

**NOTICE TO PARTICIPANTS IN THE [NAME OF GROUP HEALTH PLAN]  
OF THEIR RIGHTS UNDER THE  
CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT**

You are receiving this notice, as a participant or eligible participant (which may include dependents of participants), on the [Group Health Plan] ("Plan"), concerning your rights under the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding special enrollment rights in the event of loss of eligibility under Medicaid or the Children Health Insurance Program of any of the states and the potential eligibility for premium assistance in those states which have adopted a program compliant with CHIPRA.

1. Enrollment Rights due to loss of eligibility for SCHIP or Medicaid. Eligible participants (which may include dependents of participants) who are not enrolled in the Plan have the right to enroll in the Plan for coverage in the event the eligible participant's enrollment in a State Children's Health Insurance Program (under Title XXI of the Social Security Act) ("SCHIP") or as an enrollee in Medicaid is terminated due to a loss of eligibility.
  - a. In the event of the loss of enrollment in either program, an eligible participant (which may include dependents of eligible participants) must request coverage in the Plan within sixty (60) days of the loss of eligibility.
  - b. In that event, the eligible participant shall notify the Plan Administrator in writing (as indicated below) of their interest in enrollment, provide proof of loss of eligibility and provide the necessary information (as that process is established by the Plan Administrator) to complete enrollment within \_\_ days of requesting coverage.
2. Enrollment Rights due to eligibility for premium subsidy under CHIPRA. As of January 1, 2009, the following states have implemented some form of premium assistance subsidy programs under Medicaid or SCHIP:

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| ▪ Alabama       | ▪ Nevada        |
| ▪ California    | ▪ New Hampshire |
| ▪ Colorado      | ▪ New Mexico    |
| ▪ Georgia       | ▪ New York      |
| ▪ Idaho         | ▪ Oklahoma      |
| ▪ Indiana       | ▪ Oregon        |
| ▪ Iowa          | ▪ Pennsylvania  |
| ▪ Kentucky      | ▪ Rhode Island  |
| ▪ Maine         | ▪ Tennessee     |
| ▪ Maryland      | ▪ Texas         |
| ▪ Massachusetts | ▪ Utah          |
| ▪ Michigan      | ▪ Vermont       |
| ▪ Minnesota     | ▪ Washington    |
| ▪ Missouri      | ▪ Wisconsin     |
| ▪ Montana       |                 |

In the event that a participant or an eligible participant in one the states listed above becomes eligible for premium assistance subsidy through that state's SCHIP or Medicaid, that eligible participant shall have sixty (60) days to notify the Plan Administrator in writing (as indicated below) of their interest in enrollment, provide proof of eligibility and provide the necessary information (as that process is established by the Plan Administrator) to complete enrollment within \_\_ days of requesting coverage.

The specific provisions of each state's premium assistance vary and the Plan makes no representations about the rules of eligibility or the benefits provided by each program. The determination for program eligibility will be exclusively by the appropriate agency within each state.

In the event that an eligible participant requires information about the Plan and/or its benefits to assist the state agency in determining eligibility for premium assistance, the Plan will provide the necessary information upon receipt of a written request for information, which shall be in the form specified by the Plan Administrator, and shall include the specific information requested by the state agency, and contact information for delivery of the information.

3. Disenrollment Rights due to eligibility for SCHIP. In the event that a participant in the Plan becomes eligible for enrollment in Medicaid or an SCHIP program, that participant is permitted to terminate their group coverage by providing notice of eligibility for the publically-funded health program and completing the necessary paperwork to terminate the existing coverage through our group health plan. The loss of coverage through the Plan would trigger a qualifying event under state and/or federal law, but eligibility for continuation would vary. Please consult the notice received following termination of coverage for additional details.

For further information, please contact the Plan Administrator.

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#### **Administrative Information**

**Name of Plan:**

Medical Expense Reimbursement Plan for Employees of  
[Name of Group]

**Sponsoring Employer:** [Name of Group]

**Address:** [Address]

**Sponsor's Telephone Number:** [Phone Number]

**Plan Administrator:** [Decision Maker]

**Address:** [Address]

**Administrator's Telephone Number:** [Phone Number]

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If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or to the following address:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington, D.C. 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration, (800) 998-7542.