



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 Human Services (DHS), 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, <http://www.dhs.state.pa.us/HIPP> and direct questions to your [local regional office](#) (see page 3 of the booklet enclosed) or e-mail [ra-hipp@pa.gov](mailto:ra-hipp@pa.gov).

Thank you,

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

Veronica Ressler  
HIPP Program Director  
Department of Human Services  
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

P. O. Box H

Torrance, PA 15779-0115

(724) 459-3119

(800) 684-7730

[HIPPchestnutridge@pa.gov](mailto:HIPPchestnutridge@pa.gov)

**Counties:** Allegheny      Columbia      Greene  
Chester      Delaware      Washington  
Clearfield

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#### Clark Summit Regional Office

HIPP Program

1451 Hillside Drive – Newton Hall

Clarks Summit, PA 18411

(570) 587-9661

(888) 819-9206

[HIPPClarksummit@pa.gov](mailto:HIPPClarksummit@pa.gov)

**Counties:** Adams      Luzerne      Pike  
Centre      Lycoming      Sullivan  
Huntingdon      McKean      Union  
Indiana      Mifflin      Wayne  
Lackawanna      Philadelphia      Wyoming

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#### Harrisburg Regional Office

HIPP Program

P. O. Box 8195

Harrisburg, PA 17105-8195

(717) 705-8134

(800) 644-7730

[HIPP Harrisburg@pa.gov](mailto:HIPP Harrisburg@pa.gov)

**Counties:** Berks      Forest      Perry  
Bradford      Lancaster      Somerset  
Cumberland      Lehigh      Tioga  
Dauphin      Mercer      York  
Elk      Northumberland

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#### Torrance Regional Office

HIPP Program

P. O. Box H

Torrance, PA 15779-0115

(724) 459-3124

(800) 684-7730

[HIPPtorrance@PA.gov](mailto:HIPPtorrance@PA.gov)

**Counties:** Bedford      Clinton      Montgomery  
Blair      Franklin      Montour  
Cambria      Fulton      Potter  
Cameron      Jefferson      Schuylkill  
Carbon      Juniata      Snyder  
Clarion      Lawrence      Westmoreland

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#### Warren Regional Office

HIPP Program

589 Hospital Drive Suite D

Warren, PA 16365

(814) 726-4122

(814) 440-9391

(800) 440-9391 (800) 440-9391

[HIPPWarren@PA.gov](mailto:HIPPWarren@PA.gov)

**Counties:** Armstrong      Erie      Northampton  
Beaver      Fayette      Susquehanna  
Bucks      Lebanon      Venango  
Butler      Monroe      Warren  
Crawford

## B. HIPP Program Glossary

| <b>Acronyms</b>     | <b>Definitions</b>   |
|---------------------|--|
| 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 – DHS’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 Human Services (DHS), 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 14<sup>th</sup> and will be sent out to the payee in time for the following month's premium due date.

## **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 60<sup>th</sup> 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 Human Services  
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 HIPAA program obtains information for paying claims and health care operations and therefore HIPAA 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 Human Services, DHS, 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 the Employee'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 Human Services 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 Human Services 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 when there is an overpayment on the case. This form notifies the payee of any money the HIPP Program may have overpaid.

## **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.

## **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.

### **How do I open an encrypted email from HIPP?**

When you receive an encrypted email, you receive the email without the actual email content. The email will look like the one shown below (the formatting may look different depending on which email application or web-mail interface you are using; the screenshot below is from Gmail).

to me ▾

 Office 365

Sender N (sender@email-doman.com) has sent you a protected message.

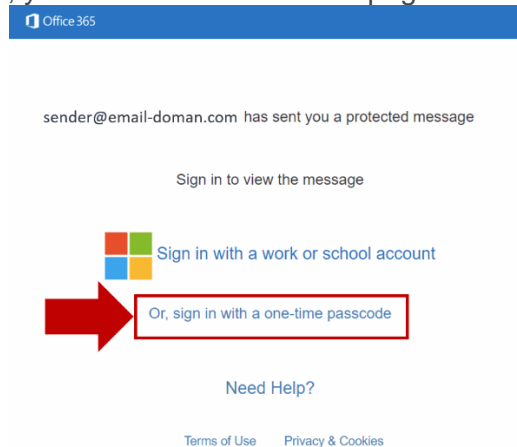


[Learn about messages protected by Office 365](#)

Microsoft respects your privacy. To learn more, please read our [Privacy Statement](#).  
Microsoft Corporation, One Microsoft Way, Redmond, WA 98052

Click the **Read the message** button. (The button may show up as a link in certain email applications.)

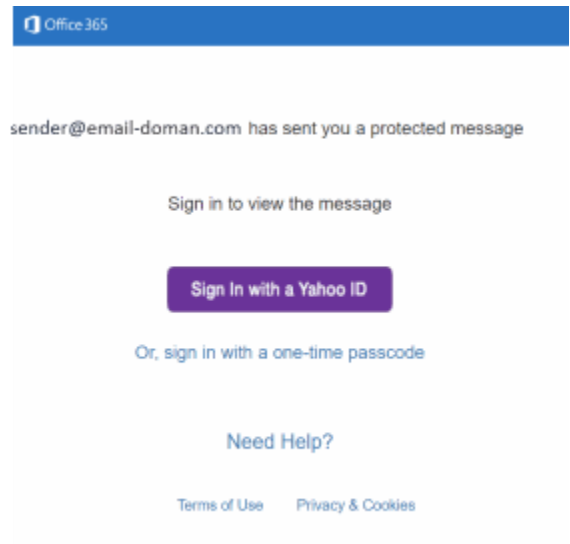
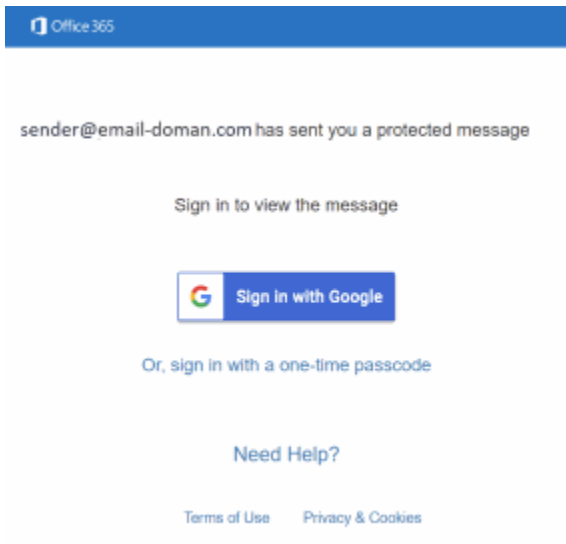
Upon clicking the button, you will be taken to a web page that looks like the one below:



**Note:** The option to *Sign in with a work or school account* will only work if you have an Office 365 subscription with the same email address that you received the email at.

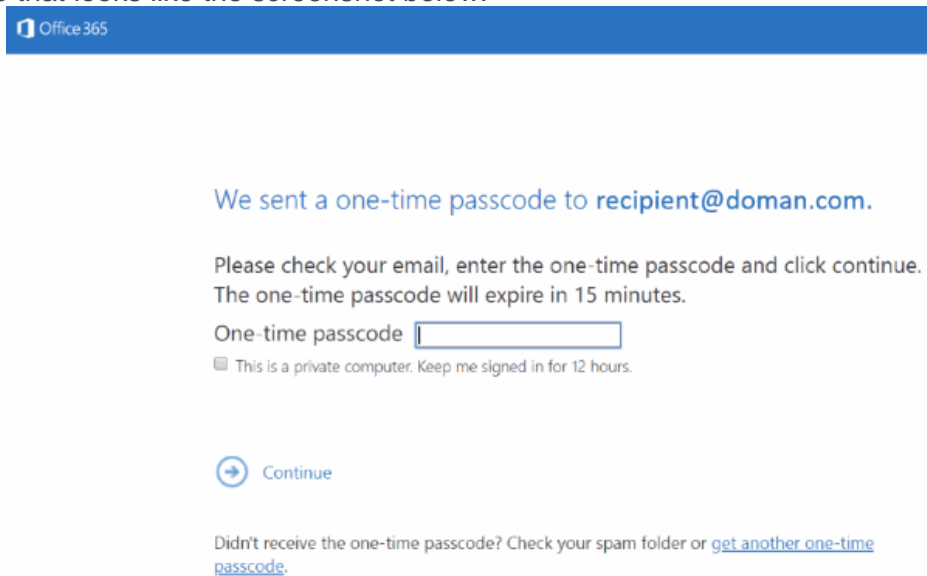
If you do not have an Office 365 subscription with the same email address, you should click the link **Or, sign in with a one-time passcode**.

(For certain recipient email addresses, those on Gmail or Yahoo! Mail, the above web page will look a little different and you will see a button to login with either Google or Yahoo:



These recipients may click the relevant sign-in option and then login with their Yahoo or Google account.)

After you click “Or, sign in with a one-time passcode”, you will be taken to a second web page that looks like the screenshot below:



You will need to switch away from the web browser and go back to your email account for an email from *Microsoft Office 365 Message Encryption* ([MicrosoftOffice365@messaging.microsoft.com](mailto:MicrosoftOffice365@messaging.microsoft.com)).

Note: This email comes from Microsoft's email address and not the original sender, you may have to look for it in spam or junk email folders if it is not found in your inbox. The email you will receive contains a passcode and looks like the screenshot below:



Here is your one-time passcode

**19978456**

To view your message, enter the code in the web page where you requested it.

NOTE: This one-time passcode expires 15 minutes after it was requested.

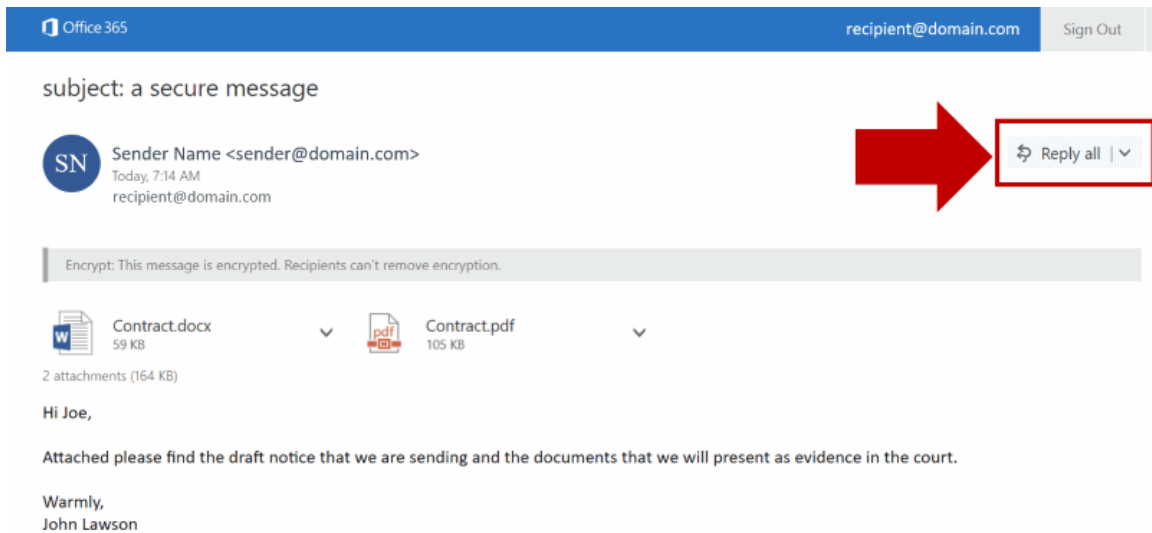
Don't want to use one-time passcode every time you get a protected message? Use your email address to [create a Microsoft account](#)

This message is automatically generated. Please don't reply to it.

Copy the passcode and go back to the web page that was asking for the passcode to be entered.

Note: If you close the web page prior to entering the passcode, the passcode will no longer be valid, you will have to start over and request a new passcode.

Once you enter the passcode and click *Continue*, you will arrive at the secure email message. The web page that shows the encrypted message looks like the one below.



Clicking an attachment either shows a preview, or in the case of Office files (Word, PowerPoint, Excel etc.), you will have to manually download the file and then open it.



# 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 Human Services, 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  
HIPPP Representative  
717-555-1802  
1-800-644-7730  
maryjones@state.pa.us  
67/0001234

E04 12/14

# 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:

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

| <b>MEDICAL COVERAGE</b> | <b>DATE COVERAGE STARTED</b> |
|-------------------------|------------------------------|
| 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 12/14

## CHIPRA OF 2009



February 3, 2011

ACME INC  
224 HESS DRIVE  
SUITE 120  
HARRISBURG, PA 17105

Dear Benefits Officer:

The Pennsylvania Department of Human Services' Health Insurance Premium Payment (HIPP) program is in the process of reviewing eligibility for the household of your employee, John Doe, SSN xxx-xx-1234, 01/02/82. Their Managed Care Organization coverage in UPMC for You which includes medical, dental and vision will end effective 08/31/16. Their eligibility for the HIPP Program will begin effective 09/01/16.

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 Human Services 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 06/16

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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  
<http://www.dhs.pa.gov/hipp>

## 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 Human Services' 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 12/14

## DISCONTINUANCE NOTICE



February 2, 2011

John Smith  
123 ABC Lane  
Apartment 4  
Harrisburg, PA 17105

Employee ID:

### 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 Human Services 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 Human Services whenever it is no longer cost effective for the Department of Human Services 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 12/14

## DISCONTINUANCE NOTICE - LEVEL OF COVERAGE



February 2, 2011

John Smith  
123 ABC Lane  
Apartment 4  
Harrisburg, PA 17105

Employer ID:

### **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 Parent & Child 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 Human Services 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 Human Services whenever it is no longer cost effective for the Department of Human Services 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 12/14

**EMPLOYEE BENEFITS SURVERY**



August 16, 2016

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

Dear Employee Benefits Coordinator:

The Pennsylvania Department of Human Services' Health Insurance Premium Payment (HIPP) program is in the process of reviewing eligibility for the household of your employee, John Doe, 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.**

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 A SUMMARY OF BENEFITS AND CURRENT RATE SHEET FOR THE HEALTH, DENTAL AND VISION INSURANCE YOUR COMPANY OFFERS** in accordance with Section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, Section 701(f)(3)(B)(ii) of the Employee Retirement Income Security Act of 1974 (ERISA), Section 9801(f)(3)(B)(ii) of the Internal Revenue Code of 1986, and Section 2701(f)(3)(B)(ii) of the Public Health Service Act.

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 is on the insurance and what plan they have for medical, dental and vision:

\_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_

<c\_county>/<c\_rec>



**EMPLOYEE BENEFITS SURVEY**  
**PAGE 2**

5. If the client is no longer employed, is/was COBRA offered? \_\_\_\_\_  
Enrollment period if applicable: Begin Date \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date \_\_\_\_/\_\_\_\_/\_\_\_\_
6. Is your health insurance self-funded?  Yes  No
7. When was their last pay day and date? \_\_\_\_\_
8. How many times per year are premiums deducted from the employee's paycheck? \_\_\_\_\_
9. Please supply your insurance carrier's name and address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Indicate if your health insurance coverage type is a:  PPO  POS  HMO  EPO
11. Does the plan include Autism Spectrum Disorder in accordance with the PA Autism Insurance Act (Act 62)?  Yes  No
12. Plan Administrator Representative/Contact Person:  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

Plan Administrators are required to participate per Section 502(c)(9)(B) of the Employee Retirement Income Security Act (ERISA) (29 U.S.C. §1001 et seq.).

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  
PO BOX 8195  
HARRISBURG, PA 17105-8195

67/0001234

E01 01/15

# 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 Human Services 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**

HIGHMARK BC/BS

**EMPLOYEE ID**

001234

**POLICY #**

XXXXXXXX1234

**PAY DATE**

00/00/00

**GROUP #**

0123456

**EMPLOYEE'S CONTRIBUTION**

\$450.65/Monthly

**LEVEL OF COVERAGE PAID BY HIPP**

Family

**HIPP ELIGIBILITY DATE**

03/01/11

**HEALTH INSURANCE DEDUCTIBLES**

PPO Min: \$500.00 Max: \$1,500.00

**SUPPLEMENTAL PLAN**

Dental DELTA DENTAL OF PA  
Prescription EXPRESS SCRIPTS

**SUPPLEMENTAL DEDUCTIBLE/COPIAY**

Min: \$50.00  
Min: \$0.00 Generic Copay: \$10.00

**COBRA ELECTION DATE**

00/00/00

**COBRA TERMINATION DATE**

00/00/00

67/0001234

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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  
<http://www.dhs.pa.gov/hipp>

**EMPLOYER AGREEMENT/CONFIRMATION NOTICE**



**PAYMENT MADE TO**  
ACME INC.  
224 HESS DRIVE  
SUITE 120  
HARRISBURG, PA 17105

**AMOUNT OF FIRST CHECK**  
\$450.65 03/1/11-03/31/11

**DATE OF FIRST PAYMENT**  
03/01/11

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**

<employer\_agree>

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 08/17



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 Human Services 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".

Diana C. Clark  
Assistant Counsel

Telephone: 717-783-2800  
Facsimile: 717-772-0717  
Email: [diclark@state.pa.us](mailto:diclark@state.pa.us)

67/0001234

E12 12/14



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 Human Services 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 12/14

**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**  
**Employee ID: <c\_employee\_id>**

We are reviewing the above mentioned employee for continued eligibility in the HIPP program. Please complete and return this form via fax before **08/31/16**.

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 03/16

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  
<http://www.dhs.pa.gov/hipp>

**REFERRAL LETTER**

**PAGE 1**

ADDRESS  
ADDRESS 1  
ADDRESS 2  
ADDRESS 3  
ADDRESS 4



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

NAME  
ADDRESS 1  
ADDRESS 2  
ADDRESS 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 an employer) may be available to you or other members of your family.

The Department of Human Services, DHS, 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:

- 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; and,
- Your employer's insurance plan may provide more coverage to you and your family than MA.

According to DHS policy, 55 Pa.Code §§178.1(g) and 178.6, it is a condition of MA eligibility that you cooperate with DHS 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.

DHS staff will evaluate the information you provide in your response. You will receive an enrollment notice for the Health Insurance Premium Payment Program (HIPP) if you qualify. DHS will not pay your insurance premiums until we determine that you are eligible and send you an enrollment acceptance 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.

If you have any questions or need help completing this required form, please contact us at <Regional\_Office\_800\_Number> or via email at <Regional\_Office\_email>. You may fax completed forms to <Regional\_Fax>.

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



**HIPP Application**

System Code:                      Region #:                      CIR#:                      Telephone #:                      Date:

**Tell us about the person in your household who may be able to get health insurance at work or has lost a job in the last 30 days.**

|  |       |       |                   |
|--|-------|-------|-------------------|
| NAME   |       | SSN   |                   |
| ADDRESS  | CITY  | STATE | ZIP CODE          |
| EMAIL ADDRESS  | PHONE | CELL  |                   |
| If no one in the household is working or lost a job in the last 30 days note it in the employment status box, sign and return this form. |       |       | EMPLOYMENT STATUS |

**Tell us about the employer.**

Are you currently employed?  Yes  No      If no, when was employment terminated? \_\_\_\_\_

|               |                               |
|---------------|-------------------------------|
| EMPLOYER NAME | PHONE                         |
| ADDRESS       | CITY      STATE      ZIP CODE |

**Tell us about the health insurance or COBRA benefits available.**

Is the employee currently enrolled in health insurance?  Yes  No      If no, when will the employee be eligible to enroll? \_\_\_\_\_

Is this COBRA coverage?  Yes  No      If yes, when was the COBRA begin date? \_\_\_\_\_

**List household members who are currently on employer insurance or may be added.**

| Name:    | Relationship to Employee: | Is this person receiving treatment for a serious illness, mental health, behavioral health, or orthodontics? | Is this person pregnant? |
|----------|---------------------------|--|--------------------------|
| 1. _____ | _____                     | ILLNESS  | DUE DATE                 |
| 2. _____ | _____                     | ILLNESS  | DUE DATE                 |
| 3. _____ | _____                     | ILLNESS  | DUE DATE                 |
| 4. _____ | _____                     | ILLNESS  | DUE DATE                 |
| 5. _____ | _____                     | ILLNESS  | DUE DATE                 |

**List anyone in the household who may be able to get health insurance through a non-custodial parent.**

| Name:    | Name of Non-custodial Parent | Employer Name | Non-custodial Parent's Phone |
|----------|------------------------------|---------------|------------------------------|
| 1. _____ | _____                        | _____         | _____                        |
| 2. _____ | _____                        | _____         | _____                        |
| 3. _____ | _____                        | _____         | _____                        |

I hereby authorize and request the disclosure to the PA Department of Human Services 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: _____ | DATE: _____ |
|---------------------------|-------------|

HS 1001 7/17



# REMITTANCE EXPLANATION

Department of Human Services  
 HIPP Program  
 P.O. Box 8195  
 Harrisburg, PA 17105-9766



## REMITTANCE EXPLANATION

DATE:

EMPLOYEE: \_\_\_\_\_ of \_\_\_\_\_

| EMPLOYEE SSN                  | EMPLOYEE NAME   | PAYMENTS                  |        |                |
|-------------------------------|---|---------------------------|--------|----------------|
|                               |   | COVERAGE DATES<br>FROM TO | AMOUNT | REASON<br>CODE |
| <b>OVERPAYMENT<br/>NOTICE</b> |   |                           |        |                |
|                               |   | <b>OVERPAYMENTS</b>       |        |                |
|                               |   |                           |        |                |
| CHECK AMOUNT ▶                |   | EMPLOYEE AMOUNT ▶         |        |                |
| REASON<br>CODE                | EXPLANATION   |                           |        |                |
|                               | For questions regarding this letter, contact the <Regional Office Name><br>Regional HIPP office at <800 line> or <email address>. |                           |        |                |

WA-883 0/17

## 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**  
**Employee SSN: xxx-xx-1234**  
**Employee ID: 123456**

We are reviewing the above mentioned employee for continued eligibility in the HIPP program. Please complete and return this form via fax before **08/31/16**.

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.

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

E15 03/16

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Bureau of Program Integrity | Division of Third Party Liability | Health Insurance Premium Payment Program  
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