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2023-2024 EMPLOYEE BENEFITS GUIDE

For benefits effective March 1, 2023 – February 28, 2024

In this guide

[[Client Name]] offers you and your eligible family members a comprehensive and valuable benefits program. This guide has been developed to assist you in learning about your benefit options and how to enroll.

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

ENROLLMENT INFORMATION

When Does Coverage Begin?

Coverage will be effective the first of the month following 30 days of employment, provided you complete your enrollment within 45 days of your hire date.

Who is Eligible to Elect Benefits?

If you are a benefits-eligible employee (regular full-time employee scheduled to work a minimum of 30 hours per week), you can enroll in the benefits described in this Guide. Please remember that only eligible dependents can be enrolled. Eligible dependents include: an employee's spouse or civil union partner; if under the age of 26, a natural child, adopted child, foster child, stepchild or grandchild (if court-ordered custody); or a disabled dependent.

Medical, Dental and Vision coverage is available for employees with same-sex domestic partnerships in states that do not recognize civil union partnerships. However, the domestic partnership must be legally recognized by the state and the employee would need to present a certificate to certify such. Opposite-sex domestic partnerships are not covered.

Making Plan Changes

IRS S 125 prohibits you from changing your enrollment during the Plan Year unless you experience a qualifying life event (QLE). A qualifying life event includes (but is not limited to) a marriage, divorce, death of a spouse or a dependent, birth or adoption of a child, termination or commencement of employment for your spouse, a change in employment status for you or your spouse that affects benefits eligibility, etc.

If you experience a qualifying life event you must report and submit required documentation to Human Resources within 31 days of the event occurrence date to be eligible to make changes to your elections.

MEDICAL PLAN: HORIZON BCBS

Below is a summary of the medical plans available to you, effective January 1, 2023.

	Option 1: Advantage EPO HRA	Option 2: Advantage EPO HSA
	In-Network	**In-Network**
Plan Year Deductible Individual/Family	$2,500/$5,000	$2,000/$4,000
Firm Contribution to HSA or HRA Individual/Family	$1,250/$2,500	$750/$1,500
Coinsurance	Plan pays 100%*	Plan pays 80%*
Plan Year Out-of-Pocket Maximum** Individual/Family (Includes deductibles, medical and prescription drug copays, out-of-pocket costs)	$5,000/$10,000	$4,000/$8,000
PCP Office Visit	$20 copay*	$20 copay*
Specialist Office Visit	$40 copay*	$40 copay*
Preventive Care	Plan pays 100% NO deductible	Plan pays 100% NO deductible
Inpatient Hospital	$250 copay per day (up to 5 days)*	Plan pays 80%*
Outpatient Surgery Hospital Surgical Center	 $200 copay* $100 copay*	 Plan pays 80%* Plan pays 80%*
Emergency Room	$100 copay*	Plan pays 80%* and $100 copay
Telemedicine	Not Covered	$15 copay*

* After deductible

** The Out-of-Pocket Maximum is the most you pay during the policy period (3/1/2023 through 2/28/2024) before your health plan starts to pay 100% for covered services for the remainder of the policy year. This limit includes your out of pocket and employer funded costs toward deductible, coinsurance and medical/prescription drug copayments.

For more details regarding this coverage, please refer to the BenePortal by visiting: **www.samplebenefitsportal.com**

Annual Physical Exam
Blood pressure
Cholesterol
Diabetes
Breast cancer
Colorectal cancer
Prostate cancer
Thyroid disease
Glaucoma

*Don't Forget: **Preventive Care and Wellness Services** are covered **100%** in-network—no copays or coinsurance!*

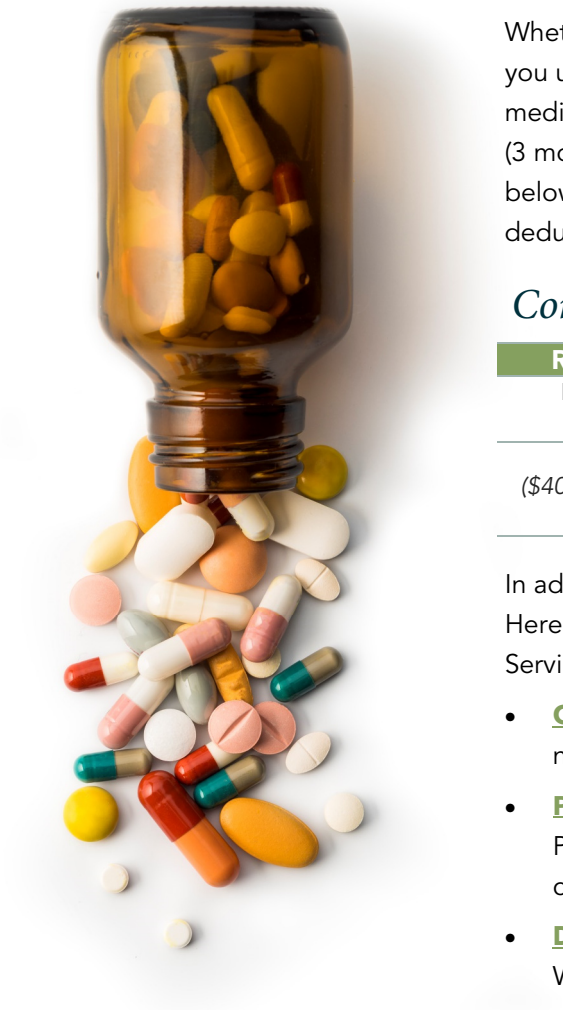
The screenings to the left represent just some of the preventive care screenings available through our medical plan. Don't guess when it comes to your health—make the most of your healthcare investment and take advantage of the preventive care services that are covered 100% in-network.

PRESCRIPTION DRUG PLAN:

HORIZON BLUE CROSS BLUE SHIELD

Below is the prescription drug benefit for the 2023-2024 plan year. If you elect to participate in the medical plan, you are automatically enrolled in the corresponding prescription drug plan. For more details regarding this coverage, please refer to the BenePortal by visiting: **www.samplebenefitsportal.com**. **All member out-of-pocket prescription drug costs accumulate towards your medical plan out-of-pocket maximum.**

Benefits	Option 1: Advantage EPO HRA	Option 2: Advantage EPO HSA
Retail (up to a 30-day supply) Generic Formulary Non-Formulary	 $20 copay $40 copay $70 copay	Plan pays 80% after deductible
Mail-Order (up to a 90-day supply) Generic Formulary Non-Formulary	 $40 copay $80 copay $140 copay	Plan pays 80% after deductible



Save on Your Prescriptions With Mail-Order

Whether you enroll in the HRA plan or the HSA plan, you can save money when you use Horizon PrimeMail by Walgreens Mail Service for your maintenance medications. If in the HRA plan, you can fill a script up to a 90 day supply (3 months) for two retail copays by using Horizon PrimeMail as illustrated below. If in the HSA plan, the discounted rate you pay (which goes toward your deductible) is lower when filling your prescription through PrimeMail.

Compare for yourself…

Retail Pharmacy	Mail Order	Annual Savings
Formulary Copay **$40**	Formulary Copay **$80**	**$160 per script**
Annual cost *($40 per month x 12 fills)* **$480**	Annual cost *($80 per order x 4 fills per year)* **$320**	

In addition to the savings, your prescriptions will be delivered right to your home. Here is how you can begin to use the Horizon PrimeMail by Walgreens Mail Service:

- **Online and Mobile:** Visit **www.walgreens.com/primemail**, click "register now" to create an account and follow the directions.
- **Phone:** Call **888.844.3828**, 24/7 to refill or transfer a current prescription. Please have your member ID card, prescription information and your doctor's contact information ready.
- **Doctor:** Ask your doctor to send your prescription electronically to Walgreens Mail Service or fax a prescription request to **800.332.9581**.

HEALTH REIMBURSEMENT ACCOUNT (HRA): FURTHER

How to Access Your HRA Information

There are two ways you can access your HRA information; through Horizon's website **www.horizonblue.com** or through the mobile app Horizon *MyWay*.

How HRA Claims are Processed

Your HRA account is administered by Further, a Horizon BCBS partner. The HRA claims process is set up to pay the first 50% of your deductible ($1,250 for individual coverage and $2,500 for family coverage) directly to the provider until it is depleted.

1. Your provider bills Horizon
2. Horizon processes the claim and determines your responsibility
3. Horizon sends your billed amount to be processed through your HRA, which is administered by Further
4. Further then issues a payment for the billed amount out of your HRA
5. The provider receives the payment

This process is considered the most convenient for members, but issues can transpire.

Common Issues Include:

Provider asks for your payment upfront

If your provider requires you to make your portion of the payment upfront, you can have them call a Horizon MyWay customer service representative at **888.215.0025**. The provider will be able to determine the following:

1. You have a Health Reimbursement Account
2. If there is enough remaining in the HRA to cover the service, the provider will **not** be able to obtain the account balance.

HRA payment not received by provider

This can occur if the provider's address is not updated in Horizon/Further's system. In the event you encounter this issue, please ask your provider to confirm their address. Once confirmed, you may reach out to the Conner Strong & Buckelew Member Advocacy team for further assistance. The Member Advocacy team will contact Horizon on your behalf in an effort to ensure that your provider's address is accurate in the Horizon/Further systems. If an address update is needed, Horizon will relay this information to Further so that Further can issue the provider payment using the provider address that applies.

Partial HRA payment

When the HRA is exhausted, and only a portion of the amount due is paid, members who are unaware can have their portion of the bill sent to collections. This makes it critical for members to be aware of their account balance.

Out of Network Services

If services are rendered by an out of network provider, your HRA will **not** reimburse you for out-of-pocket expenses.

HEALTH SAVINGS ACCOUNT (HSA): FURTHER

The Health Savings Account (HSA) is available to eligible employees enrolled in the Advantage EPO HSA plan. The funds in your HSA can be used to offset your out-of-pocket healthcare expenses. Unused account dollars are yours to keep even if you leave [[Client Name]]. HSA participants will receive a debit card via mail from Further to be used for eligible expenses.

HSA Contributions

- The company will contribute to your HSA each pay period (24 per year), up to the annual amounts below:
  - **Single: $750**
  - **Family: $1,500**
- You may also contribute to your HSA on a pre-tax basis via payroll deductions. The maximum amount that can be contributed to your HSA (including any company contributions) is set by the IRS at the below amounts:
  - **Single: $3,650**
  - **Family: $7,300**
- If you are age 55 or older you may contribute up to an additional $1,000 annually into your HSA.
- The funds in your account are yours to keep! There is no 'use-it-or-lose-it' rule with HSAs, meaning that unused funds rollover from year-to-year with no limit on the amount that may be carried forward. This also means that any funds in your account should you leave [[Client Name]] remain with you!

Triple Tax Advantage

Like 401(k) contributions, HSA money is tax-free when it enters the plan and when it grows through investment earnings. Unlike a 401(k), HSAs offer a third tax advantage: money remains tax-free when it is withdrawn - as long as you use it to pay for eligible healthcare expenses.

HSA Eligibility

Any employee can contribute to an HSA if you:

- Have coverage under the HSA-qualified, High Deductible Health Plan (HDHP)
- Have no other first-dollar medical coverage (other types of insurance, including specific injury or accident, disability, dental care, vision care, or long-term care insurance are generally permitted)
  - Health Flexible Spending Accounts, including your spouse's, are considered other first-dollar coverage. A Limited Purpose FSA (discussed further in this guide) is available if you wish to have both the HSA and an FSA.
- Are not enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return

Please Note: If you are 65 or older, and are automatically enrolled in Medicare Part A, you are ineligible to make HSA contributions (unless you decline enrollment in Medicare Part A), but you can continue to use the HSA for qualified medical expenses. If you wish to decline Medicare Part A, you may also not accept Social Security Benefits.

Eligible Expenses

The IRS determines which expenses qualify for reimbursement from an HSA. A full list of eligible expenses can be found at **www.irs.gov/publications/p502**, however some examples are listed below:

- Deductibles and coinsurance, prescription drugs, physician office visits including mental health professionals and chiropractors, ambulance, emergency room visits, and x-rays, dental cleanings, sealants, extractions, and orthodontia, eye exams, contact lenses, eyeglasses, and eye surgery

Please Note: If funds are used for non-qualified expenses, they are subject to normal income tax plus an additional 20%.

DENTAL PLANS: DELTA DENTAL OF NJ

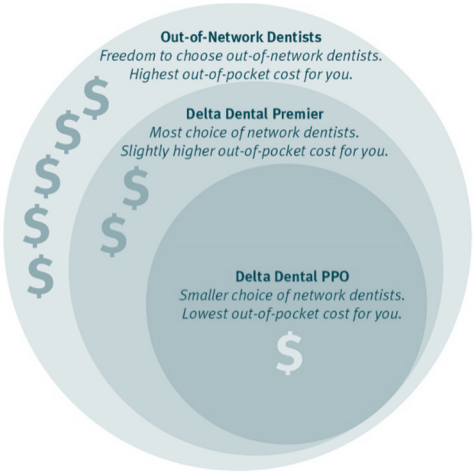
For more details regarding this coverage, please refer to the BenePortal by visiting: **www.samplebenefitsportal.com**

	PPO Plan	Premier Plan
	In-Network / Out-of-Network	**In-Network / Out-of-Network**
Calendar Year Deductible	$50 per person / $150 family aggregate	$50 per person / $150 family aggregate
Calendar Year Maximum (per patient)	$1,500	$1,500
Preventive & Diagnostic Services	Plan pays 100% Deductible does not apply	Plan pays 100% Deductible does not apply
Basic Services	Plan pays 50% after deductible	Plan pays 50% after deductible
Major Services	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontia Benefits (child only)	Plan pays 50%	Plan pays 50%
Orthodontia Lifetime Maximum (per patient)	$1,000	$1,000

* For illustrative purposes only

Premier Plan vs PPO Plan

Both plans have the same basic design, however, the Premier Plan includes a broader network of providers. To confirm which networks your dentist participates with, please visit **www.deltadental.com** and click on **"Find a Dentist"**.



Delta Dental Carryover Benefit

This is a Delta Dental benefit feature that allows members to carry over part of their unused standard annual maximum in one year to increase benefits for the following year and beyond. In order to qualify for Carryover Max Benefits, members must meet the following criteria:

- Enroll on or before the effective date of the Carryover Max benefit year which is March 1, 2023 for this contract year. Members enrolling after the March 1, 2023 effective date are not eligible to accrue carryover benefits until the start of the next benefit year.
- Use no more than 50% of the standard annual maximum during the benefit year.
- See a dentist during the benefit year for an exam or cleaning and submit a claim for these services. **If a claim for an exam or cleaning is not received, any accumulated Carryover Max benefit will be lost.**

Savings Opportunity!

Utilizing providers who participate in the PPO network may help you achieve additional savings. Not only are payroll deductions lower when enrolling in the PPO plan, but PPO dentists have generally agreed to lower fees for services. If your dentist participates in the Delta Dental PPO Network, then your best option for dental coverage would be the PPO Plan.

VISION PLAN:
HORIZON BLUE CROSS BLUE SHIELD OF NJ

If you are enrolled in one of the Horizon Blue Cross Blue Shield medical plans, you are automatically enrolled in the corresponding Horizon Blue Cross Blue Shield of NJ vision benefit plan. Please visit **www.horizonblue.com** for more information regarding your vision benefits.

Horizon Blue Cross Blue Shield of NJ Vision Benefit Plan

	Option 1: Advantage EPO HRA	Option 2: Advantage EPO HSA
Annual Eye Exam	$20 copay*	$40 copay*
Hardware	$50 every 2 years	$50 every 2 years

* After deductible

VOLUNTARY VISION PLAN: EYEMED

[[Client Name]] is offering a **Voluntary Vision benefit administered by EyeMed.** This vision plan is in addition to the vision benefits offered to you through your Horizon BCBS medical plan. EyeMed has the largest mix of national and regional retail providers including Luxxotica optical. For further information on your EyeMed vision benefits, claims assistance, or to locate a participating vision provider, visit **www.eyemed.com** or call customer service at **1.866.939.3633.**

EyeMed Vision Benefit Plan

	In-Network (Insight)	Out-of-Network
Exam	$10 copay	Up to $40 reimbursement
Frames	$175 Allowance; 20% off balance over $175	Up to $123 reimbursement
Lenses Single Vision Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses	$25 copay*	Up to $70 reimbursement
Contact Lenses (in lieu of eyeglasses)	$175 Allowance ; 15% off balance over $175 (conventional) 100% covered (medically necessary)	Up to $175 reimbursement (elective) Up to $210 reimbursement (medically necessary)
Frequency Vision Exam Lenses Frames	 Every 12 months Every 12 months Every 12 months	

* For progressive lenses tiers and prices see schedule of benefits
** For illustrative purposes only. Additional benefit information is available via EyeMed plan documents.

EyeMed Retail Chains: LensCrafters, Pearle Vision, Luxottica, Target Optical

Additional Discounts

- Sunperks - up to $50 off at Sunglass Hut
- **www.glasses.com** and Contacts Direct online retail store - 3D virtual try on app and free shipping and returns
- Amplifon hearing aid discount program

EMPLOYEE CONTRIBUTIONS:

PER PAY (24 PER YEAR)

The following contributions are effective through February 28, 2024.

Per Pay Medical and Prescription Drug Payroll Deductions - Non-Tobacco Users

	Option 1: Advantage EPO HRA	Option 2: Advantage EPO HSA
Employee Only	$0.00	$0.00
Employee + Spouse	$200.09	$178.65
Employee + Child(ren)	$103.21	$104.86
Family	$348.35	$314.65

Per Pay Medical and Prescription Drug Payroll Deductions - Tobacco Users

	Option 1: Advantage EPO HRA	Option2: Advantage EPO HSA
Employee Only	$25.00	$25.00
Employee + Spouse	$225.09	$203.65
Employee + Child(ren)	$128.21	$129.86
Family	$373.35	$339.65

Per Pay Dental Payroll Deductions

	PPO Plan	Premier Plan
Single	$0.00	$3.51
Employee + 1	$5.57	$11.83
Employee + 2 or more	$14.04	$24.51

Per Pay Vision Payroll Deductions

	EyeMed
Employee Only	$4.49
Employee + Spouse	$8.53
Employee + Child(ren)	$8.97
Family	$13.19

All payroll deductions are taken on a pre-tax basis unless otherwise noted.

FLEXIBLE SPENDING ACCOUNTS:
PAYLOCITY

[[Client Name]] provides you with the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through the Flexible Spending Accounts (FSA).

Healthcare FSA

The Healthcare FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. The maximum you can contribute to the Healthcare FSA is **$2,850**.

Eligible Expenses Include:

- Doctor office copays
- Non-cosmetic dental procedures (crowns, dentures, orthodontics)
- Prescription contact lenses, glasses, and sunglasses
- LASIK eye surgery

Dependent Care FSA

The Dependent Care FSA is used to reimburse expenses related to the care of eligible dependents. The maximum that you can contribute to the Dependent Care FSA is $5,000 if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is $2,500.

Eligible Expenses Include:

- Au Pair
- After school programs
- Baby-sitting/dependent care to allow you to work or actively seek employment
- Day camps and preschool
- Adult/eldercare for adult dependents

Limited Purpose FSA

For those enrolled in Option 2: Advantage EPO with a Health Savings Account, you may participate in a Limited Purpose FSA. The maximum you can contribute to the Limited Purpose FSA is $2,850. **Eligible expenses under the Limited Purpose FSA include dental and vision expenses only.**

How Much Should I Contribute?

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period. While **up to $570** of unused funds will carry over from year to year, any additional amounts will be forfeited if not used by the end of the plan year.

Please note: You cannot participate in both the Health Savings Account (HSA) and Healthcare Flexible Spending Account (FSA).

LIFE/AD&D INSURANCE: THE STANDARD

Group Insurance

[[Client Name]] employees working 30 hours or more per week are automatically enrolled in Group Life and Accidental Death and Dismemberment (AD&D).

Group Life/AD&D Benefit:

1 times annual earning up to a maximum of $500,000 (max is combined with Supplemental Life/AD&D coverage). A guarantee issue amount of $330,000 applies to the Group Life/AD&D benefit.

The following schedules apply:

Life/AD&D Reduction:

- Ages 65-69 = 65%;
- Age 70 or more = 50%;

Supplemental Life/AD&D Insurance

If you would like to purchase additional Life/AD&D coverage for yourself, an eligible spouse and/or child, you may do so through after-tax payroll deductions. Employees must elect supplemental coverage for themselves in order to elect supplemental coverage for a spouse and/or child. Below is a brief description of the Supplemental Life/AD&D benefits offered.

Supplemental Life/AD&D	
Employee	Benefit: Up to 5 times your salary in increments of $10,000 Max Benefit: $500,000 (combined with Group Life/AD&D) Guarantee Issue*: $200,000
Spouse	Benefit: $5,000 increments Guarantee Issue*: $25,000 Overall Max Benefit: The lesser of $250,000 or 100% of the employee supplemental amount
Children (from live birth through age 25)	Benefit: $2,000 increments Max Benefit: $10,000

*Guarantee Issue is only available during a benefit eligible employee's initial eligibility period. An Evidence of Insurability (EOI) form must be completed when electing outside of initial eligibility window AND/OR when electing coverage above the Guaranteed Issue amount.

Employee Supplemental Life Monthly Rate per $1,000 of coverage
$.19 per $1,000

Age Band	Spouse Supplemental Life Rate per $1,000 of coverage
15-24	$.030
25-29	$.040
30-34	$.040
35-39	$.050
40-44	$.090
45-49	$.130
50-54	$.210
55-59	$.330
60-64	$.350
65-69	$0.500
70-74	$1.530
75+	$1.530

Child Supplemental Life Monthly Rate per $1,000 of coverage
$.20 per $1,000
NOTE: The premium for child coverage is the total paid, regardless of how many children you have.

Supplemental AD&D Monthly Rate per $1,000 of coverage	
Employee	$0.02
Spouse	$0.02
Child	$0.02

DISABILITY INSURANCE: THE STANDARD

Long-Term Disability Coverage

Eligible full-time [[Client Name]] employees regularly working 30 hours or more per week are automatically enrolled in long-term disability coverage. This benefit is provided by the company at no cost to you.

Long-Term Disability Benefits

- **Class 1 (Shareholders):** 60% of monthly earnings to a maximum benefit of $20,000 per month.
- **Class 2 (Attorneys):** 70% of monthly earnings to a maximum benefit of $10,000 per month.
- **Class 3 (All Other Employees):** 60% of monthly earnings to a maximum benefit of $5,000 per month.

Age at Disability	Maximum Period of Payment
Less than age 62	To Social Security Normal Retirement Age (SSNRA)
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age (SSNRA)
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

Employee Assistance Program

All benefit eligible employees are automatically enrolled in the Employee Assistance Program (EAP) through Charles Nechtem Associates (CNA). You and your dependents have 24/7/365 access to a work life assistance program designed to assist you with problems you encounter during daily living.

When you have questions, concerns or emotional issues surrounding your personal or work life, CNA can help.

CNA's work-life balance employee assistance program offers unlimited access to master's and PhD level consultants by telephone, resources and tools online, and up to six face-to-face visits with a consultant for help with a short-term problem.

Help is a Call or Click Away:

- **Call: 800.531.0200**
- **Online:** Visit **www.charlesnechtem.com**
- **Email: inquiries@charlesnechtem.com**

For more information about these benefit plans, please refer to the BenePortal by visiting **www.samplebenefitsportal.com**.

OUTSIDE RESOURCES

Member Advocacy

AVAILABLE MONDAY-FRIDAY, 8:30 AM - 5:00 PM EST

Member Advocacy, provided by our benefits consultant, Conner Strong & Buckelew, is here to help you with your benefits related needs. This convenient service allows you to speak to a specially trained and experienced Member Advocate who can help you with inquiries such as:

- Understanding your benefits and coverage questions
- Assistance if you believe your claim was not paid properly
- Clarification on information from the insurance company
- Questions regarding a bill from a doctor, lab or hospital
- Enrollment inquiries

Call **1.800.563.9929** or submit a request online at **www.connerstrong.com/memberadvocacy**

BenePortal

YOUR BENEFITS INFORMATION IS A CLICK AWAY!

At [[Client Name]], you have access to a full-range of valuable employee benefit programs. You are able to review your current employee benefit plan options online, 24 hours a day, 7 days a week!

By using BenePortal, our new online tool that houses our benefit program information, you can:

- Review your options for medical, prescription drug and dental coverage
- Download plan designs, Summary Plan Descriptions, wellness information, etc.

You and your family can access BenePortal anytime at: **www.samplebenefitsportal.com**

CARRIER CONTACTS

Carrier/Vendor	Phone Number	Website
Horizon BCBS of NJ: Medical & Prescription Drug Benefits	1-800-355-2583	www.horizonblue.com
Further: Health Savings Account (HSA) & Health Reimbursement Account (HRA)	1-800-859-2144	www.hellofurther.com
Delta Dental of NJ: Dental Benefits	1-800-452-9310	www.deltadentalnj.com
EyeMed: Vision Benefits	1-866-939-3633	www.eyemed.com
Paylocity Flexible Spending Accounts (FSAs)	1-888-873-8205	www.paylocity.com
The Standard: Life/AD&D, Long-Term Disability Benefits	1-888-937-4783	www.standard.com
Charles Nechtem Associates: Employee Assistance Program	1-800-531-0200	www.charlesnechtem.com

LEGAL NOTICES

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

Special Enrollment Notice

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [30 days or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage. Coverage will be effective the first of the month following your request for enrollment.

Loss of coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. 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 new dependents. However, you must request enrollment within [30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources.

Important Notice from [[Client Name]] About Your Prescription Drug Coverage and Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. [[Client Name]] has determined that the prescription drug coverage offered by the Advantage EPO is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current [[Client Name]] coverage will be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage. (See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D).

If you do decide to join a Medicare drug plan and drop your current [[Client Name]] coverage, be aware that you and your dependents will be able to get this coverage back if there is a Life Event or at open enrollment.

LEGAL NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with [[Client Name]] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [[Client Name]] changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contact: Human Resources
Address: 9000 Midlantic Drive, Suite 300
Mount Laurel, NJ 08054
Phone Number: 856-596-8900

Continuation of 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 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

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;
- 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 the COBRA vendor.

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.

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, Medicaid, 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.

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.

Plan contact information

Contact: Human Resources
Address: 9000 Midlantic Drive, Suite 300
Mount Laurel, NJ 08054
Phone Number: 856-596-8900

Newborns' and Mothers' Health Protection Act Notice

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

Women's Health and Cancer Rights Act Notice

If you have 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 (WHCRA). 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;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

LEGAL NOTICES

Mental Health Parity and Addiction Equality Act of 2008

This Act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Notice of Privacy Practices

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of [[Client Name]]'s group health plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.
The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

1) your past, present or future physical or mental health or condition;
2) the provision of health care to you; or
3) the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact your Human Resources representative.

Effective Date
This Notice is effective January 1, 2023.

Our Responsibilities
We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices **by mail to your address on file**.

How We May Use and Disclose Your Protected Health Information
Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. If the Plan uses or discloses protected health information for underwriting purposes, including determining eligibility for benefits or premium, the Plan will not use or disclose protected health information that is genetic information for such purposes, as prohibited by the Genetic Information Nondiscrimination Act of 2008 (GINA) and any regulations thereunder.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

LEGAL NOTICES

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information 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 able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations
In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health 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.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.
Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official—
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures of Your Medical Information Require Your Authorization
Written Authorization: Your medical information will not be used or disclosed for

any purpose not mentioned above in the "How We May Use and Disclose Your Protected Health Information" section except as permitted by law or as authorized by you. This includes disclosures to personal representatives and spouses and other family members as described below. In the event that the Plan needs to use or disclose medical information about you for a reason other than what is listed in this notice or required by law, we will request your permission to use your medical information and the medical information will only be used as specified in your authorization. You may complete an Authorization form if you want the Plan to disclose medical information about you to someone else.

Any authorization you provide will be limited to the specific information identified by you and you will be required to specify the intended use or disclosure and name then person or organization that is permitted to use or receive the information specified in the authorization form. You have the right to revoke a previous authorization. Requests to revoke an authorization must be in writing. The Plan will honor your request of revocation for the prospective period of time after the Plan has received your request. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

In addition, the Plan will not sell your medical information or use it for marketing purposes (that are not considered as part of treatment or healthcare operations) without a signed authorization from you. Also, if applicably, the Plan will not disclose psychotherapy notes without a signed authorization from you.

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
2) treating such person as your personal representative could endanger you; and
3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information maintained in any form (paper or electronic) that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to Human Resources. If you request a copy of the information, we may charge a reasonable 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 your medical information, you may request that the denial be reviewed by submitting a written request to Human Resources.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to Human Resources. In addition, you 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 information that:

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

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state a time period of not 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 provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

LEGAL NOTICES

To request restrictions, you must make your request in writing to Human Resources. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information. You will receive a notification to your last know address within 60 days of the discovery. The notification will include:

- specific information about the breach including a brief description of what happened
- a description of the types of unsecured medical information involved in the breach
- any steps you should take to protect yourself from potential harm resulting from the breach
- a brief description of the investigation the Plan is performing to mitigate the harm to you and protect you from future breaches
- a contact information where you may direct additional questions or get more information about the breach.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Human Resources.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

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 October 15, 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

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - medicaid
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
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
GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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

LEGAL NOTICES

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 realy 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-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: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (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

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

LEGAL NOTICES

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
https://www.coverva.org/en/famis-select
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
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: 800-251-1269

To see if any other states have added a premium assistance program since October 15, 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