dauphin | Perry |
| P. O. Box 8195 | | Armstrong | Lancaster | Schuylkill |
| Harrisburg, PA 17105-8195 | | Bradford | Lebanon | Snyder |
| (717) 705-8134 | | Carbon | Lehigh | Sullivan |
| (800) 644-7730 | | Centre | Lycoming | Tioga |
| | | Clinton | Mifflin | Union |
| | | Columbia | Montour | York |
| | | Cumberland | Northumberland | |

Torrance Regional Office

| | | | | |
|-------------------------|------------------|------------|------------|--------------|
| HIPP Program | Counties: | Bedford | Fayette | Juniata |
| P. O. Box H | | Blair | Franklin | Potter |
| Torrance, PA 15779-0115 | | Cambria | Fulton | Somerset |
| (724) 459-3124 | | Cameron | Huntingdon | Westmoreland |
| (800) 684-7730 | | Clearfield | Indiana | |

Warren Regional Office

| | | | | |
|--------------------|------------------|----------|----------|---------|
| HIPP Program | Counties: | Butler | Forest | Mercer |
| 589 Hospital Drive | | Crawford | Lawrence | Venango |
| Suite D. | | Erie | Mckean | Warren |
| Warren, PA 16365 | | | | |
| (814) 726-4122 | | | | |
| (800) 440-9391 | | | | |

B. HIPP Program Glossary

Acronyms

Definitions

| | |
|---------------------|--|
| HIPP | Health Insurance Premium Payment Program |
| HSA | Health Savings Account |
| HDHP | High Deductible Health Plan |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| Creditable Coverage | <i>Continuous period</i> of participation in a group health insurance plan, individual health insurance plan, Medicaid or government health plan |
| Continuous Period | A period without interruption in coverage of more than 63 days |
| TPL | Third Party Liability |
| Medicaid | Medical Assistance both federally and state funded |
| CIS | Client Information System – DPW’s main computer system |
| CAO | County Assistance Office |
| COBRA | Consolidated Budget Reconciliation Act |
| EGHP | Employer Group Health Plan |
| FFS | Fee For Service |
| MA | Medical Assistance – Medicaid |
| TANF | Temporary Assistance for Needy Families |
| MC | Managed Care |
| HOS | HIPP Operation Specialist |
| VT | Voucher Transmittal |
| RE | Remittance Explanation |

C. Introduction

Pennsylvania's Department of Public Welfare (DPW), manages the HIPP program that is a federally mandated cost containment program designed to identify Employment Related health insurance benefits available to active Medical Assistance recipients.

The HIPP Program's main responsibility is to identify Medical Assistance recipients with access to medical insurance through employment and to evaluate the cost effectiveness of enrolling those recipients into private health insurance.

Referrals to the HIPP program primarily generate from County Assistance Office staff identifying the availability of employment-related group health insurance during the application process. Along with the County Assistance Office referrals, HIPP receives referrals from other State agencies and departments.

D. HIPP Operations Unit

The HIPP Operational Unit consists of five Regional Offices located throughout the state. These Regional Offices receive and process HIPP referrals. During processing, a HOS will determine the cost effectiveness of purchasing the EGHP insurance. The HOS will serve as the employer contact and will work with the employer to verify the group plans and the benefits included within the plan. Also, the Regional Office updates demographic and program eligibility changes received from phone calls or change report forms and completed quarterly or annual cost effectiveness Re-Evaluations.

E. HIPP Enrollment Process

Referrals

HIPP mails approximately 8,000 [referral letters](#) each week to potential eligible Medicaid recipients. The completed referral forms are then returned to HIPP Regional Office for review and cost analysis.

Employer Contact

During the cost analysis process, a HIPP Operation Specialist (HOS) contacts the MA recipient's employer to verify the medical insurance cost, included benefits, and deductible amounts. The HOS then follows up the initial phone contact with a FAX or the [HIPP Employer Benefit Survey](#) to the Employer requesting written verification of the insurance benefits and costs.

If an employee is found eligible for the HIPP program, the HOS will send the employee and employer an [eligibility letter](#) informing them of their enrollment.

Establishing Payment Methods

When a HOS is enrolling an employee into the HIPP program, they will contact the employer to set up a payment method. There are 3 types of payment methods available.

1. Payment to Employer

The Payment to Employer Method is when the premium payment check is made out to the employer and is sent directly to the employer. This method is the preferred

payment method unless a direct payment to the employer is impossible to accommodate.

2. Payment to Employee c/o Employer

The Payment to Employee c/o Employer method is when a premium payment check is made out to the employee but is sent directly to the employer. This is the second choice in payment methods.

3. Payment to Employee

The Payment to Employee method is when a check is made out to the employee and is sent directly to their home. This method is only used when the first two methods cannot be accommodated.

Premium checks are created on the 14th and will be sent out to the payee in time for the following month's premium due date. A monthly [Remittance Explanation Notice](#) is mailed out to the HIPP payee providing the period for the payment and the payment amount.

F. HIPP Program Re-Evaluations

Households enrolled with the HIPP program are required to have their program eligibility evaluated annually. For families receiving payment directly, the re-evaluations are required every three months.

Interim Re-evaluation

If a case is set to employee pay, the region will contact the employer every 3 months for an Interim Re-evaluation. Once a case is determined to be an Interim Reevaluation, a [Yearly Fax Coversheet](#) is sent to the employer. At this time the region contacts the employer to verify the following:

1. Employment and Continued Enrollment of all HIPP recipients in the Employer Group Health Plan (EGHP)
2. The premium amount and frequency

Annual Re-Evaluation

Every case that is enrolled will have an annual re-evaluation. The HIPP Regional Office will send the [Yearly Fax Coversheet](#) to the employer to verify the following:

1. Employment and Continued Enrollment in the Employer Group Health Plan (EGHP)
2. Insurance Information
 - a. Plan Type
 - b. Supplemental Benefits (Prescription Drugs, Dental, Vision)
 - c. Co-pays and deductibles
 - d. Policy Limitations
 - e. The premium amount and frequency
 - f. For insurance plan changes, verification of the correct group and policy numbers
 - g. Effective dates of reported changes
 - h. The day and date of the last pay

G. HIPP Program Overpayments

An overpayment of HIPP payments occurs when the check amount exceeds the actual premium amount due. This may occur for unreported employment terminations, the family losing their eligibility for Medical Assistance programs or various reasons concerning HIPP eligibility.

Overpayments – First Warning

When an overpayment occurs, HIPP generates a Remittance Explanation to notify the payee of the overpayment and provides the timeframes for repayment. Instructs the payee that repayment is due within 60 days along with the following information:

1. Time period of overpayment
2. Amount of the overpayment
3. Instructions to return the payment to the RE's return address

Overpayments – Second Warning

Repayments not received by the 60th day generate a Second Warning notifying the payee that they have 30 days to repay the overpayment.

Note:

- ***If partial payments are received, a First Warning Remittance Explanation is sent for the remaining balance.***

Overpayments – Repayment Methods

HIPP payments may be repaid by:

1. Check or money order:

The payee may mail a check or money order to the HIPP Program to cover the amount of the overpayment. The Check or money order is made payable to the Commonwealth of Pennsylvania and mailed to:

Department of Public Welfare
HIPP Program
P O Box 8195
Harrisburg, PA 17105-8195

2. Return the original check

The payee may also return the original Commonwealth check to the HIPP program when they know they have received the check in error. This check is mailed to the **above** address.

H. Rules and Regulations

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This [HIPAA privacy rule](#) established federal safeguards to help protect an individual's personal health information. The Act gives patients a myriad of rights in order to protect their information. In conjunction with protecting an individual's privacy, it allows for the disclosure of this information when it is needed for patient care and other pertinent purposes.

Based on 45CFR, Part 164.506 (Standards for privacy of Individually Identifiable Health Insurance; Final Rule), the HIPAA Privacy Rule allows the release or disclosure of Protected Health Information without consent or authorization for the purposes of "Treatment, Payment or Health Care Operations". The HIPP program obtains information for paying claims and health care operations and therefore HIPP falls under this HIPAA exclusion.

Preexisting Condition

According to HIPAA, a preexisting condition is defined as a condition that has received medical advice, diagnosis, care, or treatment within the 6-month period prior to an individual's enrollment date. After an individual is enrolled, their preexisting condition may not be rejected by a group health plan's coverage for more than 12 months or 18 months for late enrollees. If an individual had previous health care coverage for a continuous period of 63 days or more, the new health plan must credit the entire time they had previous coverage. This in turn reduces or eliminates the 12 or 18 month exclusion period.

Creditable Coverage

Creditable coverage is defined as a continuous period that has no interruption of health care coverage for more than 63 days. This coverage can be provided by a group health plan, individual health plan, Medicaid, or other government health plan. What this means is if an individual has a preexisting condition and switched to a new health care provider, the new provider cannot subject the individual to the preexisting condition exclusion. The new healthcare provider must cover the individual's condition if they meet the Creditable Coverage criteria.

Note:

- ***A waiting period or affirmation period does not constitute a break in coverage***
- ***Pregnancy is not a preexisting condition and not excluded from medical coverage.***

Pennsylvania Autism Insurance Act (Act 62)

The Pennsylvania Autism Insurance Act, Act 62, requires many private health insurance companies to cover the cost of diagnostic assessment and treatment of autism spectrum disorder and services for children under the age of 21, up to \$36,000 per year. It also requires the Pennsylvania Department of Public Welfare, DPW, to cover the cost of services for individuals who are enrolled in the Medical Assistance program and do not have private insurance coverage, or for individuals whose costs exceed \$36,000 in one year. The Pennsylvania Department of State is required to license professional behavior specialists who provide services to children.

Who is covered by the Autism Insurance Act?

Children or young adults under age 21 with a diagnosis of an autism spectrum disorder who:

- Are covered under an employer group health insurance policy (including HMOs and PPOs) that has more than 50 employees and the policy is not a "self-insured" or "ERISA" policy; Although some self insured plans are including this coverage i.e. PEBTF
- Are on Medical Assistance; or
- Are covered by Pennsylvania's Children's Health Insurance Program, CHIP, or Adult Basic.

Consolidated Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers with group health plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status (referred to as "qualifying events").

Qualifying Event

The Qualifying Event may be any of the events listed below that cause a person to lose coverage under a group health plan subject to COBRA requirements:

- A covered employee's reduction in hours or termination of employment for any reasons other than gross misconduct
- A covered employee's death
- A covered employee's divorce or legal separation from the spouse
- A covered employee's entitlement to Medicare under Title XVIII of the Social Security Act
- A child's loss of dependent status under the generally applicable eligibility requirements of the plan
- An employer's commencement of a title 11 bankruptcy proceeding that causes a retiree (or retiree's spouse or child) a substantial loss or elimination of coverage within one year of the filing

COBRA Exempt Employers

COBRA exempts employers of less than 20 employees, Churches and the Federal Government from participating in COBRA.

I. HIPP Employer Letters

Certificate of Medical Assistance Coverage

The Certificate of Medical Assistance Coverage verifies the Employees prior health coverage for individuals with preexisting medical conditions. HIPP provides this Certificate to Employees when the Employers Group Health Insurance coverage excludes coverage for certain medical conditions.

CHIPRA 2009

The CHIPRA 2009 letter is sent out to employers to explain and inform them about the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"). This law permits an exchange of information between Employers and the HIPP program to help determine an employee's eligibility.

COBRA Subrogation Notice

The COBRA Subrogation Notice is sent out to employers to inform them of an employee's eligibility to be enrolled into COBRA. This informs employers that HIPP is able to enact on the behalf of the client to enroll them into COBRA.

CHIPRA also requires that group health plans provide special enrollment rights for the employee or dependent who becomes eligible for assistance. Group health plans must permit employees and their eligible dependents to enroll in the plan if they (Including self-insured plans): lose Medicaid or CHIP coverage; or become eligible to participate in a Medicaid or CHIP premium assistance program.

Employee Benefits Survey

To verify the Employee's group health insurance benefits the Regional Office mails to the Employer the Employer Benefit Survey. This Survey identifies the Employee by name and the last four digits of their Social Security Number.

Employer Agreement/Confirmation Notice

The HIPP Employer Agreement/Confirmation Notice authenticates a family's enrollment in the HIPP Program. This letter requests the Employer to verify information and return the signed letter to the Regional Office.

Discontinuance Notice/Discontinuance Notice – Level of Coverage

The Discontinuance Notice notifies both the Employee and Employer upon the disenrollment of a Household from the HIPP program.

The notice includes the date of HIPP closure, the names of individuals no longer eligible for the program, the reason for discontinuance and the overpayment amount if applicable.

HIPAA - Protected Health Information

This is a letter sent out to employers to explain the Health Insurance Portability and Accountability Act of 1996 (HIPAA) — Release of Protected Health Information to the Department of Public Welfare Without Authorization or Opportunity to Object, Pursuant to 45 C.F.R. § 164.506(c)(3).

House Bill 1168

This letter is sent out to employers to explain that effective July 7, 2005, per Act 2005-42, 62 P.S. Section 1415 (2008), companies are required upon request from the Department of Public Welfare's Health Insurance Premium Payment (HIPP) Program to provide the benefit information needed to determine the eligibility of a medical assistance recipient for employee group healthcare coverage.

Every insurer shall honor a request for enrollment and purchase of employee group health insurance submitted by the department with respect to a medical assistance recipient with consideration for enrollment season restrictions, but no enrollment restrictions shall delay enrollment more than ninety days from the date of the department's request.

Newborn Fax

When a client reports a newborn in the household, this letter will get sent out to employer to verify health insurance coverage information

Referral Letter

This document is sent out to potential clients when a HIPP Regional office receives a referral notice from the CAO or other source.

Remittance Explanation

The Remittance Explanation is mailed monthly to the HIPP Payee. This form reflects the HIPP payment sent to cover the employee's portion of the premium for their health insurance.

Note:

- ***HIPP Remittance Explanations and HIPP Payment Checks mail separately.***

Yearly Reeval Fax Coversheet

Every case that is enrolled will have an annual re-evaluation. The HIPP Regional Office contacts the employer to verify information by sending out the Yearly Reeval Fax Coversheet.

19 Year Old Fax

When a child in the household is turning 19, the regional office will send this fax to verify whether or not there will be insurance coverage for the child when they turn 19.

J. Frequently Asked Questions

What is HIPP?

The purpose of the HIPP Program is to save taxpayer dollars by purchasing cost effective employment related medical insurance available to medical insurance to Medical Assistance clients.

Who is eligible for HIPP?

Active Medical Assistance recipients who are eligible for medical insurance through employment are referred to HIPP.

How is eligibility determined?

A HIPP Operation Specialist (HOS) conducts a review of the medical insurance that is available through the employer. They will conduct a cost analysis based on the amount of the premium and the policy benefits that are offered. If the Medical Assistance costs for a client are greater than the cost of the employer insurance, the client is enrolled into the HIPP Program.

How much money will it cost me?

Your cost will be the same as for any employee who chooses to participate in your group health benefits.

Why pay for only some employee's health insurance premium and not others?

The Department is paying the premium to save taxpayers money, not to give Medicaid recipients additional benefits.

Are welfare payments income?

According to the IRS Publication 17, welfare payments are not income. If an employer has questions about pre-tax payments they must consult their own tax lawyer.

What does Cost-Effective mean?

Cost-Effective is when it's less expensive to purchase employer-related medical coverage in order to pay medical expenses than having the medical expenses paid by Medical Assistance.

APPENDIX

CERTIFICATE OF MEDICAL ASSISTANCE COVERAGE

PAGE 1



February 2, 2011

John Smith
123 ABC Lane
Apartment 4
Harrisburg, PA 17105

Important Notice of Your Right to Documentation of Health Coverage

RE: JOHN SMITH

Recent changes in Federal Law may affect health coverage for persons who are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). This exclusion period is reduced by the number of months you were enrolled in your prior health coverage. If you buy health insurance other than through an employer group plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion.

Enclosed is a certificate of prior health coverage, provided through Pennsylvania's Department of Public Welfare, based on information currently available. You may need to provide other documentation for earlier periods of health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

Mary Jones
HIP Representative
717-555-1802
1-800-644-7730
maryjones@state.pa.us
67/0001234

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CERTIFICATE OF MEDICAL ASSISTANCE COVERAGE

PAGE 2



February 2, 2011

Certificate of Medical Assistance Coverage

PLAN PARTICIPANT:

SSN: XXX-XX-1234

John Smith
123 ABC Lane
Apartment 4
Harrisburg, PA 17105

This information is supplied for:

| NAME | RELATIONSHIP TO PARTICIPANT | SSN |
|--------------|-----------------------------|-------------|
| Jane Smith | Wife | XXX-XX-2345 |
| Jordan Smith | Son | XXX-XX-3456 |

| MEDICAL COVERAGE | DATE COVERAGE STARTED |
|------------------|-----------------------|
| Medical | 02/1/11 |

IMPORTANT:

This Certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions. This certificate may be necessary if medical advice, diagnosis, care, or treatment was recommended or received for the excluded condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that excludes coverage for medical conditions that are present before you enroll.

Mary Jones
HIPP Representative
717-555-1802
1-800-644-7730
maryjones@state.pa.us
67/0001234

E04 09/10

CHIPRA OF 2009



February 3, 2011

ACME INC
224 HESS DRIVE
SUITE 120
HARRISBURG, PA 17105

Dear Benefits Officer:

Effective April 1, 2009, Section 311 of the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") requires all Employers and/or Plan Administrators to disclose upon request from the Department of Public Welfare Health Insurance Premium Payment (HIPP) benefit information sufficient to permit HIPP to determine the cost effectiveness of providing medical or child health assistance through premium assistance for the purchase of coverage under the group health plan.

CHIPRA also requires that group health plans provide special enrollment rights for the employee or dependent who becomes eligible for assistance. Group health plans must permit employees and their eligible dependents to enroll in the plan if they (Including self-insured plans):

- Lose Medicaid or CHIP coverage; or
- Become eligible to participate in a Medicaid or CHIP premium assistance program.

These individuals will have 60 days to request special enrollment in the group health plan.

Please contact Daron Morrill at (717)772-6370 with questions concerning CHIPRA.

Sincerely,

Mary Jones
HIPP Representative
717-555-1820 or 1-800-644-7730
maryjones@state.pa.us
717-555-1920 FAX

67/0001234

E17 09/10

COBRA SUBROGATION LETTER



February 2, 2011

John Smith
123 ABC Lane
Apartment 4
Harrisburg, PA 17105

RE: SMITH< JOHN
XXX-XX-1234

Dear COBRA Unit:

The Department of Public Welfare's Health Insurance Premium Payment program (HIPP) will begin making health insurance premium payments on behalf of JOHN SMITH. It is my understanding that he/she has the option of continuing healthcare coverage through COBRA. It is also my understanding that he/she has not yet elected to continue this coverage. Please consider this notice as JOHN SMITH'S agreement to continue his/her medical coverage. This is pursuant to our rights of subrogation under Public Law 31 Section 1404(B) of the Public Welfare Code.

Payment of the premiums will begin 03/1/11 at which time you will receive payment for coverage period 03/1/11 through 11/1/11. The total amount of the initial check will be \$625.30. You will receive \$450.27 from the Department every month thereafter as long as our client remains eligible for the HIPP program.

Mary Jones
HIPP Representative
717-555-1820
800-644-7730
maryjones@state.pa.us
717-555-1920 FAX
Harrisburg Region
Willow Oak Bldg Rm 316
PO BOX 8195
HARRISBURG, PA 17105-8195

67/0001234

E05 09/10

Bureau of Program Integrity | Division of Third Party Liability | Health Insurance Premium Payment Program
Central Office Regional Office | PO Box 8195 | Harrisburg, PA 17105-8195
www.dpw.state.pa.us/HIPP

DISCONTINUANCE NOTICE



February 2, 2011

John Smith
123 ABC Lane
Apartment 4
Harrisburg, PA 17105

Discontinuance Notice

THIS NOTICE PERTAINS TO YOUR HIPP PREMIUM PAYMENT ONLY

Based on the information below, Health Insurance Premium Payments will be discontinued for the indicated recipients effective **02/28/11**. You may wish to contact your carrier for the date your coverage will lapse and/or to make arrangements for the payment of future insurance premiums in order to keep your insurance coverage in force.

This action affects the following: John Smith, Jane Smith, Jordan Smith

The above recipient(s) is/are being disenrolled from the HIPP Program because **<reason>**.

In order to comply with federal requirements of the Medicaid program, the Department of Public Welfare has the power to disenroll clients from group health plans without imposing personal liability upon the client. Accordingly, group health plans must honor a request for disenrollment submitted by the Department of Public Welfare whenever it is no longer cost effective for the Department of Public Welfare to pay the health insurance premium or when the recipient is no longer eligible for Medical Assistance.

Mary Jones
HIPP Representative
717-555-1820
800-644-7730
maryjones@state.pa.us

cc: ACME INC.
67/0001234

R02 09/10

DISCONTINUANCE NOTICE - LEVEL OF COVERAGE



February 2, 2011

John Smith
123 ABC Lane
Apartment 4
Harrisburg, PA 17105

Discontinuance Notice – Level of Coverage Change

THIS NOTICE PERTAINS TO YOUR HIPP PREMIUM PAYMENT ONLY

The HIPP Program has received notice that **Jane Smith and Jordan Smith** is no longer eligible for Medical Assistance. **Jane Smith and Jordan Smith** will no longer be eligible for the HIPP Program effective **02/28/11**. After **02/28/11**, the HIPP Program will reimburse 220.57 monthly for Family level of coverage.

You may wish to contact your carrier/employer for the date your coverage will lapse and/or to make payment arrangements to keep your current level of insurance coverage in force.

In order to comply with federal requirements of the Medicaid program, the Department of Public Welfare has the authority to disenroll clients from group health plans without imposing personal liability upon the client. Accordingly, group health plans must honor a request for disenrollment submitted by the Department of Public Welfare whenever it is no longer cost effective for the Department of Public Welfare to pay the health insurance premium or when the recipient is no longer eligible for Medical Assistance.

Mary Jones
HIPP Representative
717-555-1820
800-644-7730
maryjones@state.pa.us

cc: ACME INC.
67/0001234

R20 09/10

EMPLOYEE BENEFITS SURVERY

PAGE 1



February 2, 2011

ACME INC
ATTN: EMPLOYEE BENEFITS COORDINATOR
224 HESS DRIVE
SUITE 120
HARRISBURG, PA 17105

Dear Employee Benefits Coordinator:

The Pennsylvania Department of Public Welfare's Health Insurance Premium Payment (HIPP) program is in the process of reviewing eligibility for the household of your employee, SMITH, JOHN, SSN XXX-XX-1234.

To determine eligibility, the HIPP Program is requesting the information below. This information is being requested in accordance with PA Public Welfare Code 62 P.S. Section 1415 (a) which states the Department is authorized to purchase employee group health care coverage on behalf of any medical assistance recipient whenever it is cost effective to do so. **If this client is determined eligible, a HIPP representative will contact you to make enrollment and payment arrangements.**

Please submit the following information:

1. Is the employee/dependents eligible for your Group Health Insurance Plan(s)?
 Yes No

2. Is anyone in the household, including the employee, currently enrolled in the insurance?
 Yes No
 If yes, please indicate who: _____
 Date enrolled: _____

3. Your employer's Federal ID #: _____

4. On what date can your employee/dependents enroll in the insurance or change the level of current enrollment? ____/____/____
 Plan Anniversary/rate change date: ____/____/____
 COBRA enrollment period: Begin Date ____/____/____ End Date ____/____/____
 Pre-existing clause applicable? Yes No
 Time length of pre-existing clause: _____
 Is your health insurance self funded? Yes No

5. Please supply your insurance carriers' Name and Address below. Indicate if your health insurance coverage type is: PPO POS HMO

67/0001234



| Health Insurance | Dental Insurance | Vision Insurance | Prescription |
|------------------|------------------|------------------|--------------|
| Phone no. | Phone no. | Phone no. | Phone no. |
| Group no. | Group no. | Group no. | Group no. |
| Deductible | Deductible | Deductible | Deductible |
| | | | Co-Pay |

Does the plan include Autism Spectrum Disorder in accordance with the PA Autism Insurance Act (Act 62)? Yes No

6. Employee's payroll deduction amount: (If you offer multiple plans or options, please duplicate this form for each plan.)

The HIPP Program will only purchase employment related group health insurance premiums for the employee and/or their dependents based upon what the employee's costs are; and **does not** reimburse any of the employer's portion of their employment related group health insurance premiums.

PLEASE INCLUDE ALL PREMIUM RATES

| Level of Coverage | *Active Employee's Contribution Amount | Frequency | COBRA Rate per Month |
|---------------------|--|-----------|----------------------|
| Individual | | | |
| Family | | | |
| Parent and Child | | | |
| Parent and Children | | | |
| Husband and Wife | | | |

***If dental and vision rates are separate from the plan, please include the rates.**

7. When was your last pay day and date? _____
8. Person to contact for further information:
 Name: _____
 Title: _____
 Phone: _____ Ext: _____ Fax: _____
 Email: _____

67/0001234



Please include a Summary of Benefits for the health, dental and vision insurance your company offers.

Thank you for your assistance. If you have any questions, please contact me at the number listed below. Please return this letter via fax or mail to the address listed below.

Mary Jones
HIPP Representative
717-555-1820
800-644-7730
maryjones@state.pa.us
717-555-1920 FAX
Harrisburg Region
Willow Oak Bldg Rm 316
PO BOX 8195
HARRISBURG, PA 17105-8195
67/0001234

E01 02/11

Bureau of Program Integrity | Division of Third Party Liability | Health Insurance Premium Payment Program
Central Office Regional Office | PO Box 8195 | Harrisburg, PA 17105-8195
www.dpw.state.pa.us/HIPP

EMPLOYER AGREEMENT CONFIRMATION NOTICE

PAGE 1



February 2, 2011

ACME INC
224 HESS DRIVE
SUITE 120
HARRISBURG, PA 17105

Health Insurance Premium Payment Agreement/Confirmation Notice

ATTN: CINDY MIKES

FIN: 0123456789

The Pennsylvania Department of Public Welfare's Health Insurance Premium Payment (HIPP) Program operates in accordance with Section 1906 of the Social Security Act. This legislation requires states to pay the premiums for employment related group health insurance available to Medical Assistance recipients, when it is cost effective.

The HIPP Program will only purchase employment related group health insurance premiums for the employee and/or their dependents based upon what the employee's costs are **and does not** reimburse any of the employer's portion of their employment related group health insurance premiums.

Your employee, or COBRA continuant, has been approved for the HIPP Program. Please verify the information listed below, and return this notice, via mail or fax, upon completion. HIPP will purchase the level of coverage listed below for the recipients listed below and the employee may add other family members.

EMPLOYEE NAME

John Smith

HEALTH INSURANCE PLAN / ADDRESS

HIGHMARK BC/BS
FIFTH AVENUE PLACE
PITTSBURGH, PA 15222-0000

POLICY #

XXXXXXXX1234

LEVEL OF COVERAGE PAID BY HIPP

Family

PAY DATE

02/18/11

GROUP #

0123456

EMPLOYEE'S CONTRIBUTION

\$450.65/Monthly

HEALTH INSURANCE DEDUCTIBLES

PPO Min: \$100

SUPPLEMENTAL PLAN

Dental DELTA DENTAL OF PA

SUPPLEMENTAL DEDUCTIBLE/COPAY

Min: \$50 Max: \$150

PAYMENT MADE TO

ACME INC.
224 HESS DRIVE
SUITE 120
HARRISBURG, PA 17105

AMOUNT OF FIRST CHECK

\$450.65 02/1/11-02/28/11

67/0001234

Bureau of Program Integrity | Division of Third Party Liability | Health Insurance Premium Payment Program
Central Office Regional Office | PO Box 8195 | Harrisburg, PA 17105-8195
www.dpw.state.pa.us/HIPP

EMPLOYER AGREEMENT/CONFIRMATION NOTICE

PAGE 2



HIPP ELIGIBILITY DATE

02/01/11

DATE OF FIRST PAYMENT

03/1/11

COBRA ELECTION DATE

02/28/11

COBRA TERMINATION DATE

00/00/00

You are requested to verify that the employee, or COBRA continuant, has cooperated and is enrolled in the health insurance plan(s) indicated above. **If there is an additional cost due to adding other family members the employee would be responsible for the additional expense.** If the individual has not complied by your enrollment deadline or within 10 days from the date of this notice, whichever occurs first, please notify us immediately.

I confirm the above information used to determine HIPP eligibility is correct, and the individuals listed below have been enrolled in our company's health insurance plan.

John Smith, Jane Smith, Jordan Smith

YES **NO**

Our company will accept payments from the Department on behalf of an employee(s) eligible for the HIPP Program. We agree to promptly report any changes in services, termination of employment, termination of coverage or change in premium to the Department. We agree to reimburse the Commonwealth for any payment made to us in error.

The terms of this agreement shall remain in effect for as long as the employer group health insurance plan meets HIPP cost-effectiveness criteria and the Medicaid-eligible member(s) of the household is/are covered by the employer group health insurance plan. If the member(s) of the household, who are covered by the employer group health insurance, are no longer eligible for HIPP, the employee shall be given the option of continuing the coverage from his/her own funds. Should the employee elect not to continue the coverage from his/her own funds, a request for disenrollment from the employer group health insurance, effective on the HIPP discontinuance date, shall be honored.

Signature of Employer Representative Title Date

Please complete and return both pages via fax or mail to the HIPP Program within 10 days.

Thank you in advance for your cooperation.

Mary Jones
HIPP Representative
717-555-1820
800-644-7730
maryjones@state.pa.us
717-555-1920 FAX

67/0001234

E09 09/10



February 2, 2011

ACME INC
224 HESS DRIVE
SUITE 120
HARRISBURG, PA 17105

RE: Health Insurance Portability and Accountability Act of 1996 (HIPAA) — Release of Protected Health Information to the Department of Public Welfare Without Authorization or Opportunity to Object, Pursuant to 45 C.F.R. § 164.506(c)(3)

Dear Benefits Officer:

I write this on behalf of the Department's Third Party Liability (TPL) staff, who request protected health information (PHI) from your company for the purpose of determining our respective payment liability for our mutual clients/subscribers. TPL staff must obtain coverage and claim-related information for the purpose of determining and verifying the extent to which Medicaid (MA), private insurance and/or other third party payors are responsible for the payment of client medical services. As you may know, HIPAA does not require the Department to obtain an authorization before this information may be released to her as a TPL staff member.

In determining payment liability, all covered health plans (such as MA and your company) face many of the same issues and obstacles under HIPAA. Generally, these covered health plans agree that they, as well as the Department, may disclose PHI to another covered health plan (or other covered entity) for the payment activities of either entity. See 45 C.F.R. §§ 164.506(c), which provides that without authorization, a covered entity may release PHI to another covered entity also for the payment activities of the entity that receives the PHI. As such, your company, a covered health plan/entity, may release PHI to the Department, another covered entity, for the Department's payment activities without authorization. Indeed, releasing PHI to the Department is also for the payment activities of your company, where the purpose of release involves determining the extent of its own payment responsibility. HIPAA permits disclosure for a covered entity's own payment activities under 45 C.F.R. § 164.506(c)(1).

Because this regulation so clearly authorizes insurance companies and other covered health plans, etc. to disclose PHI to the Department for payment purposes, our TPL staff continue receive PHI freely from these covered entities post-HIPAA—for example, Capital Blue Cross, Blue Shield/Highmark, AARP/United Health Care and Keystone Health Plan. Requiring client authorization as a prerequisite to obtaining payment information would unnecessarily cripple the Department's ability to conduct its normal payment and healthcare operations. Because companies like yours must also obtain third party payor information for their own payment and healthcare operations, 45 C.F.R. § 164.506 is equally helpful for achieving that goal.

Thank you for taking the time to consider this. TPL staff will likely contact you shortly.

Sincerely,

A handwritten signature in black ink that reads "Diana C. Clark". The signature is written in a cursive, flowing style.

Diana C. Clark
Assistant Counsel

Telephone: 717-783-2800
Facsimile: 717-772-0717
Email: diclark@state.pa.us

67/0001234

E12 09/10



February 3, 2011

ACME INC
224 HESS DRIVE
SUITE 120
HARRISBURG, PA 17105

Dear Benefits Officer:

Effective July 7, 2005, Act 2005-42, 62 P.S. Section 1415 (2008) requires your company upon request from the Department of Public Welfare Health Insurance Premium Payment (HIPP) Program to provide benefit information needed to determine the eligibility of a medical assistance recipient for employee group healthcare coverage. The Act 42 provisions apply to all entities providing healthcare coverage within the Commonwealth, including third party administrators of self-insured plans subject to the Employee Retirement Income Security Act (ERISA).

Every insurer shall honor a request for enrollment and purchase of employee group health insurance submitted by the department with respect to a medical assistance recipient with consideration for enrollment season restrictions, but no enrollment restrictions shall delay enrollment more than ninety days from the date of the department's request. Once enrolled, the insurer shall honor a request for disenrollment submitted by the department, without imposing personal liability upon the medical assistance recipient, whenever it is no longer cost effective for the department to pay the premiums or when the recipient is no longer eligible for medical assistance.

Please contact Daron Morrill at (717)772-6370 for questions concerning House Bill 1168.

Sincerely,

Mary Jones
HIPP Operations Specialist
717-555-1820 or 1-800-644-7730
maryjones@state.pa.us
717-555-1920 FAX

67/0001234

E11 09/10

NEWBORN FAX



FAX

TO CINDY MIKES
ACME INC.

FROM Mary Jones
HIPP Program

FAX 717-444-1234

FAX 717-555-1902

PHONE 717-444-1243

PHONE 717-555-1802
800-644-7730

DATE February 2, 2011

EMAIL maryjones@state.pa.us

PAGES 1

Employee name: SMITH, JOHN

We are reviewing the above mentioned employee for continued eligibility in the HIPP program. Please complete and return this form via fax before **02/28/11**.

Has **SMITH, JOHN** added their newborn JAMIE SMITH, to the health insurance coverage? Yes No

If yes, what is the cost of the health insurance with the newborn included? _____

Effective date of change: _____

Current carrier: Basic - HIGHMARK BC/BS
Current generic RX co-pay: \$10
Premium paid by HIPP: \$450.27/Monthly Family

In-Network Deductible: Individual: \$_____ Family Maximum: \$_____
(Please include a copy of the Summary of Benefits if the carrier or policy has changed)

Are there any other changes to the health insurance? _____

Provide contact person's name, phone/fax number **if different** from above:

If you have any questions, please call me at 717-555-1802 or 800-644-7730. Thank you for your assistance.

Note: This information contains Protected Health Information that is strictly confidential and legally privileged. It is to be delivered promptly to the addressee and read by that person only. PLEASE NOTE: The HIPAA Privacy Rule creates stringent penalties for covered entities that violate the privacy rule.

The documents accompanying this FAX transmission contain information that is private, confidential or legally privileged. The information is intended only for the use of the individual or entity named on this FAX sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this FAXED information is strictly prohibited.

67/0001234

E18 09/10

REFERRAL LETTER

PAGE 1

ADDRESS
ADDRESS LINE 1
ADDRESS LINE 2
ADDRESS LINE 3
ADDRESS LINE 4



System Code:
Region #:
C/R #:
Telephone #:

NAME
ADDRESS LINE 1
ADDRESS LINE 2
ADDRESS LINE 3

Date:

THIS LETTER REQUIRES YOUR IMMEDIATE ATTENTION

Dear Medical Assistance Applicant/Recipient:

Our records show that you or someone who lives with you may be working or recently lost a job. This means that employer group health insurance (health coverage offered by your employer) may be available to you or other members of your family.

The Department of Public Welfare, DPW, may buy this employer-sponsored insurance for you if it is available, in addition to providing coverage through Medical Assistance, MA. This is important for two reasons:

- Your employer's insurance plan may provide **more coverage to you and your family** than MA; and,
- Because employers often help pay a portion of the cost, this type of insurance typically costs less than MA. The money saved can be used to provide additional services to more Pennsylvania citizens.

According to DPW policy, 55 Pa.Code §§178.1(g) and 178.6, it is a condition of MA eligibility that you cooperate with DPW in determining the availability of third party resources to pay your medical expenses. **To remain eligible for MA, you must complete and return the form on the back of this letter within 10 days of receipt.** If you have any questions or need help completing this required form, please contact us at <Regional_Office_800_Number>.

DPW staff will evaluate the information you provide in your response. You will receive an enrollment notice for the Health Insurance Premium Payment, HIPP, Program if you qualify. **DPW will not pay your insurance premiums until we determine that you are eligible and send you an enrollment notice.** After you are enrolled in an employer group health plan, you will need to show both your ACCESS card and the new employer insurance card when you receive medical services and/or have a prescription filled.

Thank you for taking the time to respond to this letter regarding your health insurance coverage.

HEALTH INSURANCE PREMIUM PAYMENT, HIPP, APPLICATION

| | |
|--|--|
| WHO IN YOUR HOUSE IS CURRENTLY WORKING? | |
| (NAME) _____ (SSN) _____ / / (DATE OF BIRTH) | (NAME) _____ (SSN) _____ / / (DATE OF BIRTH) |
| WHO IN YOUR HOUSE LOST A JOB IN THE LAST 30 DAYS OR MAY BE ELIGIBLE FOR COBRA? | |
| (NAME) _____ (SSN) _____ | (NAME) _____ (SSN) _____ |
| EMPLOYER/COMPANY | EMPLOYER PHONE # |
| () () - | () () - |
| EMPLOYER/COMPANY ADDRESS | EMPLOYER/COMPANY ADDRESS |
| (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE) _____ | (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE) _____ |
| DOES YOUR EMPLOYER OFFER HEALTH INSURANCE? | DOES YOUR EMPLOYER OFFER HEALTH INSURANCE? |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| IF YES: When are you eligible? | IF YES: When are you eligible? |
| <input type="checkbox"/> ANYTIME | <input type="checkbox"/> ANYTIME |
| <input type="checkbox"/> DATE: / / | <input type="checkbox"/> DATE: / / |
| IF YES: Who is covered? | IF YES: Who is covered? |
| WHO CAN BE ADDED: | WHO CAN BE ADDED: |
| IS ANYONE IN THE HOUSEHOLD PREGNANT? YES <input type="checkbox"/> NO <input type="checkbox"/> NAME: _____ DUE DATE: / / | |
| IS ANYONE IN THE HOUSEHOLD RECEIVING TREATMENT FOR A SERIOUS ILLNESS? | |
| NAME | ILLNESS |
| NAME AND PHONE NUMBER OF DOCTOR | NAME AND PHONE NUMBER OF DOCTOR |
| () () - | () () - |
| () () - | () () - |
| () () - | () () - |
| I hereby authorize and request the disclosure to the PA Dept. of Public Welfare any information that would be needed to determine eligibility for the Health Insurance Premium Payment, HIPP, Program, and appoint the department my limited attorney-in-fact with the power to elect group health benefit coverage on my behalf, to enroll me in such coverage and to pay premiums or contributions on my behalf. This power of attorney shall remain in effect until revoked in writing by me. I understand this information will be kept confidential and will be used only for the purpose of determining eligibility for the HIPP Program. In compliance with Federal HIPAA privacy regulations, I understand and agree that the HIPP Program may use and disclose protected health information (including but not limited to name, address, diagnosis and treatment) for treatment, payment or health care operations. I understand that I must consent to this use and disclosure in order to enroll in or receive services through the HIPP Program. | |
| Employee Signature(s): _____ | DATE: / / |
| Phone Number(s): Home: () () - - Cell: () () - - Work: () () - - | |

PW/1681 5/11

REMITTANCE EXPLANATION

HIPP Program
P.O. Box 8195
Harrisburg, PA 17105-9766



REMITTANCE EXPLANATION

DATE:

EMPLOYEE: of

| EMPLOYEE SSN | EMPLOYEE NAME | PAYMENTS | | |
|---|---------------|--|--------|----------------|
| | | COVERAGE DATES FROM TO | AMOUNT | REASON CODE |
| CHECK ISSUED IN SEPARATE MAILING | | | | |
| | | OVERPAYMENTS | | |
| | | | | |
| CHECK AMOUNT ▶ | | EMPLOYEE AMOUNT ▶ | | |
| REASON CODE | EXPLANATION | | | |
| | | | | |

MA483 3/11

YEARLY REEVAL FAX COVER SHEET



FAX

TO CINDY MIKES
ACME INC.

FROM Mary Jones
HIPP Program

FAX 717-444-1234

FAX 717-555-1902

PHONE 717-444-1243

PHONE 717-555-1802
800-644-7730

DATE February 2, 2011

EMAIL maryjone@state.pa.us

PAGES 1

Please include a copy of the Summary of Benefits if the carrier or policy has changed.

Employee name: SMITH, JOHN

We are reviewing the above mentioned employee for continued eligibility in the HIPP program. Please complete and return this form via fax before **2/28/11**.

Is this employee still employed by your company and enrolled in benefits? Yes No

Persons covered on plan: John Smith, Jane Smith, Jordan Smith, Jamie Smith

Current carrier: Basic – Highmark BC/BS

Current generic RX co-pay: \$10

Premium paid by HIPP: \$450.27/Monthly Family

New Employee contribution rate: Health \$ _____ Rx \$ _____ Dental \$ _____ Vision \$ _____

Effective date of change: _____

In-Network deductible: Individual: \$ _____ Family Maximum: \$ _____

Does the plan include Autism Spectrum Disorder in accordance with the PA Autism Insurance Act (Act 62)? Yes No

Are there any other changes to the health insurance? _____

Provide contact person's name, phone/fax number **if different** from above:

If you have any questions, please call me at 717-555-1802 or 800-644-7730. Thank you for your assistance.

Note: This information contains Protected Health Information that is strictly confidential and legally privileged. It is to be delivered promptly to the addressee and read by that person only. PLEASE NOTE: The HIPAA Privacy Rule creates stringent penalties for covered entities that violate the privacy rule.

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67/0001234

E15 09/10

19 YEAR OLD FAX



FAX

TO CINDY MIKES
ACME INC.

FROM Mary Jones
HIPP Program

FAX 717-444-1234

FAX 717-555-1902

PHONE 717-444-1243

PHONE 717-555-1802
800-644-7730

DATE February 2, 2011

EMAIL maryjones@state.pa.us

PAGES 1

Employee name: SMITH, JOHN

We are reviewing the above mentioned employee for continued eligibility in the HIPP program. Please complete and return this form via fax before **02/28/11**.

John Smith's child Jordan Smith's turning 19 on 3/1/11. Will Jordan Smith remain on the health insurance coverage after turning 19? Yes No

Current carrier: Basic – HIGHMARK BC/BS

Current generic RX co-pay: \$10

Premium paid by HIPP: \$450/Monthly Family

Rate/Level of Coverage if 19 year old is being removed \$ _____

Effective date of change: _____

In-Network deductible: Individual: \$ _____ Family Maximum: \$ _____

Does the plan include Autism Spectrum Disorder in accordance with the PA Autism Insurance Act (Act 62)? Yes No

(Please include a copy of the Summary of Benefits if the carrier or policy has changed)

Are there any other changes to the health insurance? _____

Provide contact person's name, phone/fax number **if different** from above:

If you have any questions, please call me at 717-555-1802 or 800-644-7730. Thank you for your assistance.

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67/0001234

E19 09/10