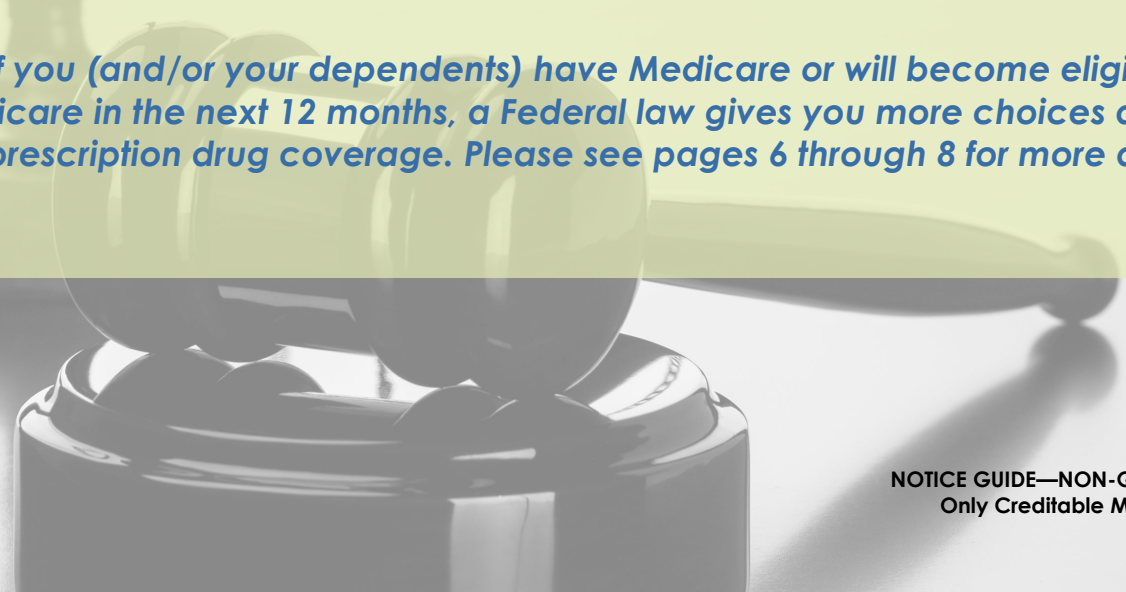




ANNUAL NOTICE GUIDE & OTHER IMPORTANT NOTICES

**BROUGHT TO YOU BY
KAPNICK INSURANCE**



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 6 through 8 for more details.

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PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
<p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p>Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov</p>
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
<p>The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx</p>	<p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711</p> <p>Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442</p>
ARKANSAS – Medicaid	FLORIDA – Medicaid
<p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>

<p>GEORGIA – Medicaid</p> <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/mashealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p>INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>	<p>MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>
<p>IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>KANSAS – Medicaid</p> <p>Website: http://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>	<p>MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPProgram@mt.gov</p>
<p>KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p>LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>
<p>MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218</p>

NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	TEXAS – Medicaid Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	UTAH – Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid Website: http://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	VERMONT– Medicaid Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	VIRGINIA – Medicaid and CHIP Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
OREGON – Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid and CHIP Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	WEST VIRGINIA – Medicaid and CHIP Website: http://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa 1 (866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1 (877) 267-2323, Menu Option 4, Ext. 61565

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE

Your Medicare Part D Notice has information about the current prescription drug coverage available under the Plan provided by your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is provided at the end of your applicable Medicare Part D Notice.

Medicare beneficiaries who are not covered by creditable prescription drug coverage and who choose not to enroll in Medicare Part D before the end of their initial enrollment period will likely pay higher premiums if they later enroll in Part D prescription drug coverage.

NOTICE OF YOUR MEDICARE PART D CREDITABLE COVERAGE STATUS

Under the Medicare Part D program, group health plans—like this Plan—are required to provide, or arrange for providing, a notice of creditable prescription drug coverage at least annually to those Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the Plan. You will also be provided with your creditable coverage status at the following times:

- Prior to your initial enrollment period;
- Prior to your effective date of coverage if you are a Medicare Part D eligible individual who enrolls in your Employer's Group Health Plan prescription drug coverage;
- Whenever your prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and
- Upon your request.



IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered by the Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. **Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Employer coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Employer coverage, be aware that you and your dependents may not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Employer changes. You also may request a copy of this notice at any time. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE DRUG PLANS, YOU MAY BE REQUIRED TO PROVIDE A COPY OF THIS NOTICE WHEN YOU JOIN TO SHOW WHETHER OR NOT YOU HAVE MAINTAINED CREDITABLE COVERAGE AND, THEREFORE, WHETHER OR NOT YOU ARE REQUIRED TO PAY A HIGHER PREMIUM (A PENALTY).



SUMMARY OF BENEFITS AND COVERAGE

A summary of benefits and coverage ("SBC") is a summary of plan benefits coverage and cost-sharing arrangements required under the Affordable Care Act. Group health plans and health insurance issuers provide SBCs to participants. Generally an SBC is provided for each health benefit option available to you under the Plan and is provided to you annually at open enrollment and upon renewal or reissuance of coverage. If your plan is self-funded, the Plan Administrator will provide an SBC. If the plan is insured, the Plan Administrator and issuer will provide the SBC.

Other times an SBC must be provided:

- Upon application (i.e., when you are initially eligible for coverage);
- By the first day of coverage (if there have been any changes);
- When an event triggers HIPAA special enrollment rights; and
- Within 7 business days upon request.

For more information about SBCs and the Uniform Glossary of Terms, contact the Plan Administrator.

NOTE: A copy of any relevant SBC is not included with this Notice Guide, but rather will be distributed to you separately.

On October 21, 1998, Congress enacted the Women's Health & Cancer Rights Act (WHCRA) of 1998. WHCRA requires all health plans that provide medical and surgical benefits for a mastectomy to also cover breast reconstruction. As required by law, annual notice of the mandated post-mastectomy benefits must be provided to all covered persons.

Please review this information carefully. If your spouse is also covered under this sponsored health plan, please make sure that he/she also has had the opportunity to review this information.

The Women's Health & Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- **All stages of reconstruction of the breast on which the mastectomy has been performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance;**
- **External breast prostheses (breast forms that fit into a bra) that are needed before or during the reconstruction;**
- **Treatment of physical complications in all states of mastectomy, including lymphedema.**

The Act requires that coverage be provided in a manner that is consistent with other benefits provided under the Plan. The coverage may be subject to annual deductibles and coinsurance provisions.

Please keep this information with your other group health plan documents. If you have any questions about this Plan's coverage of mastectomies and reconstructive surgeries, please speak with the Human Resources Department.

FREQUENTLY ASKED QUESTIONS:

Q. I must have a mastectomy for medical reasons, although I have not been diagnosed with cancer. Does WHCRA apply to me?

A Yes, the law applies if your group health plan covers mastectomies and you are receiving benefits in connection with a mastectomy. Despite its name, nothing in the law limits WHCRA rights to cancer patients.

Q. Will I have to pay a deductible or coinsurance?

A Possibly. Group health plans may impose deductibles or coinsurance requirements on mastectomies and post-mastectomy treatment, but no more than those established for other benefits. In other words, the deductible for post-mastectomy reconstructive surgery should be similar to the deductible for any similar procedure covered by the plan.

Q. My employer's group health plan provides coverage through an insurance company. Following my mastectomy, my employer changed insurance companies. The new insurance company is refusing to cover my reconstructive surgery. Is that legal?

A. No, that is not legal if the new insurance company provides coverage for mastectomies, you are receiving benefits under the plan related to your mastectomy, and you elect to have reconstructive surgery. If these conditions apply, then the new insurance company must provide coverage for breast reconstruction as well as the other benefits required under WHCRA. It does not matter that you were not covered by the new insurance company when you had the mastectomy.

(Source: dol.gov/general/topic/health-plans/womens)

ACA AGE 26 MANDATE

Under the Affordable Care Act, all non-excepted group health plans must cover all children to age 26 if the plan provides dependent coverage. Both married and unmarried adult children qualify for this coverage. Although the mandate requires up to age 26, employers can extend coverage through the calendar year in which the child turns 26 and receive the tax benefit. The plan must offer the same coverage at the same cost. Dependent adult children cannot be required to pay more than similarly situated individuals. They are included in the family or employee plus dependent coverage.

ACA NOTICE OF EXCHANGE AVAILABILITY

This Notice provides certain basic information about the employer's group health coverage and the Health Insurance Marketplace. Employees will be able to compare the different types of coverage information. New hire employees must receive this notice within 14 days of their start date. This notice is only provided once.

ACA PATIENT PROTECTION NOTICE

The Affordable Care Act requires plans and issuers to provide a notice to participants of their right to:

- A. choose a primary care provider or a pediatrician when a plan requires designation of a primary care physician; or
- B. obtain obstetrical or gynecological care without prior authorization.

– **Primary Care Provider**

If the Plan requires or allows you to designate a primary care physician, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator.

For children, you may designate a pediatrician as the primary care provider.

– **Obstetrical or Gynecological Care**

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

ACA REPORTING REQUIREMENTS UNDER IRC SECTIONS 6055 & 6066

Employees may receive a Form 1095-B by January 31* of each year from a fully insured plan provider or will receive a Form 1095-C from the employer/plan sponsor of a self-funded group health plan by January 31* of each year which conveys information about the employer's offer of group health coverage. This reporting is required by the Affordable Care Act for the purposes of determining full-time employees and compliance with the employer shared responsibility mandate. This Form will be provided to each full-time employee via an individual statement.

**Forms may be provided later than this date when permitted by the IRS.*

COBRA CONTINUATION COVERAGE GENERAL NOTICE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law which provides participants who are enrolled in a group health plan with the ability to extend coverage for a designated period of time. COBRA continuation coverage can become available to the participant and the participant's family when group health coverage would otherwise end because of a life event called a "qualifying event". This temporary extension of coverage has certain rights and obligations that are provided in the COBRA Continuation Coverage General Notice.

Participants will receive the General Notice from a private sector employer with 20 or more employees, or by state or local governments. COBRA does not apply to plans sponsored by the Federal Government or by churches and certain church-related organizations. COBRA continuation coverage is often more expensive than the amount participants are required to pay for group health coverage, since the employer generally pays a portion of the cost of employees' coverage and all of the cost of COBRA coverage may be charged to the individual. Employees may consider coverage through alternative sources: spouse's group health plan; the Health Insurance marketplace; or Medicaid.

This notice is generally provided within the first 90 days of coverage and COBRA rights are also described in the SPD. If you have any questions, please contact the Plan Administrator for more information and a copy of the notice.

HIPAA BREACH NOTIFICATION RULE

The HIPAA Breach Notification Rule requires covered entities (your group health plan) to notify affected individuals, the Department of Health and Human Services (HHS) and in some cases, the media of a breach of unsecured protected health information (PHI). For individuals, notifications must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach. The notice must be provided in written form by first-class mail or alternatively, by e-mail if the affected individual has agreed to receive such notices electronically. The covered entity must include a toll-free phone number that remains active for at least 90 days where individuals can learn if their information was involved in the breach. If you have additional questions, please contact your Plan Administrator.

IMPORTANT NOTE: For the effective date of this HIPAA Notice of Privacy Practices and the Privacy Official's contact information, please refer to the Memorandum attached to this Annual Notice Guide.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information as required under HIPAA. Please review it carefully.

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by our company. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under the group health plan. We are committed to protecting the privacy of your health information, sometimes referred to as "protected health information" or "PHI".

As a plan sponsor, we often need access to health information in order to perform plan administrator functions. We want to assure the plan participants covered under our group health plan that we comply with federal and state privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

YOUR RIGHTS

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

- **Get a copy of your health and claims records.** You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records.** You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, via home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit the information we share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.



- **Get a list of those with whom we've shared your information.** You can ask for a list (accounting) of the times we've shared your health information for 6 years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of the HIPAA privacy notice at any time, even if you have agreed to receive the notice electronically. We are providing you with a paper copy of the privacy notice annually in this Notice Guide.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You can complain if you feel we have violated your rights by contacting us using the information stated in the Memorandum provided in conjunction with this Annual Notice Guide, or you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

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

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

If you are unable to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will never share your information for marketing purposes or sell your information unless you give us written permission.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.

- **As we help manage the health care treatment you receive.** Although the law allows use and disclosure of your health information for purposes of treatment, as a plan sponsor, we generally do not need to disclose your health information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment and healthcare operations.
- **As we pay for your health services.** We can use and disclose your health information for purposes of determining payment for your health services, eligibility for benefits, to seek reimbursement from a third party, and/or to coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your written information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

- **As we run our organization.** We can use and disclose your information to run our organization and contact you when necessary. For example, we can use your health information to develop better services for you. **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.
- **As we administer your health plan.** We can use and disclose your health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.
- **Other ways we use or share your health information.** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/index.html.
- **As we help with public health and safety issues.** We can share health information about you for certain situations such as:
 - ◇ Preventing disease
 - ◇ Helping with product recalls
 - ◇ Reporting adverse reactions to medication
 - ◇ Reporting suspected abuse, neglect, or domestic violence
 - ◇ Preventing or reducing a serious threat to anyone's health or safety
- **As we do research.** We can use or share your information for health research.
- **As we comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **As we respond to organ and tissue donation requests and work with a medical examiner or funeral director.** We can share health information about you with organ procurement organizations. We can also share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **As we address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you:
 - ◇ For workers' compensation claims
 - ◇ For law enforcement purposes or with a law enforcement official
 - ◇ With health oversight agencies for activities authorized by law
 - ◇ For special government functions such as military, national security, and presidential protective services
- **As we respond to lawsuits and legal actions.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- **Disclosures that Require Written Authorization.** We will never use or disclose psychotherapy notes, sell your protected health information, or share your health information for marketing purposes, unless you give us written authorization to do so. If you choose to sign an authorization to disclose such information, you can later revoke that authorization to cease any future uses or disclosures.

OUR RESPONSIBILITIES

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

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

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice and the changes will apply to all information we have about you. A revised notice will be provided to you within 60 days of any material revision of this notice.

This HIPAA Notice of Privacy Practices (or Privacy Notice) is not an annual notice. It must be distributed at least once every three years. It must also be provided to new enrollees at the time of enrollment; within 60 days of a material change to the notice and any time upon a participant's request. If the Plan sends out a revised notice due to a material change to the notice, it will reset the 3-year notice requirement.

The Health Insurance Portability and Accountability Act (HIPAA) requires special enrollment opportunities to be provided in certain situations. This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

If your employer is subject to HIPAA, special enrollment must be made available to you under this Plan in the following three situations:

1. A loss of eligibility for other health coverage (examples of reasons for loss of eligibility include legal separation, divorce, death of an employee, voluntary or involuntary termination or reduction in the number of hours of employment (with or without electing COBRA), exhaustion of COBRA, reduction in hours, "aging out" under other parent's coverage, and moving out of an HMO's service area);
2. The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and
3. Becoming eligible for a premium assistance subsidy under Medicaid or State Children's Health Insurance Program (CHIP), as required under the Children's Health Insurance Program Reauthorization Act (CHIPRA).

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR ALL SPECIAL ENROLLMENT RIGHTS

For any of these changes, it is the employee's responsibility to notify the Human Resources Department of any change in status within 30 (or 60 for Medicaid or CHIP, if applicable) days of the event. Requests for change which are submitted more than 30 (or 60 for Medicaid or CHIP, if applicable) days after the event will not be processed until the next open enrollment period.

MEDICAL SUPPORT NOTICE

The Medical Child Support Order (MCSO) Notice is a notice to participants and any child named in a MCSO (and his/her representative) regarding receipt of a MCSO directing the plan to provide health insurance coverage to a participant's noncustodial child(ren). The Notice must include the plan's procedures for determining its qualified status. **Notice must be provided promptly upon receipt of a MCSO.** A separate notice must be provided as to whether the MCSO is qualified called a Qualified Medical Child Support Order (QMCSO).

The National Medical Support (NMS) Notice is used by the State agency responsible for enforcing health care coverage provisions in a MCSO. Depending upon certain conditions, the employer must complete and return Part A of the NMS notice to the State agency or transfer Part B of the notice to the plan administrator for a determination on whether the notice is a qualified MCSO. The employer and Plan Administrator have responsibilities to comply with this notice.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) NOTICE

The Mental Health Parity and Addiction Equity Act (MHPAEA) notice informs participants of the criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder (MH/SUD) benefits. It also requires that financial requirements and treatment limits imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limits that apply to substantially all medical and surgical benefits. The disclosure must furnish the reason for denials of reimbursement or payment for services regarding MH/SUD benefits to participants and beneficiaries. Participants are provided with this notice upon request. This notice is not applicable to employers with fewer than 50 employees. Also, self-funded public sector plans can opt out of MHPAEA if they provide notice to their plan participants and the Centers for Medicare & Medicaid Services (CMS).

WELLNESS NOTICES

HIPAA imposes a notice requirement on health contingent wellness programs that are offered by group health plans. A health contingent wellness program requires individuals to satisfy standards related to health factors in order to obtain rewards. If you are eligible to participate in a health contingent wellness program, you will receive a **General Disclosure Notice** describing the incentives available to employees based on attainment of certain health outcomes (for example, receiving certain results on biometric screenings) or participation in an activity (for example, participating in a walking or exercise program). A reasonable alternative standard (or waiver) must be offered to an individual: 1) for an activity-only wellness program if it is unreasonably difficult due to a medical condition or inadvisable to attempt to satisfy the standard; or 2) if you fail to meet the designated initial standard of an outcome based program. Under the Americans with Disabilities Act (ADA), employers that offer wellness programs that collect employee health information are required to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential (**EEOC ADA Wellness Program Disclosure**). Also, if the program requests family or genetic information, written authorization is required by employees and spouses and it must indicate the genetic information obtained, how it will be used and any restrictions on its disclosure. This information must be communicated in a **GINA Wellness Disclosure**.

If any of these Wellness Notices are applicable to you, your Plan Administrator will provide the required Notice(s) to you. Contact your Plan Administrator for more details.

Important Note: Under the Affordable Care Act, group health plans (i.e., large, small, self-funded, fully insured and governmental group health plans) and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. If your plan provides dependent coverage beyond age 26 for a covered dependent child who is enrolled in a post-secondary educational institution, Michelle's Law is still applicable.

WHAT DOES MICHELLE'S LAW REQUIRE?

Plan sponsors and insurers are prohibited from terminating group health plan coverage if a covered dependent child takes a medically necessary leave of absence and the plan provides dependent coverage beyond age 26 for a covered dependent child who is enrolled in a post-secondary educational institution.

"Medically necessary leave of absence" means with respect to a dependent child in connection with a group health plan or health insurance coverage offered in connection with a group health plan, a leave of absence from or other change in enrollment status in a post-secondary educational institution that begins while the child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the plan or coverage.

A "dependent child" is a beneficiary who is a dependent child under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage, and who was enrolled in the plan or coverage on the basis of being a student at a post-secondary educational institution immediately before the first day of the medically necessary leave of absence involved.

If your health plan provides coverage beyond age 26 for a covered dependent child who is enrolled in a post-secondary educational institution, it must continue plan coverage for the dependent child upon written certification by the dependent's treating physician that states the dependent is suffering from a serious illness or injury and that a leave of absence (or reduction in student hours) is medically necessary until the earlier of: one year after the first day of the medically necessary leave of absence; or the date on which the coverage under the plan would otherwise terminate.

In the event that any dependent child is covered under the above circumstances and the dependent child has a change in his or her health coverage that results in a loss of plan coverage under the plan, but new coverage is provided under another plan, the new plan **must** honor the remaining period of leave. For example, if a covered dependent has been on a medically necessary leave of absence for six months and the individual's health coverage changes from Insurer A to Insurer B, the dependent child will still be eligible for the remaining six months of leave under Insurer B.

For more information about Michelle's Law, including if it is applicable to this Plan, please contact the Human Resource Department.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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



Annual Notice Guide Rev. 08.25.2023(Non-Grandfathered Plan with only creditable Medicare Part D Notice)

