2023

Benefits Guide

An overview of the wide array of benefits provided by 323 Transit to help you enjoy increased well-being and financial security.

These benefits are effective on July 01, 2023.

TNST

Prepared by Christensen Group, Inc for 323 Transit

2023 Plan Changes

Below is an outline of the premium and plan design changes from 2022 to 2023. All vision costs are remaining the same. Providing strong and affordable health plan options for staff and their families is a top priority for 323 Transit, which is why the company will continue to pay for a very large portion of the premiums on behalf of the staff. Please take some time to review each of the plans and choose which plan best fits the needs of you and your family.

In an effort to limit cost impact to employee paychecks, the $5,000-50% HSA plan option will be replaced by a $6,000-60% Copay plan option in 2023. This change is meant provide an option that is as cost efficient as possible for staff. Those enrolled in the $5,000-50% HSA plan will need to select a new plan design for 7/1/2023. This change will not impact the $1,400-80% Copay or $2,800-60% Copay plans.

Please refer to the medical plan summary pages in this guide for more plan design details.

Medical

2022 Employee Costs (per week)			
	$1400-80%	$2800-60%	$5000-50% HSA
Employee	$113.93	$86.16	$49.73
Employee+Spouse	$305.89	$250.35	$117.50
Employee+Child(ren)	$248.30	$201.09	$139.16
Family	$469.06	$389.91	$286.10

2023 Employee Costs (per week)			
	$1400-80%	$2800-60%	$6000-60%
Employee	$128.86 *Change: (+$14.93)*	$87.13 *Change: (+$0.97)*	$51.30 *Change: (+$1.57)*
Employee+Spouse	$341.43 *Change: (+$35.54)*	$257.99 *Change: (+$7.64)*	$186.32 *Change: (+$68.82)*
Employee+Child(ren)	$277.66 *Change: (+$29.36)*	$206.73 *Change: (+$5.64)*	$145.81 *Change: (+$6.65)*
Family	$522.12 *Change: (+$53.06)*	$403.21 *Change: (+$13.30)*	$301.08 *Change: (+$14.98)*

Dental

Employee Costs (per week)	2022	2023
Employee	$3.25	$2.32 *Change: (-$0.93)*
Employee+Spouse	$9.63	$7.05 *Change: (-$2.58)*
Employee+Child(ren)	$13.43	$10.05 *Change: (-$3.38)*
Family	$19.60	$14.80 *Change: (-$4.80)*

Contents

323 Transit is proud to offer a comprehensive benefits package for you and your family. This program is designed to take great care of you when you need it. Make sure to explore your options to help you make the selections that best meet your needs.

Benefits Offered

Throughout this booklet we will cover the following employee benefits being offered by 323 Transit.

Medical Insurance
Dental Insurance
Vision Insurance

This document does not replace the certificate booklets or Summary Plan Descriptions (SPDs). The benefits described in this document are only summaries; in case of error and for all claim adjudication, the Master Contracts will prevail. 323 Transit reserves rights to change, amend, terminate, or otherwise alter any plan at any time. Please refer to your certificates for more details and complete information.

Benefits Eligibility

As an employee of 323 Transit you may opt-in to annual benefits for you and your dependents when you meet certain work requirements.

Eligible Members

The following members are eligible to receive benefits during the upcoming plan year:

- Employee
- Legal Married Spouse
- Legal Children
- Step Children
- Domestic Partner

Work requirements

Benefit eligible employees are those that, with respect to any month, are employed on average at least 30 hours of service per week.

If you enroll in benefits, but take an unpaid week off – the employee is responsible for working with 323 Transit to ensure proper compensation of medical deductions. Example – a double deduction the following week.

If you are receiving workers compensation benefits, and no longer receiving a paycheck and not making your weekly deductions, coverage will be cancelled within 30 days.

When your benefits begin

All benefits begin on the first of the month following 30 days of employment.

Benefits Summary

323 Transit provides an array of benefits that can help you enjoy increased well-being, deal with an unexpected illness or accident, build and protect your financial security, balance your personal and professional life and meet everyday needs. These benefits are affordable, comprehensive and competitive.

The table below summarizes the benefits available to eligible employees and their dependents. These benefits are described in greater detail in this booklet.

Coverage	Carrier	Group #	Phone	Website
Medical	Aetna	108292214	(800) 872-3862	www.aetna.com
Dental	Aetna	108292214	(800) 872-3862	www.aetna.com
Vision	Aetna	108292214	(877) 973-3238	www.aetna.com

QUESTIONS?

If you have any questions about your benefit options, please contact:

Sean Donovan
323 Transit LLC
PO Box 176
Liverpool, NY 13088
(315) 427-1081
seandonovan@323transit.com

Key terms

Annual deductible

The amount you must pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their individual accumulated expenses (the amount varies by plan).

Copays & coinsurance

These expenses are your share of costs paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service and is generally billed to you after the insurance company reconciles the bill with the providers.

Embedded vs non-embedded

Embedded plans effectively have two deductibles amounts within one plan; single and family. The single deductible is embedded in the family deductible, so no one family member can contribute more than the single amount toward the family deductible.

Non-embedded means the entire family deductible must be met before the plan pays.

Network

The facilities, providers and suppliers your insurer or plan has contracted with to provide health care services.

Out-of-pocket maximum

This is the total amount you can pay out-of-pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible, copays and coinsurance.

Premium

The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

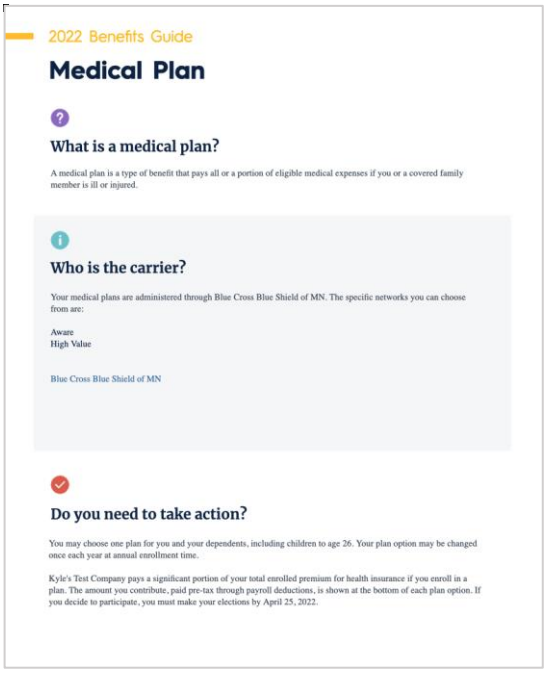
Preventive care

Preventive care helps detect or prevent serious diseases and medical problems before they can become major. Annual check-ups, immunizations, and flu shots, as well as certain tests and screenings, are a few examples of preventive care. This may also be called routine care.

How to use this guide

323 Transit offers a competitive benefit package that can be shaped and molded to fit your needs. This benefits guide, along with additional communication and decision-making tools, will help you make the best health care choices for you and your family.

If you decide to enroll in benefits through 323 Transit, some benefits will be provided automatically. Other benefits are voluntary or require you to make elections.


2022 Benefits Guide

Medical Plan

What is a medical plan?

A medical plan is a type of benefit that pays all or a portion of eligible medical expenses if you or a covered family member is ill or injured.

Who is the carrier?

Your medical plans are administered through Blue Cross Blue Shield of MN. The specific networks you can choose from are:

Aware
High Value

Blue Cross Blue Shield of MN

Do you need to take action?

You may choose one plan for you and your dependents, including children to age 26. Your plan option may be changed once each year at annual enrollment time.

Kyle's Test Company pays a significant portion of your total enrolled premium for health insurance if you enroll in a plan. The amount you contribute, paid pre-tax through payroll deductions, is shown at the bottom of each plan option. If you decide to participate, you must make your elections by April 25, 2022.

As you go through each section of this booklet you will see which benefits require action on your behalf.

Update on health care reform

Effective January 1, 2019, the Tax Cuts and Jobs Act (TCJA) repealed the individual mandate to maintain health insurance or be responsible for a "shared responsibility payment". We hope to keep offering these benefits as a valuable part of your total compensation in the future. However, because we offer you coverage that satisfies all the health reform requirements, you will not qualify for any federal assistance to purchase an individual or family policy on the open market (the "marketplace").

Medical Plan

What is a medical plan?

A medical plan is a type of benefit that pays all or a portion of eligible medical expenses if you or a covered family member is ill or injured.

Who is the carrier?

Your medical plans are administered through Aetna.

Aetna
(800) 872-3862
www.aetna.com

Do you need to take action?

You may choose one plan for you and your dependents, including children to age 26. Your plan option may be changed once each year at annual enrollment time.

323 Transit pays a significant portion of your total enrolled premium for health insurance if you enroll in a plan. The amount you contribute, paid pre-tax through payroll deductions, is shown is shown on the following pages.

All elections must be made on the 323 Transit Ease site at https://323transit.ease.com

Medical Plan

Preventive Care

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporate healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations.

Through the plan offered by 323 Transit all covered employees and dependents are eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers.

The following is a list of common services that are included in the plans offered this year.

Covered Preventive care services

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation Programs
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

Medical Plan

Summary of Benefits

The following is a summary of the medical benefits associated with your plans during the upcoming year.

	$1,400-80%	$2,800-60%	$6,000-60%
In Network			
Deductibles (Single / Family) – Calendar Year	$1,400/$2,800	$2,800/$5,600	$6,000/$12,000
Out-of-Pocket Maximum (Single / Family) – Calenda Year	$6,000/$12,000	$9,100/$18,200	$8,700/$12,000
Preventive Care	100% coverage	100% coverage	100% coverage
Primary Care Visit	$30 copay	$50 copay	Ded; then 60% coverage
Specialist Visit	$75 copay	$75 copay	Ded; then 60% coverage
E-Visit	$30 copay	$50 copay	Ded; then 60% coverage
Urgent Care	$75 copay	$90 copay	Ded; then 60% coverage
Inpatient & Outpatient	Ded; then 80% coverage	Ded; then 60% coverage	Ded; then 60% coverage
Emergency Room	$750 copay	Ded; then 60% coverage	Ded; then 60% coverage
Pharmacy / RX (31 Day Supply)	RX Deductible: $100/$200 Generic: $15 copay Formulary: $65 copay Non-Formulary: 50% coverage	RX Deductible: $200/$400 Generic: $15 copay Formulary: $65 copay Non-Formulary: 50% coverage	RX Deductible: $100/$200 Generic: $15 copay Formulary: $65 copay Non-Formulary: 50% coverage
Employer Contribution per week			
323 Transit contributes $362.78 per month for employee coverage. The below rates reflect the deducted contribution and are the responsibility of the employee.			
Employee	$128.86	$87.13	$51.30
Employee + Spouse	$341.43	$257.99	$186.32
Employee + Child(ren)	$277.66	$206.73	$ 145.81
Employee + Family	$522.12	$403.21	$301.08

Medical Plan

Aetna Networks

New York Elect Choice Open Access (OAEPO)

To find a network provider,

- visit https://www.aetna.com/docfind .Enter your zip code in the box on the right that says "Enter Location Here" and click search. Scroll down to *2023 Small Group Under 101 Employees*. Choose New York Elect Choice Open Access (OAEPO)
- Register and sign in as an Aetna member at www.aetna.com
- Call Aetna at the number on your member ID card or (800) 872-3862

Dental Insurance

What is Dental Insurance?

Dental Insurance is designed to pay a portion of the costs associated with dental care. Like medical insurance there can be copays, deductible and coinsurance for certain type of services; however preventive services are almost always covered at 100%.

Who is the provider?

Your Dental Insurance is provided by Aetna.

Aetna
(800) 872-3862
www.aetna.com

Do you need to take action?

You will need to make an enrollment election every year to participate in the dental plan.

If you enroll on the plan, 323 Transit pays 50% of the employee premium. You pay the premium balance with pre-tax contributions through payroll deductions.

All elections must be made on the 323 Transit Ease site at https://323transit.ease.com

Dental Plan

Summary of Benefits

The following summary outlines your dental benefits for the upcoming year.

	Dental
In Network	**PPO/PDN with PPO II**
Calendar Year Deductible (Single / Family)	$50/$150
Calendar Year Maximum (per person)	$1,000
Preventative Care: *Exams, Cleanings, Fluoride, Sealants, X-Rays, Space Maintainers*	100% coverage
Basic Services: *Periodontal Maintainers, Fillings, Simple Extractions, Endodontics*	80% coverage
Major Services: *Oral Surgery, Crowns, Bridges, Dentures*	50% coverage

Employer Contribution per week	$2.32/week
Your rate per weekly pay period (The 323 Contribution has already been deducted)	
Employee	$2.32
Employee + Spouse	$7.05
Employee + Child(ren)	$10.05
Employee + Family	$14.80

Vision Insurance

What is Vision Insurance?

Vision Insurance is designed to provide routine preventive care such as eye exams, eyewear and other vision services at a reduced rate.

Who is the provider?

Your Vision Insurance is provided by Aetna.

Aetna
(800) 872-3862
www.aetna.com

Do you need to take action?

You will need to make an enrollment election every year to participate in the vision plan.

All elections must be made on the 323 Transit Ease site at https://323transit.ease.com

Vision Plan

Summary of Benefits

The following summary outlines your vision benefits for the upcoming year.

	Vision
In Network	**Aetna Vision Preferred**
Eye Exams (Once every 12 months)	$20 copay
Lenses (Once every 12 months)	
Single, Bifocal, Trifocal	$20 copay
Progressive	$85 copay
Frames (Once every 12 months)	$100 allowance plus 20% discount on any balance
Elective Contact Lenses (in lieu of lenses and frames)	
Conventional	$105 allowance plus 15% discount on any balance
Disposable	$105 allowance
Medically Necessary Contact Lenses (Once per 12 months)	$0 copay
Additional glasses or sunglasses	Receive up to 40% off extra pairs when using network providers
Employee Contribution per week	
This is your contribution, paid pre-tax through payroll deductions.	
Employee	$1.34
Employee + Spouse	$2.55
Employee + Child(ren)	$2.69
Employee + Family	$3.95

Open Enrollment Reminders

What do I need to do to enroll?

All benefits elections are done through an online system called Ease. Please login to Ease before to make your benefits elections:

Go to https://323transit.ease.com to make your benefits elections for the new year.

Who to contact with questions?

Sean Donovan
323 Transit LLC
PO Box 176
Liverpool, NY 13088
(315) 427-1081
seandonovan@323transit.com

Enrollment Deadline

Enrollment decisions must be completed and submitted by 6/30/23 .

Legal Notices

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, 2022. Contact your State for more information on eligibility –

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

Legal Notices

GEORGIA-Medicaid
A 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
INDIANA-Medicaid
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
IOWA-Medicaid and CHIP (Hawki)
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
KANSAS-Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY-Medicaid
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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA-Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE-Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003/TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740/TTY: Maine relay 711
MASSACHUSETTS-Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
MINNESOTA-Medicaid
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
MISSOURI-Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA-Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

Legal Notices

NEBRASKA-Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE-Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
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
NEW YORK-Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA-Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA-Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA-Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON-Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA-Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462
RHODE ISLAND-Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA-Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA-Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS-Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493

Legal Notices

UTAH-Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT-Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA-Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON-Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA-Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
WISCONSIN-Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING-Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Legal Notices

To see if any other states have added a premium assistance program since July 31, 2022, 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

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Legal Notices

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

Legal Notices

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

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

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

Legal Notices

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Legal Notices

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

Legal Notices

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

If you have questions

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

Keep your Plan informed of address changes

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

Legal Notices

Women's Health and Cancer Rights Act of 1998 Notice

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As specified in the Act, if you or a covered family member had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WCHRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

All stages of reconstruction of the breast on which the mastectomy was performed;

Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

Prostheses and

Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The coverage will be provided in a manner determined in consultation with the attending physician and the patient. Deductibles and co-insurance established for other benefits under your plan also apply to these reconstructive surgery benefits.

USERRA Rights

If you, or your spouse or dependent, are absent from work for uniformed service, you may have the right to continue participating in the Plan under the Uniform Services Reemployment and Rights Act (USERRA). USERRA is intended to lessen the difficulty that may occur if you need to be absent from your civilian employment to serve in the United States uniformed services. USERRA seeks to make sure that those who serve their country can keep their civilian employment and benefits, and can seek reemployment without discrimination because of their service.

Under USERRA, employees absent for uniformed service (and their covered spouse and covered dependents) are eligible for continuation coverage for the period of service (plus time allowed under USERRA to apply for reemployment) or for up to twenty-four (24) months, whichever is less. If your service is for less than thirty-one (31) days, the plan may charge only your share of the monthly health care premium. If your service is more than thirty-one (31) days, your employer may charge the full premium plus 2% (for a total of 102% of the premium). You may have rights under both COBRA and USERRA and are entitled to the continued coverage that provides the more favorable benefit.

An individual who serves in the military will be considered on leave of absence and will be entitled to all rights and benefits not determined by seniority that are generally provided to similarly situated employees on leave of absence or other types of leave.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA.

Legal Notices

Mental Health Parity and Addiction Equity Act of 2008

Under the Mental Health Parity and Addiction Equity Act of 2008, the conditions (for example, copayments and deductibles) and treatment limitations for mental health and substance use disorders generally must not be more restrictive than those applicable to medical and surgical procedures. Review your plan documents for additional information about mental health coverage.

Michelle's Law

Certain covered dependents may be eligible to extend their plan coverage for a limited period of time when that coverage would otherwise end due to loss of student status.

Under Michelle's Law, the Plan cannot terminate coverage for a dependent child whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a medically necessary leave of absence. In this situation, the Plan will continue the dependent's coverage until the earlier of:

The date that is one year after the first day of the medically necessary leave of absence.

The date on which the dependent's coverage would otherwise end under the Plan's terms.

A dependent in this situation will be eligible for continued Plan coverage under Michelle's Law if you provide the Plan a written certification from the dependent's treating physician stating that:

The dependent is suffering from a serious illness or injury.

The leave of absence (or other change of enrollment) is medically necessary.

A medically necessary leave of absence means a leave of absence from a postsecondary educational institution, or any other change in enrollment of the dependent at the institution, that:

Begins while the dependent is suffering from a serious illness or injury.

Causes the dependent to lose student status for purposes of coverage under the Plan's terms.

Newborns' and Mothers' Health Protection Act

Generally, group health plans, cannot restrict any hospital length of stay in connection with childbirth for the mother or the baby to less than forty-eight (48) hours after a vaginal delivery, or less than ninety-six (96) hours after a cesarean delivery. Group health plans cannot require that an attending doctor get permission from the plan to keep the mother and baby longer than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean delivery. The attending doctor may consult with the mother and decide to release the mother and baby earlier than forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a cesarean delivery.

Legal Notices

HIPAA Notice of Privacy Practices (1 of 5)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes numerous requirements on employer health plans regarding how certain individually identifiable health information – known as protected health information or PHI – may be used and disclosed. This Notice describes how the plan, and any third party that assists in the administration of the plan, may use and disclose your protected health information for treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information that is maintained or transmitted by the Plans, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We will use PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request of it. Our insurers' Notices of Privacy Practices will apply, except for the limited medical information the we may receive and maintain from you when you ask us to assist you in a claims processing or benefit determination dispute, information related to your enrollment or disenrollment in the plan, and certain summary health information.

Your personal doctor or health care provider may have different policies or notices regarding their use and disclosure of your medical information.

We are required by law to abide by the terms of this notice to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect.

It is important to note that these rules apply to the Plans, not the company as an employer.

1. How We May Use and Disclose Medical Information About You. HIPAA generally permits use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. These uses and disclosures are more fully described below. Please note that this Notice does not list every use or disclosure; instead it gives examples of the most common uses and disclosures.

- Treatment: When and as appropriate, medical information may be used or disclosed to facilitate medical treatment or services by providers.
- Payment: When and as appropriate, medical information may be used and disclosed to determine your eligibility for the Plans' benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility and coverage under the plan, or to coordinate your coverage.
- Health Care Operations: When and as appropriate, medical information may be used and disclosed for the plan's operations, as needed. Your genetic information will not be used or disclosed for underwriting purposes.
- The plan will always try to ensure that the medical information used or disclosed is limited to a "Designated Record Set" and to the "Minimum Necessary" standard, including a "limited data set," as defined in the law for these purposes.

Legal Notices

HIPAA Notice of Privacy Practices (2 of 5)

OTHER PERMITTED USES AND DISCLOSURES

- Disclosure to Others Involved in Your Care: Medical information may be disclosed to a relative, a friend, or to any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care.
- Disclosure to Health Plan Sponsor: Information may be disclosed to another health plan for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to personnel solely for purposes of administering benefits under the plan.
- Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- To Comply with Federal and State Requirements: Medical information will be disclosed when required to do so by federal, state, or local law.
- To Avert a Serious Threat to Health or Safety: Medical information may be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is able to help prevent the threat.
- Military and Veterans: If you are a member of the armed forces, medical information may be released as required by military command authorities.
- Business Associates: Medical information may be disclosed to business associates. We have contracted with entities (defined as "business associates" under HIPAA) to help us administer your benefits. We will enter into contracts with these entities requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.
- Other Uses: If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical examiner. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Uses and disclosures other than those described in this notice will generally require your written authorization. Your written authorization is required for: most uses and disclosures of psychotherapy notes; uses and disclosures of PHI for marketing purposes; and disclosures that are a sale of PHI. You may revoke your authorization at any time, but you cannot revoke your authorization if the Plans have already acted on it.

The privacy laws of a particular state or other federal laws might impose a more stringent privacy standard. If these more stringent laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974 (ERISA), the plan will comply with the more stringent law.

2. Your Rights Regarding Medical Information About You. You have the following rights regarding medical information that we maintain about you:

Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your benefits under the Plans. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. If the Plans do not maintain the health information, but know where it is maintained, you will be informed of where to direct your request.

Legal Notices

HIPAA Notice of Privacy Practices (3 of 5)

- Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You also must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:

- Information that is not part of the medical information kept by or for the plan.
- Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Information that is not part of the information which you would be permitted to inspect and copy.
- Information that is accurate and complete.

- Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" (that is, a list of certain disclosures the plan has made of your health information). Generally, you may receive an accounting of disclosures if the disclosure is required by law, made in connection with public health activities, or in situations similar to those listed above as "Other Permitted Uses and Disclosures". You do not have a right to an accounting of disclosures where such disclosure was made:

- For treatment, payment, or health care operations.
- To you about your own health information.
- Incidental to other permitted disclosures.
- Where authorization was provided.
- To family or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a limited data set where the information disclosed excludes identifying information.

To request this list or accounting of disclosures, you must submit your request, which shall state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. Notwithstanding the foregoing, you may request an accounting of disclosures of any "electronic health record" (that is, an electronic record of health-related information about you that is created, gathered, managed, and consulted by authorized health care clinicians and staff). To do so, however, you must submit your request and state a time period, which may be no longer than three years prior to the date on which the accounting is requested.

Legal Notices

HIPAA Notice of Privacy Practices (4 of 5)

- Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. If the Plans do agree to a request, a restriction may later be terminated by your written request, by agreement between you and the Plans (including orally), or unilaterally by the Plans for health information created or received after the Plans have notified you that they have removed the restrictions and for emergency treatment. To request restrictions, you must make your request in writing and must tell us the following information:

- What information you want to limit.
- Whether you want to limit our use, disclosure, or both.
- To whom you want the limits to apply (for example, disclosures to your spouse).

- Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

3. Breach Notification. Pursuant to changes to HIPAA required by the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH Act") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), this Notice also reflects federal breach notification requirements imposed on the Plans in the event that your "unsecured" protected health information (as defined under the HITECH Act) is acquired by an unauthorized party.

- The plan will notify you following the discovery of any "breach" of your unsecured protected health information as defined in the HITECH Act (the "Notice of Breach"). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by email if you have previously agreed to receive such notices electronically. If the breach involves:

- 10 or more individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute individual Notice of Breach by either posting the notice on the benefits website on the company intranet or by providing the notice in major print or broadcast media where the affected individuals likely reside.
- Less than 10 individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute Notice of Breach by an alternative form.

Legal Notices

HIPAA Notice of Privacy Practices (5 of 5)

Your Notice of Breach shall be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and shall include, to the extent possible:

- A description of the breach.
- A description of the types of information that were involved in the breach.
- The steps you should take to protect yourself from potential harm.
- A brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches.
- Relevant contact information.

Additionally, for any substitute Notice of Breach provided via web posting or major print or broadcast media, the Notice of Breach shall include a toll-free number for you to contact us to determine if your protected health information was involved in the breach.

4. Changes to This Notice. We can change the terms of this notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will send you a copy of the revised notice.
5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the plan or with the Secretary of the Department of Health and Human Services.

All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

6. Other Uses of Medical Information. Other uses and disclosures of medical information that are not covered by this notice or the laws that apply to us will be made only with your written permission. If you grant us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we may be required to retain our records related to your benefit determinations and enrollment.

Legal Notices

HIPAA Initial Notice of Special Enrollment Rights

This notice is to inform you of your right, under a federal law called the Health Insurance Portability and Accountability Act (HIPAA), to enroll in Plan at times other than the Plan's annual open enrollment periods, upon the occurrence of specified events (for example, if have a baby). These enrollment periods are known as "special enrollment" opportunities. Generally, you must request enrollment within 30 days or as outlined in the plan documents.

- If you or your dependents lose eligibility for other coverage that you were enrolled in, you may be able to enroll in this plan.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan.
- If you, you spouse, or your dependents become eligible for assistance under Medicaid or a state children's health insurance program, or lose coverage under such a program, you may be allowed to enroll yourself and your dependents in the Plan.

Plan Benefits While on FMLA Leave

If you take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), the way in which you participate in the Plan will depend on whether or not you continue to get a paycheck from your employer while you are on leave. If your employer does not pay you while you are on leave, your participation in the Plan will be treated in the same way as if you had terminated your employment, unless you pay for benefits, on an after-tax basis while you are on leave. When you return to work your prior benefits will start again.

If you take a leave of absence that is a family or medical leave under the FMLA, you should contact the employer in order to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid family or medical leave under the FMLA, you may continue to participate in the Plan, but you may be required to continue your contribution.

Please contact the company as soon as you know you will be taking a Family or Medical Leave.

Qualified Medical Child Support Orders (QMCSOs)

A description of the procedures governing qualified medical child support orders (QMCSOs) can be obtained, without cost, from the plan administrator.

Wellness Plans

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us your employer and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

Legal Notices

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers covered under the law from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by the law. GINA's employment nondiscrimination requirements prohibit the company from discriminating against any employee or applicant with respect to hiring, discharge, compensation, terms, conditions or privileges of employment on the basis of genetic information with respect to the employee or applicant. As a result, the company will not fail or refuse to hire, or discharge any employee or applicant because of genetic information. The company will not limit, segregate or classify employees or applicants in any way that would deprive or tend to deprive them of employment opportunities or adversely affect their status as employees because of genetic information relating to the employees or applicants. The company will not discriminate or retaliate against individuals who oppose unlawful practices under GINA, or who make a charge, testify, assist or participate in any investigation, proceeding or hearing related to the employment nondiscrimination requirements. However, the company will not violate GINA if they limit or restrict an employee's job duties based on genetic information because they were required to do so by a law or regulation mandating genetic monitoring.

"Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Additionally, the plan will generally not:

- Request or require individuals or their family members to undergo genetic testing.
- Use genetic information to determine eligibility for coverage or to impose preexisting condition exclusions.
- Collect genetic information for underwriting purposes or with respect to any individual before enrollment or coverage.
- Adjust group premium or contribution amounts on the basis of genetic information.

Notice Regarding Designation of Primary Care Providers

The plan may allow or even require the designation of a primary care provider. 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 your employer. For children, you may designate a pediatrician as the primary care provider.

Notice Regarding Coverage for Obstetric 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. Contact the plan for a list of participating health care professionals who specialize in obstetrics or gynecology.

Legal Notices

Your Rights and Protections Against Surprise Medical Bills (1 of 2)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan network.

"Out –of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network cots for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out –of-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services that you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

Legal Notices

Your Rights and Protections Against Surprise Medical Bills (2 of 2)

Minnesota law prohibits balance billing

A network provider is prohibited from billing you for any amount in excess of the allowable amount the health carrier has a contractor for with the provider as a total payment for the health care service. A network provider is permitted to bill you the approved co-payment, deductible, or coinsurance. A network provider is permitted to bill you for services not covered by your health plan as long as you agree in writing in advance before the service is performed to pay for the noncovered service.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles, that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprise Help Desk (NSHD) at 1-800-985-3059 or the Minnesota Attorney General's Office at: 445 Minnesota St., Ste.1400, St. Paul, MN 55101; (800) 657-3787.

Visit cms.gov/nosurprises for more information about your rights under federal law.

Visit https://www.ag.state.mn.us/consumer/publications/MedicalBillingPointers.asp for more information about your rights under Minnesota state law, or for information about complaints related to health care, visit https://www.health.state.mn.us/facilities/insurance/clearinghouse/complaints.html.

Legal Notices

Other notices that require plan-specific customization:

Creditable Coverage Notice: Plan sponsors must provide annual notice to Medicare eligible participants about whether their prescription drug coverage is at least as good as Medicare prescription coverage.

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index?redirect=/CreditableCoverage/

Notice to Employees of Coverage Options: Required notice to employees about the Health Insurance Marketplace / State Exchange.

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-options-notice