2023

Benefits Guide

An overview of the wide array of benefits provided by Consulting Radiologists, Ltd. to help you enjoy increased well-being and financial security.

These benefits are effective on October 1, 2023.

Prepared by Christensen Group, Inc for Consulting Radiologist, Ltd.

Open Enrollment

There is specific window of time each year where you must complete your benefits elections. For the 2023 plan year, the Open Enrollment period for Consulting Radiologists, Ltd is 8/14/2023 – 8/25/2023

Your Open Enrollment Dates

August 14th – August 25th

How to Enroll

All benefits elections are done through the online enrollment system Ease. At the beginning of Open Enrollment, you will receive an email to access the Ease portal. The URL to the Ease portal is:
https://crl.ease.com/

If you have any questions, please contact:

Kellie Haehnel
kellie.haehnel@crlmed.com
(612) 573-2207

Contents

Consulting Radiologists, Ltd. 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 Consulting Radiologists, Ltd.

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. Consulting Radiologists, Ltd. 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 Summary

CRL 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.

QUESTIONS?

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

Kellie Haehnel
kellie.haehnel@crlmed.com
(612) 573-2207

Coverage	Carrier	Group #	Phone	Website
Medical	Blue Cross Blue Shield of MN	276446	(866) 873-5943	www.bluecrossmnonline.com
Flexible Spending Account (FSA)	Discovery Benefits	18562	(866) 451-3399	www.discoverybenefits.com
Dependent Care Account (DCA)	Discovery Benefits	18562	(866) 451-3399	www.discoverybenefits.com
Dental	Simple Benefits, Inc.	216	(800) 270-4158	www.simple.us
Basic Life	Su nLife/MGIS	955142	(800) 247-6875	https://now.mgis.com/
Short Term Disability	Su nLife/MGIS	955142	(800) 247-6875	https://now.mgis.com/
Long Term Disability	Su nLife/MGIS	955142	(800) 247-6875	https://now.mgis.com/
EAP	GuidanceResources	Web ID: MGISComplete	(877) 687-6447	www. guidanceresources.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 own individual accumulated expenses (the amount varies by plan).

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.

Copays & coinsurance

These expenses are your share of cost 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 health insurance company reconciles the bill with the providers.

Network

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

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.

Preventative 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.

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.

Medical Plan

Summary of Plan Options

The following plans are your medical insurance options for the upcoming year. Deductibles are on a calendar year cycle.

	Silver	Bronze	HSA
In Network	**Aware Network**	**Aware Network**	**Aware Network**
Deductibles (Single / Family) – Calendar Year	$500 / $1,000	$1,000 / $2,000	$3,100 / $6,250
Out-of-Pocket Max (Single / Family) – Calendar Year	$2,000 / $4,000	$3,000 / $6,000	$3,100 / $6,250
Preventative Care	100% covered	100% covered	100% covered
Primary Care Visit	$30 copay	Ded; then 80% coverage	Ded; then 100% coverage
Inpatient & Outpatient	Ded; then 80% coverage	Ded; then 80% coverage	Ded; then 100% coverage
Emergency Room	$200 copay	$200 copay	Ded; then 100% coverage
Urgent Care	$30 copay	Ded; then 80% coverage	Ded; then 100% coverage
Mental Health/Chemical Dependency Inpatient Outpatient	 Ded; then 80% coverage Ded; then 80% coverage	 Ded; then 80% coverage Ded; then 80% coverage	 Ded; then 100% coverage Ded; then 100% coverage
Pharmacy / RX (30 Day Supply)	Generic: $10 copay Preferred: $25 copay Non-preferred: $40copay Specialty: 20% up to $200 max	Generic: $10 copay Preferred: $25 copay Non-preferred: $40copay Specialty: 20% up to $200 max	Ded; then 100% coverage
Out of Network			
Deductibles (Single / Family) – Plan Year	$1,000 / $2,000	$2,000 / $4,000	$3,100 / $6,250
Out-of-Pocket Max (Single / Family) – Plan Year	$5,000 / $10,000	$5,000 / $10,000	$6,000 / $12,000
Employee Contribution Pay Period			
Employee	$41 per pay period	$18.50 per pay period	$7 per pay period
Employee + Family	$268 per pay period	$175 per pay period	$54 per pay period

Medical Plan

Blue Cross Blue Shield Of MN Networks

Aware (Minnesota)

The Aware network is Blue Cross' largest network that includes all Blue Cross Blue Shield-contracted providers, including Mayo Clinic Health System, in Minnesota.

To search the Aware network, select "Aware" in the network dropdown:

https://www.bluecrossmnonline.com/find-a-doctor/landing?productName=Aware&productId=901&displayProductName=Aware

BlueCard PPO (National Network)

The BlueCard PPO network is Blue Cross's national network that has access to more than 95 percent of doctors and 96 percent of hospitals nationwide. If you are seeking services outside of the state of Minnesota, you should look for providers in the BlueCard PPO network.

To search the BlueCard PPO network, select "BlueCard PPO" in the network dropdown:

https://findadoctormn.sapphirecareselect.com/?ci=bcbsmn&network_id=323&geo_location=45.18994999999998,-93.83705000000003&locale=en_us

Medical Plan

Blue Cross Blue Shield Of MN Value Adds

Blue Care Advisor

Blue Care Advisor connects you to everything you need to easily manage your healthcare. Find in-network healthcare providers along with cost estimates on care. Access claims, medical spending and wellness tools in one convenient location. Plus, track your daily activities to help meet your health goals.

- Log in at bluecrossmn.com/bca

Health management

Receive professional support for managing chronic or serious health conditions. Includes education, treatment plan support and community resource information.

- Call the number on the back of your member ID card

Maternity Management

Receive support and guidance from a maternity case manager.

- Call 1-866-489-6948

BCBS Mobile app

The BlueCross MN Mobile app gives you convenient, on-the-go access to important plan information and helpful tools right on your phone:

- A digital member ID card
- Deductible and out-of-pocket spending amounts
- Search tool for in-network doctors and care near you
- Claim status tracking
- Medical spending account balances

And, depending on your plan, you may even be able to compare the cost of care or medications.

Log in or download the app today to discover all the features that can help you get the most from your health plan.

Quitting Tobacco

Make a solid plan to kick nicotine products with help from a wellness coach. Get started by calling 1-888-662-BLUE (2583)or TTY711.

Medical Plan

Blue Cross Blue Shield Of MN Value Adds

Doctor on Demand (Video Chat)

See a doctor in minutes. Live video visits include assessment, diagnosis, and prescription when necessary. Video capabilities are required, and service is available 24/7. Visits to treat conditions like colds, the flu, and allergies never cost more than $59.

Visit https://doctorondemand.com/bluecrossmn to get started!

Blue365

With Blue365, you get great deals on products and services that complement your health. Save on personal care, fitness gear, hearing and vision, healthy meal kits and more. It just takes a couple minutes to register, and you can start shopping for things like:

- 20 percent off at Reebok.com
- Discounts on Jenny Craig or Nutrisystem
- $29 a month gym membership
- Up to 40 percent off contact lenses
- Up to 20 percent off hotels
- 50 percent off vitamins and supplements
- And more

Visitblue365deals.com/bcbsmn to register and have your Blue Cross member ID card handy. Then watch for the weekly deal to arrive in your

Health Savings Account (HSA)

What is an HSA?

A health savings account (HSA) is a health care account and savings account in one. The main purpose of this account is to offset the cost of a qualifying high deductible health plan (HDHP) and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement.

An HSA is a "portable" account. You own your HSA. It's included in your employee benefits package, but after you set up your account, it's yours to keep, even if you change jobs or retire.

Who is the administrator?

Your HSA is administered by Further.

Further
(800) 859-2144
www.hellofurther.com

Do you need to take action?

Only certain health plans are eligible for HSAs. Depending on which health plan you select, you may or may not be eligible for an HSA.

If you are eligible for an HSA via your health plan, you will need to setup an account on your own with Further.

Flexible Spending Accounts (FSA)

Overview & Details

As a reminder, FSAs are use it or lose it accounts. Unlike HSAs, money in your FSA at the end of the year will not carry over to the next year. Therefore, it's important to not over-fund your FSA. If you are enrolled in an HSA, you are only eligible for the Limited Purpose FSA and Dependent Care FSA.

Health FSA Eligible Expenses

- Medical expenses: co-pays, co-insurance, and deductibles
- Dental expenses: exams, cleanings, X-rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services: physical therapy, chiropractor, and acupuncture
- Prescription drugs and insulin
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.

Limited Purpose FSA Eligible Expenses

- Dental expenses: exams, cleanings, X-rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery

Dependent Care FSA Eligible Expenses

- Care for your child who is under age 13
- Before and after-school care
- Baby sitting and nanny expenses
- Day care, nursery school, and preschool
- Summer day camp
- Care for a relative who is physically or mentally incapable of self-care and lives in your home

Health FSA

Election Maximum: $3,050

Limited Purpose FSA

Election Maximum: $3,050

Carry Over : If you do not use all your fund during the plan year, you can carryover up to $610 to use during the following plan year.

CRL contributes $200 per eligible employee to the medical reimbursement amount.

Dependent Care FSA

Election Maximum: $5,000
($2,500 if married, filling separately)

Dental Insurance

Summary of Coverage

The following plans are your dental insurance options for the upcoming year.

Dental Plan Summary:

Your dental plan pays the following percentages of the expenses, up to a maximum benefit per person, per coverage year. This coverage includes all eligible dependents.

100% of Diagnostic and Preventive expenses, then 80% of the next $300 of expenses, then 50% of remaining expenses to a $1,500 maximum benefit per person, per coverage year. Orthodontics is covered at 50% with a separate $1,000 lifetime maximum.

* *Please note, that 90 Degrees/Simple Dental reimburses up the reasonable and customary charges based on your dentist's zip code; therefore, you may be responsible for additional charges. Please ask for a cost estimate from your dentist prior to service.

The cost for single coverage is $13 per pay period. The cost for family coverage is $35 per pay period.

Choice of Dentist:

You under this plan, YOU ARE FREE TO SELECT THE DENTIST OF YOUR CHOICE. Upon completion of your dental treatment, the dental office will then mail or fax the claim form to Simple Benefits. Payment will be made directly to the dentist with an Explanation of Benefits (EOB) sent to the employee's home address. It is the employee's responsibility to pay any balances due the dentist.

Claims:

Most Dentist will file the claim directly with Simple**
Electronically Payor ID: 58102
Fax: 888-308-6009
Mail: Simple, 2810 Premiere Parkway, Suite 400, Duluth GA 30097.

**If the provider's office cannot submit the claim, obtain a completed ADA claim form from the provider at the time of service to submit to Simple.

Register at www.90degreebenefits.com

1. To print a temporary ID Card
2. To check the status of claims you have submitted and to view claim history

For information on eligibility, coverage verification or claims, call customer service: 800-270-4158

Life/AD&D and Disability

Summary of Coverage

CRL pays 100% of the cost of the Basic Life/AD&D, STD and LTD policies with SunLife/MGIS. All Eligible employees are automatically enrolled in this plan.

Basic Life/AD&D Insurance	
Plan Features	**Benefit**
Employee Life Benefit Amount	3 times annual salary to a maximum of $400,000
Employee AD&D Benefit Amount	3 times annual salary to a maximum of $400,000
Life insurance and AD&D benefits reduce 35% at age 65 with additional reductions of 15% at ages 70 and 75.	

Short Term Disability (STD) Insurance	
Plan Features	**Benefit**
Employee Benefit Amount	60% of the pre-disability weekly earnings
Elimination Period Accident Sickness	 Benefit begins on day 8 of a qualifying disability Benefit begins on day 8 of a qualifying disability
Benefit Duration	Up to 84 Days
Pre-existing Condition Limits	N/A

Long Term Disability (LTD) Insurance	
Plan Features	**Benefit**
Employee Benefit Amount	60% of covered monthly earnings up to $6,500/month maximum
Day Benefits Begin	91st day of qualifying disability
Benefit Duration	May be paid up to age 65. Some limitations may apply for own occupation and disabilities due to mental illness or substance abuse.
Pre-existing Condition Limits	Disabilities due to conditions treated or diagnosed during the 3 months prior to your plan effective date may not be covered until you have been insured for 12 months.

Employee Assistance Program (877.687.6447)

The Employee Assistance Program provides confidential counseling to address personal issues employees may be facing. A toll-free line is staffed 24 hours a day, seven days a week by experienced clinicians. Up to five face-to-face counseling sessions are also provided annually at no cost to the employee and dependents.

Online: www.guidanceresources.com
App: GuidanceResources® Now
Web ID: MGISComplete

Other Benefits

Summary

401(K)/PROFIT SHARING PLAN

Full-time employees may begin contributing to the 401(k) plan on the day that they become eligible (i.e.; date of hire, over the age 21, reclassification to full-time status, etc.). If no election is made following 30 days of eligibility, the employee will be automatically enrolled at 4% of your compensation. If they are automatically enrolled and do not wish to participate, the employee will have 90 days to request a refund from the date of the first automatic deferral. If automatically enrolled, the deferral rate will annually increase by 1% of compensation until the deferral rate reaches 6% of compensation.

They are able to change their contribution rate AT ANY TIME via the Securian Participant site: https://www.securianretirementcenter.com; deductions will be updated each payroll. Part-time employees must work 1,000 hours in a year and have attained age 21.

Eligible employees may contribute up to 50% of annual salary to a maximum of $22,500; $7,500 additional for those 50+ years in 2023. CRL will contribute 3% of individual compensation regardless of your personal 401(k) deferral level. Employees are always 100% vested in their 401(k) employee contributions, rollovers, and the 3% CRL contribution, as well as any earnings they generate. The vesting for the Profit-Sharing contribution is based on a three (3) year schedule as follows:

Year	1	2	3
Percentage	0%	50%	100%

Paid Time-Off (PTO)

CRL recognizes that employees need time away from work to attend to personal business, enhance health and take vacations. Therefore, eligible employees accumulate Paid Time-Off (PTO) hours each pay period, which may be used at the employee's discretion. Accruals are made on a pay period basis, based on paid hours. PTO accrual rates are based on years of service and level or type of position. Accrual rates increase at the 5-year, 10-year and 15-year anniversaries.

Other Benefits

Summary

Tuition Reimbursement

CRL encourages employees to pursue educational opportunities, at an accredited institution, which will be considered beneficial to both the employee and the company.

CRL will reimburse the employee 50% of the cost of tuition, books and other required supplies upon the appropriate approval and successful completion of the course. The employee will be reimbursed up to a total of $2,000 in any calendar year for approved educational courses.

Eligibility for CRL's Tuition Reimbursement Program requires the employee to be a permanent, fulltime employee, in good standing, and employed with CRL a minimum of one (1) year .

Continuing Education

CRL provides annual assistance to all employees (full time, part time benefit eligible and part time non-benefit eligible) to help cover the costs of pre-approved continuing education courses, seminars and/or conference fees as well as associated expenses for travel, meals, and lodging. The annual allocation is $300.00 for full time and part time benefit eligible employees and $150.00 for non-benefit eligible employees.

Professional Associations

CRL reimburses eligible employees for one annual professional association membership fee. Eligible employees include full time and part time benefit eligible employees responsible for satisfying continuing education requirements in order to maintain clinical and professional certifications and licenses.

Open Enrollment Reminders

What do I need to do to enroll?

All benefits elections are done through the online enrollment system Ease. At the beginning of Open Enrollment, you will receive an email to access the Ease portal. The URL to the Ease portal is: https://crl.ease.com/

Who to contact with questions

Kellie Haehnel
kellie.haehnel@crlmed.com
(612) 573-2207

Enrollment decisions must be made by August 25th.

Legal Notices

Premium Assistance Under Medicaid and theChildren'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 premiumassistance 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 yourState 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 dependentsmight 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 eligiblefor 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 January 31, 2022. Contact your State for more informationon eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Programhttp://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.comMedicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	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 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	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

Legal Notices

INDIANA–Medicaid	MASSACHUSETTS–Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA–Medicaid and CHIP (Hawki)	**MINNESOTA–Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/membersMedicaid 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	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
KANSAS–Medicaid	**MISSOURI–Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY–Medicaid	**MONTANA–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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA–Medicaid	**NEBRASKA–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)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA–Medicaid	**SOUTH CAROLINA–Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE–Medicaid	**SOUTH DAKOTA–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	Website: http://dss.sd.gov Phone: 1-888-828-0059

Legal Notices

NEW JERSEY–Medicaid and CHIP	TEXAS–Medicaid
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	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK–Medicaid	**UTAH–Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA–Medicaid	**VERMONT–Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA–Medicaid	**VIRGINIA–Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-selecthttps://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA–Medicaid and CHIP	**WASHINGTON–Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON–Medicaid	**WEST VIRGINIA–Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)
PENNSYLVANIA–Medicaid	**WISCONSIN–Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm Phone: 1-800-362-3002
RHODE ISLAND–Medicaid and CHIP	**WYOMING–Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	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 January 31, 2022, or for more information onspecial 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

Paperwork Reduction Act Statement

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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.

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.

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

Family and Medical Leave Act (FMLA)

Leave Entitlements Eligible employees who work for a covered employer (generally those with 50 or more employees) can take up to 12 weeks of unpaid, job protected leave in a 2-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrue paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restore to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must

- Have worked for the employer for at least 12 month;
- Have at least 1,250 hours of service in the 12 months before taking the leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave Generally, employees must give a 30-day advance notice of the need for FMLA leave. If it is not possible to give a 30-day notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share medical diagnosis but must provide enough information to the employer so it can determine if the eave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Legal Notices

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities Once an employer become aware that an employee's need for leave is a for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA eave and, if eligible, must also provide a notice of rights and responsibilities under he FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.
Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement Employees may file a complaint with the U.S Department of Labor, Wage and Hour Division at 1-866-4-USWAGE (1-866-487-9243m TTY: 1-877-889-5627 or www.dol.gov/whd), or may bring a private lawsuit against an employer The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local aw or collective bargaining agreement that provides greater family or medical leave rights.

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, elect breast reconstruction in connection with a mastectomy you also will be covered 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.