Generations Health Employee Benefits Guide

January 1—December 31, 2024

YOUR BENEFITS PACKAGE

At Generations Health Association our employees are the foundation of our success. To reflect our commitment to you, we provide a comprehensive benefits program as an important part of your total compensation package. Your benefit needs are unique—and those needs may change over time. Our benefits program is designed to be flexible to fit your personal situation. Our 2024 benefits program gives you the opportunity to select the coverage you need. In this booklet you will find summaries of the Generations Health employee benefits package. This booklet contains important information about your benefits. Please take the time to review it and share the information with your family.

Important Changes to Medical Insurance

Due to the continued increase of medical cost each year, Generations Health has decided to offer an Individual Health Reimbursement Account, also called an ICHRA in place of the traditional group medical plan like we've had in the past. So what is an ICHRA? We will go into more detail over the next few pages, but to put is simply Generations will give eligible employees a monthly contribution for them to use to purchase individual medical coverage through the Bavvy Marketplace. Bavvy provides you with the freedom to pick the individual health plan that best fits your needs under an employer-sponsored group insurance plan.

Table of Contents

BENEFITS ELIGIBILITY

For all full-time, benefit eligible employees, benefits will take effect the first of the month following 60 days of full-time employment. Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian.

You may enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children under age 26, regardless of marital or student status, are eligible to enroll in medical, dental, vision, life, critical illness, and accident insurance.
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

Other dependents who may live with you, but are NOT eligible to be added to your benefit plans:

- Grandchildren, nieces, nephews or other children who do not meet specifications listed above
- Ex-spouses, unless required via court order (documentation required)
- Parents, step-parents, grandparents, aunts, uncles, or other relatives who are not qualified legal dependents (even if they live in your house)

Making Changes to Your Benefits

Most benefit deductions are withheld from your paycheck on a pre-tax basis (medical, dental, vision) and therefore your ability to make changes to these benefits is restricted by the IRS. Once enrolled, pre-tax benefit elections cannot be changed until the next annual Open Enrollment period, unless you have a qualifying life status change.

Open Enrollment generally occurs in November with plan changes effective from January 1st through December 31st of the following year.

To make benefit changes as a result of a Life Status Change as allowed under Section 125 of the IRS Code, you must:

- Notify your Human Resources department within **60 days** of the date of the qualifying event.
- Provide proof of your life status event
- Login to your Bavvy account and the Prepare Benefits site within **60 days** of your qualified event to complete the appropriate enrollment/change.

The Most Common Life Status Changes

- Marriage, divorce, legal separation
- Birth or adoption
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order or other court order

MEDICAL BENEFITS *provided through Bavvy Marketplace*

What Does Bavvy Mean for Me?

Bavvy is an innovative way to purchase insurance. It provides you the freedom to pick the individual health plan that works best for your needs under an employer-sponsored group insurance plan. In simplest terms, Bavvy follows these four steps:

1. Your employer sets up and funs you Bavvy eCheck. You will use the routing and account number on your eCheck to pay for your health insurance premium.
2. You access the Bavvy Marketplace to shop for an individual health insurance plan.
3. Any cost above your employer contribution amount will be payroll deducted.
4. Additional support with licensed health insurance agents help you through the whole process.

Open Enrollment

Open Enrollment provides you the opportunity to shop and purchase your individual insurance plan. To avoid a gap in coverage, make sure to finalize your selection during Open Enrollment.

- Before Open Enrollment, it is helpful to gather your list of current doctors and prescriptions.
- Check your email for a registration link from Bavvy. Click on this link to begin your enrollment process.
- To establish and maintain active coverage you need to make the initial binder premium payment as well as set up monthly recurring payments to the insurance carrier using the Bavvy eCheck.
- Once Open Enrollment ends, be on the lookout for your new member ID cards from the insurance carrier.

How to Enroll

Once Open Enrollment begins, you can shop for your health insurance through the Bavvy Marketplace. Here is a brief summary of the steps to follow:

- Log in and register your Bavvy account using the link provided to you via email.
- Choose either “Enroll now” or “Waive Coverage.”
- If you choose to enroll, complete your profile and dependent profile information.
- Shop on the Bavvy Marketplace - select a plan that best fits your and your family’s needs.
- You should receive your member ID cards in the mail 10 - 14 business days after you enroll. If you do not receive them, contact your insurance carrier.

IMPORTANT: You must complete enrollment during the Open Enrollment timeframe or you will not have coverage. Set up recurring monthly payments with your carrier using the eCheck so your policy does not lapse.

Health Insurance 101

	Description	Example
Premium	The monthly cost of the plan	$200 per month
Deductible	For things without a copay, you have to pay this amount first before insurance pays	If your plan has a $1,000 deductible, you'll pay the first $1,000 each year
Copay	A fixed amount for care	$25 for a doctor visit
Coinsurance	The percentage you pay after the deductible until you reach the max out-of-pocket	If your bill after your deductible is $100 and coinsurance is 20%, you pay $20
Max Out-of-Pocket	The most you'll pay in one year. After you reach this amount, insurance pays everything else.	If the max out-of-pocket is $8,000 and you get a bill for $1M, you pay $8,000 and nothing more

OTHER PLAN FEATURES

No Cost Preventive Care

Thins like annual physicals, annual OBGYN visits, screening tests and immunizations are covered at no cost to you.

Formulary

A list of prescription drugs your health plan covers and their cost to you.

High Deductible Health Plan (HDHP)

Offers lower premiums but has a higher deductible. A great way to save money if you're relatively healthy and protect yourself from serious injuries and illnesses.

Health Savings Account (HSA)

A bank account that allows you to pay medical bills tax-free. HSAs only work with HDHPs.

Provider Network

Most insurance plans have a specific group of doctors with in their Provider Network. There are four major network types. Understanding the network type and confirming your doctor is "in-network" are important when choosing a plan.

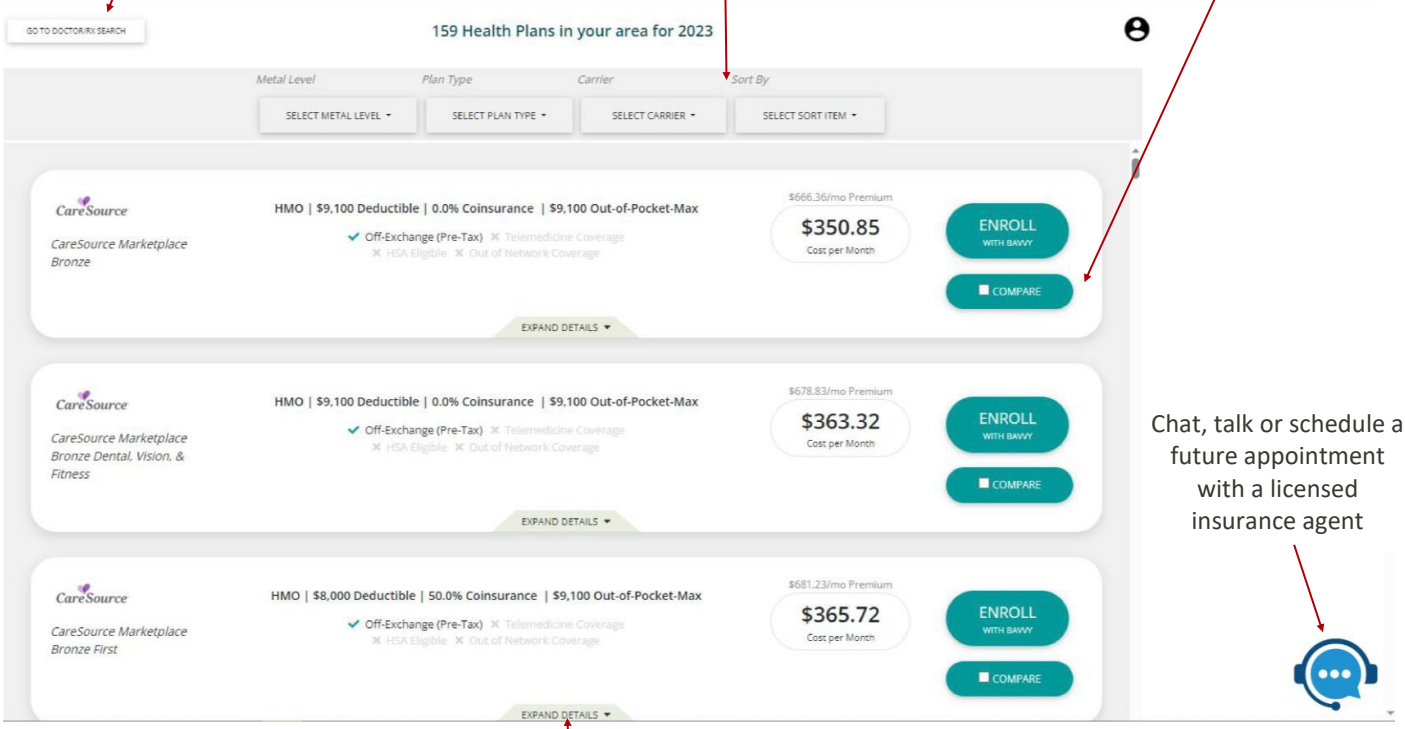
Types of Networks	PPO Preferred Provider Organization	EPO Exclusive Provider Organization	POS Point of Service	HMO Health Maintenance Organization
Primacy Care Physician (PCP) required	X	*Sometimes*	√	√
Referral required to see a specialist	X	X	*Sometimes*	√
In-network benefits	√	√	√	√
Non-emergency out-of-network benefits	√	X	√	X
Emergency coverage	√	√	√	√

Shopping Guide: The Bavvy Marketplace

Search using the doctor, hospital and prescription lookup tool

Filter plans by carrier, metal level, and type of plan

Compare up to 4 different plans to see which is right for you



Chat, talk or schedule a future appointment with a licensed insurance agent

Review additional important details of the insurance plan option.

WEBSITE NAVIGATION VIDEO

Click the graphic to the right or visit https://ohw.wistia.com/medias/mzah6ydqzy to watch the Employee Navigation Guide video. In this video, you will learn how to navigate all things Bavvy.

How to Pay with Bavvy eCheck

- The Bavvy eCheck is the only payment method you will use to cover your entire insurance premium.
- When you shop and enroll on the Bavvy Marketplace, the Bavvy eCheck is typically applied.
- Most carriers will allow you to confirm payment and recurring payment through their online portal or a customer support line.
- If a carrier refers to a “personal payment method” you should use your Bavvy eCheck.

If you need to access your Bavvy eCheck, you can find it here:

1. Log in to Bavvy
2. Select the menu icon on the upper right of your dashboard.
3. From the drop-down menu, select “My Bavvy eCheck.”
4. Easily pull your routing number (9 digits) and account number (12 digits).

IMPORTANT: To establish and maintain active coverage, it is important to make the initial binder payment as well as set up monthly recurring payments to the insurance carrier using Bavvy eCheck. To guarantee your policy is active, you need to confirm with your insurance carrier. Do not rely on payroll deductions from your employer.

Bavvy Customer Success Team

1-855-520-0188

bavvysupport@milliman.com

Qualified Life Event or Separation

If you recently experienced a Qualifying Life Event (QLE) such as having a baby, starting a new job, or moving to a different state, you are eligible to change your election.

Next Steps:

1. You can submit a QLE request in Bavvy.
2. Your employer with either approve or decline.
3. You will need to provide documentation, such as birth certificate, SEP letter or proof of address to the carrier.
4. You have 60 days from the date of the QLE to make changes or find a new plan.

For a full list of QLEs visit: https://www.healthcare.gov/glossary/qualifying-life-event/.

If you leave your employer, you can keep your insurance coverage through Bavvy by changing the payment method to your personal banking account. If you no longer want to keep coverage, please contact your carrier right away to cancel your policy.

Common Questions

How can I confirm my plan selections?

Set up recurring payments with your carrier. You can call your carrier or call our Bavvy customer success team to confirm plan selection.

When will I receive my membership ID card from my insurance carrier?

Depending on your carrier the timing and process can vary. Most carriers will send out cards within 10 -14 business days after open enrollment. If you haven't received your card and need your member ID number for treatment, reach out to your carrier.

My insurance carrier sent me a notice cancelling my coverage or for non-payment. What should I do?

First step, call your insurance carrier. This is most likely due to a recurring payment issue. In most cases Bavvy is the Agent of Record for your policy that enables us to work with the carrier on your behalf. Our Bavvy customer success team can also help navigate these questions.

When can I change my plan selection?

If you have a Qualifying Life Event (QLE) such as having a baby, starting a new job, or moving to a different state, you are eligible to change your selection. Otherwise, you can change coverage at the next open enrollment which will occur in Nov. and Dec. for a Jan.1 effective date.

I'm 65+ and need to enroll in coverage, what do I do?

Employees 65+, are eligible for Medicare. This can be completed online or at your local social security office. Contact Bavvy customer success for any other questions.

Process for Medicare-Eligible Employees

Step 1: Enroll in Original Medicare provided by the federal government

- **Part A:** Helps pay for hospital stays and inpatient care
- **Part B:** Helps pay for doctor visits and outpatient care
  - » **A Medicare enrollee must complete Step 1 (Original Medicare) before moving on to Step 2 (Medigap/ MedAdvantage)**

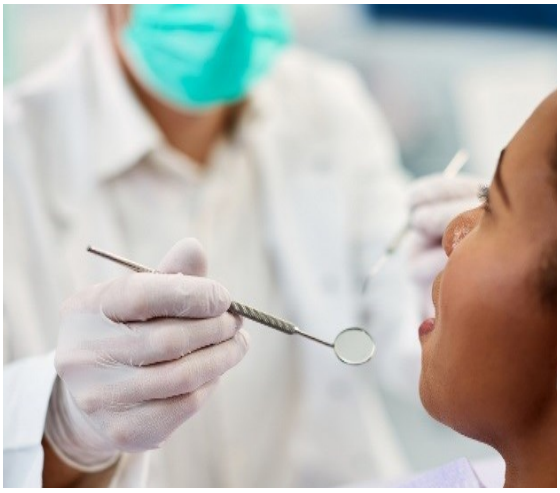
Step 2: Additional coverage

- **Option 1:** Medigap insurance offered by private companies helps pay some out-of-pocket costs not covered by Medicare. Part D—Helps pay for prescription drugs.
- **Option 2:** Medicare Advantage Plan offered by private companies. Part C– Combines Medicare A & B. Part D—Helps pay for prescription drugs.
  - » May provide additional benefits not provided by original Medicare.

Enroll in Original Medicare as soon as possible, approval process is 6-8 weeks.

- » Enrollment can be completed online or at your local Social Security office; bring your driver’s license.
- » For assistance, contact a Truist Medicare Specialist at 800-474-1471 or medicare@truist.com.

DENTAL BENEFITS *provided through Guardian*



Finding a Provider: Guardian's online directory makes it easy to find in-network dentists. Just follow these easy steps to find an in-network provider:

- Visit guardiananytime.com
- Call 1-888-600-1600
- Network: DentalGuard Preferred

Visit Your Dentist Regularly

Regular preventive visits to your dentist can help protect your health! Recent studies have linked gum disease to damage elsewhere in the body such as oral infections, diabetes, heart disease, stroke, and preterm, low-weight births.

DENTAL PLAN	Option 1: Base Plan	Option 2: Buy Up Plan
Calendar Year Deductible **Waived for Preventive Care**	$75 per person $225 per family	$50 per person $150 per family
Calendar Year Benefit	$1,250 maximum per person	$2,500 maximum per person
Preventive Services– Age limits may apply Oral Exams, X-rays, Cleanings, Fluoride Treatment, Sealants, Cleaning (every 6 months)	100% up to annual maximum benefit	100% up to annual maximum benefit
Basic Services Fillings, Perio Maintenance, Repair of Crowns, Bridges and Dentures, Simple Extractions, Scaling & Root Planing	Member pays deductible; then covered at 80%	Member pays deductible; then covered at 100%
Major Services Bridges and Dentures, Single Crowns, Inlays, Onlays, Veneers, Root Canal, Surgical Extractions	Member pays deductible; then covered at 50%	Member pays deductible; then covered at 50%
Orthodontics– Adults and Child(ren)	Excluded	50% up to $2,000 max
Maximum Rollover **Threshold** **Rollover Amount** **In-Network Only Rollover**	$600 $300 $450 $1,250	$900 $450 $700 $1,500
Benefit Election	**Your Cost Per Pay Period**	**Your Cost Per Pay Period**
Employee Only	$12.25	$15.48
Family	$35.27	$46.69

VISION BENEFITS *provided through Guardian*

For just a few dollars a month, this coverage saves you money on optical wellness, as well as providing discounts on eyewear, contacts and corrective vision services.

Guardian members can take care of their vision and have routine eye exams, while saving money on all of their eye care needs. Your vision plan through Guardian utilizes the Davis Vision network. Davis Vision offers access to over 43,000 provider locations such as Walmart, Sam's Club, Target, Sears and Pearle locations.

To find a provider call 1-888-600-1600 or visit guaridiananytime.com.

VISION PLAN	Davis Vision: In-Network
Copay Exams Copay Materials Copay (waived for elective contact lenses)	 $10 $20
Sample of Covered Services	**You Pay Amount (after applicable copay)**
Lenses Single Vision, Lined Bifocal Lined Trifocal, Lenticular	 $0 after materials copay
Frames	80% of amount over $130
Contacts Elective & Conventional Planned Replacement & Disposable Medically Necessary	 85% of amount over $130 85% of amount over $130 $0
Cosmetic Extras	Average 40-60% off retail price
Glasses (Additional pair of frames and lenses)	Courtesy discount from most providers
Laser Correction Surgery Discount	Up to 25% off the usual charge or 5% off promotional price
Network Discounts (glasses and contact lens professional service)	Applies to first purchase & courtesy discount from most providers on subsequent purchases.
Service Frequencies Exams Lenses (For glasses and contact lenses) Frames	 Every calendar year Every calendar year Every two calendar years
Benefit Election	**Your Cost Per Pay Period**
Employee Only	$3.90
Family	$8.38

VOLUNTARY BENEFITS *provided through Guardian*

Voluntary benefits can help offset costs caused by sudden illness and accidents. Voluntary benefits can also cover some non-medical expenses that your current insurance might not cover.

Meeting Your Needs

Life can be unpredictable and full of surprises. Sometimes your circumstances change and you need coverage that can help meet your needs. With access to Life, Critical Illness and Accident insurance you can rest easy knowing your future is a little more secure.

Budget Friendly

Sometimes, receiving proper healthcare can be difficult if money is tight. Our voluntary benefit options can provide valuable coverage at an affordable price. Voluntary insurance can help alleviate worry and help keep your finances strong.

Putting You First

The quality of your health shouldn't be undermined by unaffordable care. Voluntary benefits are designed to supplement any insurance you may already have and can help offset medical expenses not paid by other coverage you may have.

Advantages to You:

- Some plans are guarantee issue if elected when you are first eligible
- Benefits paid directly to you
- Benefits paid in addition to any other coverage
- Individual or family coverage
- Affordable premiums
- Wellness benefits available

VOLUNTARY LIFE/AD&D *provided through Guardian*

Life insurance isn't a fun thing to think about, and it may seem like an unnecessary expense. But, if you have people who depend on you for financial support, then life insurance is really about protecting them in case something happens to you.

As an eligible employee of Generations Health you have the option to purchase voluntary life insurance on you and your dependents at a low, group rate. Premiums are based on your age and the amount of coverage you wish to elect. Please log in to PBEnroll for pricing and more plan details.

VOLUNTARY LIFE/AD&D	Benefit Highlights
Voluntary Term Life Employee Benefit	Employees may elect life insurance in $10,000 increments to a maximum of $250,000.
Voluntary Term Life Spouse Benefit	A spouse may elect life insurance in $5,000 increments to a maximum of $250,000. Upon death, benefits would be paid to the employee. In order to purchase life insurance on your spouse, you must purchase coverage for yourself.
Voluntary Term Life Child(ren) Benefit **Note: Disabled children over the maximum child age limits may be eligible for benefits. Please contact your HR for more information.*	Your dependent children age 14 days to 26 years may elect either a $5,000 or $10,000 benefit. Upon death, benefits would be paid to the employee. In order to purchase coverage on your child(ren), you must purchase coverage for yourself.
Accidental Death & Dismemberment (AD&D)	Employee, Spouse and Child(ren) coverage will equal 1 times the life insurance benefit amount.
Guarantee Issue Amounts *This means that you are not required to answer Evidence of Insurability (EOI) questions to qualify for coverage up to the specified amount, when you sign up for coverage during the initial enrollment period.*	Employee less than age 65: $150,000 Employee age 65-69: $50,000 Employee age 70+: $10,000 Spouse less than age 65: $25,000 Spouse age 65-69: $10,000 Spouse age 70+: No benefit Dependent Children: $10,000
Age Reduction Schedule	Benefits reduce by: 35% at age 65, 60% at age 70, 75% at age 75 85% at age 80
Portability	Portability is included and allows you to take your coverage with you if you terminate employment. You would pay Guardian directly for your premiums.
Annual Enrollment Buy Up Option	During Annual Enrollment employees with existing coverage may increase their benefit by an electable amount, up to $50,000 without completing EOI. Not to exceed guarantee issue limit.

GROUP WHOLE LIFE INSURANCE *provided through Atlantic American*

Group Whole Life Insurance Protection from Atlantic American offers coverage that not only extends your own financial protection when faced with an unexpected event, but also offers guaranteed benefits to help the ones you love continue to live their lives while helping to keep their financial health intact.

Term Life vs. Whole Life—What is the Difference?

PRODUCT	Voluntary Term Life	Group Whole Life
Premium Type	Employee Paid	Employee Paid
Benefit Reductions	Guaranteed benefit reduction at specific age	No reduction in benefits
Protection Period	While employed	Through entire working period and retirement
Practical Application	Family protection (education, mortgage, etc.)	Final expenses, medical expenses for terminally ill

About Your Benefits:

- Employee: $1,000 to $100,000 benefit in $10,000 increments
- Guaranteed Issue up to $100,000 of coverage with no health questions
- Available to employees age 18-70

Optional Dependent Benefits:

- Spouse: $5,000 to $25,000 benefit, not to exceed 100% of the employee's elected amount
- Spouse coverage is provided through a Term Life Rider
- Available to spouses age 18-50
- Child Term Rider: $5,000 or $10,000; covers child(ren) ages 15 days through age 25

Policy Benefits

- Guaranteed Death Benefit
- Guaranteed Level Premiums
- Guarantee Cash Value
- Guaranteed Living Benefits
- Policy is portable
- Waiver of Premium for Disability Rider
- Accelerated Death Benefit Rider for Terminal Illness
- Lump Sum Accelerated Death Benefit for Chronic Illness Rider
- Immediate Claims Payment

Please refer to www.preparebenefits.employeenavigator.com for pricing.

Easy access to coverage

MyCoverage is an easy-to-use website that allows you to access coverage and benefit information 24/7, update your profile and more.

mycoverage.atlam.com

How it Works

* This is an example for illustrative purposes only. Actual policy amounts and payments will depend on benefits purchased, death and living benefits.

ACCIDENT INSURANCE *provided through Guardian*

Accident coverage provides cash benefits for out-of-pocket expenses associated with an accidental injury and can help protect hard-earned savings should an accidental injury occur. No one plans to have an accident, but it can happen anytime, anywhere! Accident coverage through Guardian can help pick up where other insurance leaves off. The information below is a brief summary of benefits. Please refer to the Guardian Accident benefit summary for more covered treatments, plan limit maximums and benefit exclusions.

- Guaranteed Issue coverage; no medical exams or tests to take
- Coverage available to yourself and your family
- Cash benefit paid directly to you
- $50 Wellness Benefit Per Year
- Coverage is portable, meaning if you were to leave employment at Generations Health you have the option to continue this coverage directly with Guardian

ACCIDENT	Coverage Details– Off the Job Benefit
Initial Physician Office Visit	$75
Accident Follow Up Visit	$25, up to 6 treatments
Emergency Room Visit	$150
Urgent Care Center	$75
Child Organized Sports Benefit	25% increase to child benefits
Concussion	$100
Air/Ground Ambulance	$750 / $150
Hospital Admission	$750
Daily Hospital Confinement	$150 per day up to 1 year
Hospital ICU Confinement	$1,500
Daily ICU Confinement	$300 per day up to 15 days
Diagnostic Exam (Major)	$100
X-Ray	$30
Fractures	Schedule up to $4,000
Laceration	Schedule up to $300
Burns (2nd/3rd Degree)	Up to $12,000 based on size of burn in square inches
Accidental Death Benefit	Employee: $10,000 / Spouse: $5,000 / Child(ren): $5,000

Accident Employee Premiums: (24 Payroll Deductions)			
Employee Only	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$6.68	$11.30	$12.14	$16.75

CRITICAL ILLNESS INSURANCE *provided through Guardian*

A serious medical event such as a heart attack or stroke could leave you in a period of financial difficulty. Even if you have medical insurance, there are typically uncovered expenses to consider such as deductibles, copayments, travel expenses to and from treatment centers and loss of wages or salary. Critical Illness insurance from Guardian pays you a cash benefit for covered illnesses and treatments. Coverage is based on your age and the amount of coverage you elect. Please refer to PBEnroll for pricing details.

- Lump sum benefit paid directly to you
- $50 Wellness Benefit
- Guaranteed Issue Amount: $10,000 for employees. All spouse and child(ren) amounts are guarantee issue.
- Coverage is portable, so if you were to leave employment at Generations Health you have the option to continue this coverage directly with Guardian.

Coverage Amounts		
Employee/Spouse/Child(ren)	$10,000 / $5,000 / 25 % of employee lump sum benefit	
Covered Illnesses		
Cancer	**1st Occurrence**	**2nd Occurrence**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not covered
Vascular Conditions	**1st Occurrence**	**2nd Occurrence**
Heart Attack, Stroke, Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other Category	**1st Occurrence**	**2nd Occurrence**
Organ Failure, Kidney Failure	100%	50%
Child Conditions	**1st Occurrence**	**2nd Occurrence**
Cerebral Palsy, Cleft Lip/Palate, Club Foot, Cystic Fibrosis, Down's Syndrome, Muscular Dystrophy, Spina Bifida, Type 1 Diabetes	100%	No benefit
Infectious Disease Benefit—Coronavirus, Meningitis, MRSA, Rabies, Tuberculosis, Lyme Disease, Malaria	30%	No benefit
Pre-Existing Limitation		
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.		12 months prior, 12 months after

WILL PREP SERVICES *provided through Guardian*

Special bonus for participants in voluntary life plan!

Your employer has worked with Guardian to make WillPrep Services available to eligible members with Voluntary Life plans. Keeping an up-to-date will is essential to ensuring that your assets are distributed as you intended, no matter the size of your estate. You may be avoiding creating a will because you believe you can't afford the time or legal expense. Now you can with WillPrep Services.

WillPrep Services offer support and guidance to help you properly prepare the documents necessary to preserve your family's financial security. WillPrep has a range of services including online planning documents, a resource library and access to professional to help with issues related to:

Advanced Health Care Directives	Financial Power of Attorney	Wills and Living Wills
Estate Taxes	Guardianship and Conservatorship	Resource library
Executors and Probate	Healthcare Power of Attorney	Trusts

BENEFITS RESOURCES

CARRIER/GROUP #	Phone	Web/Email
Medical—Bavvy	855-520-0188	Email: bavvysupport@milliman.com
Dental & Vision - Guardian *Group #00461551*	888-600-1600	guardiananytime.com
Voluntary Life/AD&D, Accident, Critical Illness - Guardian *Group #00461551*	888-600-1600	guardiananytime.com
Will Prep Services - Guardian	877-433-6789	ibhwillprep.com *User: WillPrep / Password: GLIC09*
Group Whole Life - Atlantic American *Group #W5191-001*	866-458-7502	mycoverage.atlam.com
Medicare Specialist - Truist	800-474-1471	medicare@truist.com

ENROLLMENT INSTRUCTIONS *through Prepare Benefits*

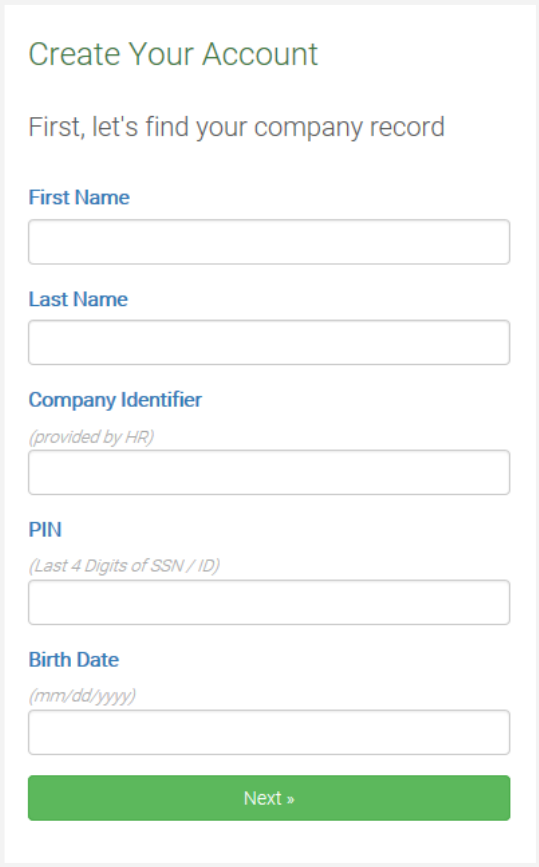
It's Time to Enroll!

Please note: Medical enrollment must be completed through your Bavvy account.

To enroll in dental, vision, life, accident or critical illness insurance follow the steps below.

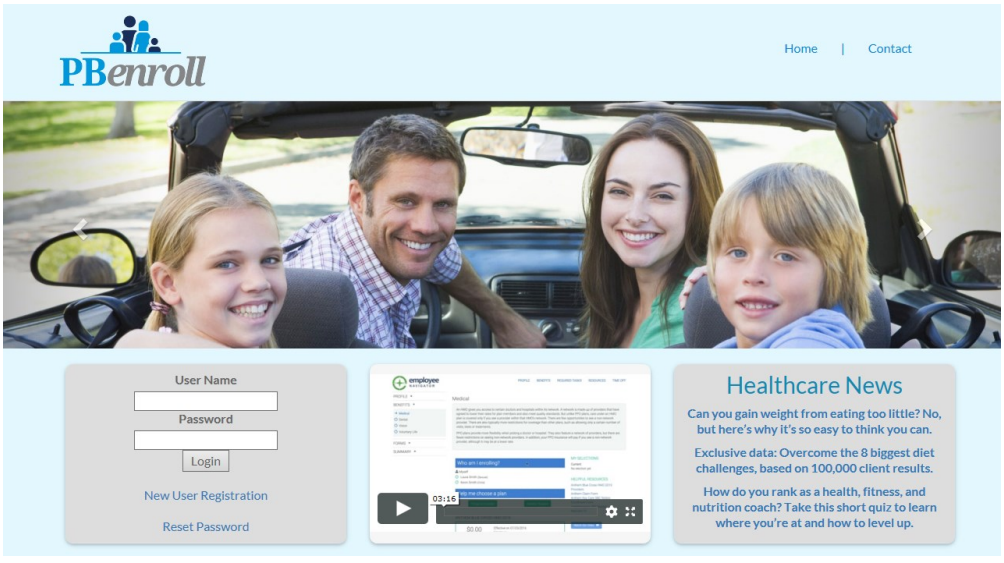
Where Do I Start:

- Visit www.preparebenefits.employeenavigator.com
- Log in using your unique username and password
- Your company identifier will be: ghealth2022
- From the homepage select START BENEFITS to begin your enrollment process



Key Points to Remember when Making Elections:

- Dependents need to be added on the dependent screen before you can add them to any plan.
- All plan documents are available on the right hand side of the screen.
- All rates are represented as "per pay period" on the plan screens.
- Remember to add beneficiary information at the end of the enrollment process for any life insurance plan
- Employees may make changes to their benefits up until the



WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to telehealth for virtual visits.

	Cost	Appointment Needed?	Wait Time	Severity	Conditions Treated
Virtual Visit	$	No	🕐	⊕	Minor health concerns such as cold and flu symptoms, allergies, sinus and ear infections, family health questions, rashes or skin conditions, minor burns, and vaccinations
Convenience Care Clinic	$$	No	🕐🕐	⊕	
Primary Care Physician	$$	Yes	🕐🕐	⊕	Routine or preventive care, track medications and get refills, or get a referral to see a specialist
Urgent Care	$$$	No	🕐🕐🕐	⊕⊕⊕	Nausea and diarrhea, headaches, minor cuts and broken bones, back and joint pain
Emergency Room	$$$$	No	🕐🕐🕐🕐	⊕⊕⊕⊕	Trouble breathing, heart attack and stroke, sudden illness and serious accidents, and severe bleeding

If you need PRESCRIPTION MEDICATIONS

Choose generic medications whenever possible to keep your medication costs lower.

TAKE THIS NOT THAT

If you need to SEE A DOCTOR

Remember, the bigger the building, the bigger the bill. Where you go makes a big difference.

GO HERE NOT THERE

If you need AFTER HOURS CARE

For after hours care or non-life-threatening emergencies, vist a convenience care clinic or an urgent care center.

GO HERE NOT THERE

If you need OUTPATIENT IMAGING

Visit an outpatient imaging center versus the hospital to save money when you need a CT or MRI.

GO HERE NOT THERE

Individual Coverage HRA Model Notice

USE THIS NOTICE WHEN APPLYING FOR INDIVIDUAL HEALTH INSURANCE COVERAGE

September 28th, 2023

You are getting this notice because your employer is offering you an individual coverage health reimbursement arrangement (HRA). Please read this notice before you decide whether to accept the HRA. In some circumstances, your decision could affect your eligibility for the premium tax credit. Accepting the individual coverage HRA and improperly claiming the premium tax credit could result in tax liability.

This notice also has important information that the Exchange (known in many states as the "Health Insurance Marketplace") will need to determine if you are eligible for advance payments of the premium tax credit. An Exchange operates in each state to help individuals and families shop for and enroll in individual health insurance coverage.

You may also need this notice to verify that you are eligible for a special enrollment period to enroll in individual health insurance coverage outside of the annual open enrollment period in the individual market.

I. The Basics

What should I do with this notice?

Read this notice to help you decide if you want to accept the HRA.

Also, **keep this notice** for your records. You'll need to refer to it if you decide to accept the HRA and enroll in individual health insurance coverage, or if you turn down the HRA and claim the premium tax credit on your federal income tax return.

What's an individual coverage HRA?

An individual coverage HRA is an arrangement under which your employer reimburses you for your medical insurance premiums (and sometimes your family members' medical insurance premiums), up to a certain dollar amount for the plan year. If you enroll in an individual coverage HRA, **you must also be enrolled in** individual health insurance coverage or Medicare Part A (Hospital Insurance) and B (Medical Insurance) or Medicare Part C (Medicare Advantage) (collectively referred to in this notice as Medicare) for each month you are covered by the HRA. If your family members are covered by the HRA, **they must also be enrolled in** individual health insurance coverage or Medicare for each month they are covered by the HRA.

The individual coverage HRA you are being offered is employer-sponsored health coverage. This is important to know if you apply for health insurance coverage on the Exchange.

Note: There are different kinds of HRAs. The HRA that's being referred to throughout this notice, and that your employer is offering you, is an **individual coverage HRA (ICHRA)**. It is not a qualified small employer health reimbursement arrangement (QSEHRA) or any other type of HRA.

What are the basic terms of the individual coverage HRA that my employer is offering?

(1) The maximum dollar amount available for each participant in the HRA is based on age. If you apply for individual health insurance coverage through the Exchange, this is the amount the Exchange will use to figure out if your HRA is considered affordable.

(2) Your family members *are* eligible for the HRA.

(3) In general, your HRA coverage will start *January 1st, 2024*. However, if you become eligible for the HRA less than 90 days before the beginning of the plan year or during the plan year, your HRA coverage will start depending on your hire date and employer's specified waiting period.

(4) The HRA plan year begins on *January 1st, 2024* and ends on December 31, 2024.

(5) Amounts newly made available under the HRA will be made available on January 1st, 2024.

Note: You will need this information if you apply for health insurance coverage through the Exchange.

Can I opt out of the individual coverage HRA?

Yes. You can opt out of the HRA for yourself (and your family members, if applicable).

Upon termination of employment, this HRA is forfeited.

If I accept the individual coverage HRA do I need to be enrolled in other health coverage too?

Yes. You (and your family members, if applicable) must be enrolled in individual health insurance coverage or Medicare for each month you (or your family members) are covered by the HRA. You may not enroll in short-term, limited-duration insurance or only in excepted benefits coverage (such as insurance that only provides benefits for dental and vision care) to meet this requirement.

II. Getting Individual Health Insurance Coverage

How can I get individual health insurance coverage?

If you already have individual health insurance coverage, you do not need to change that coverage to meet the HRA's health coverage requirement.

If you don't already have individual health insurance coverage, you can enroll in coverage through the Exchange or outside of the Exchange – for example, directly from an insurance company.

Note: People in most states use HealthCare.gov to enroll in coverage through the Exchange, but some states have their own Exchange. To learn more about the Exchange in your state, visit https://www.healthcare.gov/marketplace-in-your-state/.

If you are enrolled in Medicare Part A and B or Medicare Part C, your enrollment in Medicare will meet the HRA's health coverage requirement. For information on how to enroll in Medicare, visit www.medicare.gov/sign-up-change-plans.

When can I enroll in individual health insurance coverage?

Generally, anyone can enroll in or change their individual health insurance coverage during the individual market's annual open enrollment period from November 1 through December 15. (Some state Exchanges may provide additional time to enroll.) If your individual coverage HRA starts on January 1, you (and your family members, if applicable), generally should enroll in individual health insurance coverage during open enrollment.

In certain circumstances, such as when your individual coverage HRA starts on a date other than January 1 or if you are newly hired during the HRA plan year, you (and your family members, if applicable) can enroll in individual health insurance coverage outside of open enrollment using a special enrollment period.

If you qualify for a special enrollment period, make sure you enroll on time:

If you are newly eligible for HRA coverage that would start at the beginning of the HRA plan year, you generally need to enroll in individual health insurance coverage within the 60 days before the first day of the HRA plan year.

If the HRA was not required to provide this notice 90 days before the beginning of the plan year, or you are newly eligible for HRA coverage that would start mid-plan year (for example, because you are a new employee), you may enroll in individual health insurance coverage up to 60 days before the first day that your HRA can start or up to 60 days after this date. **Enroll in individual health insurance coverage as soon as possible** to get the most out of your individual coverage HRA.

Note: If you enroll in individual health insurance coverage through this special enrollment period, you may need to submit a copy of this notice to the Exchange or the insurance company to prove that you qualify to enroll outside of the open enrollment period. For more information on special enrollment periods, visit HealthCare.gov or the website for the Exchange in your state.

Do I need to get new individual health insurance coverage each year if I want to enroll in my individual coverage HRA each year?

Yes. Individual health insurance coverage is typically sold for a 12-month period that is the same as the calendar year and ends on December 31. If your HRA starts on January 1, you will either need to get new individual health insurance coverage or re-enroll in your individual health insurance coverage. If your HRA has a plan year that starts on a day other than January

1, because your individual health insurance coverage will stay in effect until December 31, you do not need to get new individual health insurance coverage or re-enroll until the next open enrollment period.

If you are enrolled in Medicare, your Medicare coverage generally will remain in place year to year.

Do I need to substantiate my (and my family member's) enrollment in individual health insurance coverage or Medicare to the individual coverage HRA?

Yes. You must substantiate that you (and your family members, if applicable) will be enrolled in individual health insurance coverage or Medicare for the period you will be covered by the HRA.

Also, each time you seek reimbursement of a medical insurance premium from the HRA, you must substantiate that you had (or have) (or the family member whose medical care expense you are seeking reimbursement or contribution towards for, if applicable had (or has)) individual health insurance coverage or Medicare for the month during which the expense was incurred.

If you enroll via the Bavvy solution provided by your employer, substantiation will be done automatically for you. If you do not utilize a carrier offered through this marketplace you may be asked to substantiate your coverage.

What happens if I am (or one of my family members is) no longer enrolled in individual health insurance coverage or Medicare?

If you (or a family member, if applicable) are no longer enrolled in individual health insurance coverage or Medicare, the HRA won't reimburse you for medical insurance premium that were incurred during a month when you (or your family member, as applicable) did not have individual health insurance coverage or Medicare. This means that **you may not seek reimbursement for medical insurance premiums incurred when you (or your family member, if applicable) did not have individual health insurance coverage or Medicare**.

Note: You must report to the HRA if your (or your family member's) individual health insurance coverage or Medicare has been terminated retroactively and the effective date of the termination.

III. Information About the Premium Tax Credit

What is the premium tax credit?

The premium tax credit is a tax credit that helps eligible individuals and their families pay their premiums for health insurance coverage purchased through the Exchange. The premium tax credit is not available for health insurance coverage purchased outside of the Exchange. Factors that affect premium tax credit eligibility include enrollment in Exchange coverage, eligibility for other types of coverage, and household income.

When you enroll in health insurance coverage through the Exchange, the Exchange will ask you about any coverage offered to you by your employer, including through an HRA. Your ability to claim the premium tax credit may be limited if your employer offers you coverage, including an HRA.

The Exchange also will determine whether you are eligible for advance payments of the premium tax credit, which are amounts paid directly to your insurance company to lower the cost of your premiums. For more information about the premium tax credit, including advance payments of the premium tax credit and premium tax credit eligibility requirements, see irs.gov/aca.

If I accept the individual coverage HRA, can I claim the premium tax credit for my Exchange coverage?

No. You may not claim the premium tax credit for your Exchange coverage for any month you are covered by the HRA. Also, you may not claim the premium tax credit for the Exchange coverage of any family members for any month they are covered by the HRA.

If I opt out of the individual coverage HRA, can I claim the premium tax credit for my Exchange coverage?

It depends.

- If you opt out of the HRA and the HRA is considered **unaffordable** you **may claim** the premium tax credit for yourself and any family members enrolled in Exchange coverage if you are otherwise eligible.
- If you opt out of the HRA and the HRA is considered **affordable**, you **may not claim** the premium tax credit for yourself or any family members.

If you are a former employee, the offer of an HRA will not prevent you from claiming the premium tax credit (if you are otherwise eligible for it), regardless of whether the HRA is considered affordable and as long as you don't accept the HRA.

How do I know if the individual coverage HRA I've been offered is considered affordable?

The Exchange website will provide information on how to determine affordability for your individual coverage HRA. To find your state's Exchange, visit: https://www.healthcare.gov/marketplace-in-your-state/.

Do I need to provide any of the information in this notice to the Exchange?

Yes. Be sure to have this notice with you when you apply for coverage on the Exchange. If you're applying for advance payments of the premium tax credit, you'll need to provide information from the answer to "What are the basic terms of the individual coverage HRA my employer is offering?" on page 3. You will also need to tell the Exchange whether you are a current employee or former employee.

If I'm enrolled in Medicare, am I eligible for the premium tax credit?

No. If you have Medicare, you aren't eligible for the premium tax credit for any Exchange coverage you may have.

IV. Other Information You Should Know

Who can I contact if I have questions about the individual coverage HRA?

Please contact your HR department if you have questions regarding this coverage.

[For use by an HRA subject to ERISA that meets the safe harbor set forth in 29 CFR 2510.3-1(l): **Is the individual health insurance coverage I pay for with my individual coverage HRA subject to ERISA?**]

The individual health insurance coverage that is paid for with amounts from your individual coverage HRA, if any, is not subject to the rules and consumer protections of the Employee Retirement Income Security Act (ERISA). You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.

DISCLOSURE NOTICES

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

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

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

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

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

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

ALABAMA – MEDICAID	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://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 Program Website: http://myakhipp.com/ Phone: 866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 855-692-6442
ARKANSAS – MEDICAID	**FLORIDA - Medicaid**
Website: http://myarhipp.com/ Phone: 855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 877-357-3268

GEORGIA - Medicaid	**MISSOURI - Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website:https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone 678-564-1162 Press 2	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
INDIANA - Medicaid	**MONTANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 800-457-4584	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800-694-3084 Email; HHSHIPPProgram@mt.gov
IOWA – Medicaid and CHIP (Hawki)	**NEBRASKA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 888-346-9562	Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: https://ww.kancare.ks.gov/ Phone: 800-792-4884 HIPP Phone: 1-800-867-4660	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)	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: 800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Enrollment Website: https://www.mymaineconnection.gov/benefit/s/?languare=en_US Phone: 800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800-541-2831

Private Health Insurance Premium Webpage https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 TTY: Maine relay 711	
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website:https://www.mass.gov/masshealth/pa Phone: 800-862-4840; TTY711 Email:masspremassistance@accenture.com	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800-657-3739	Website: http://www.hhs.nd.gov/healthcare Phone: 844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877-543-7669
OREGON – Medicaid	**VERMONT – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 800-699-9075	Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 800-250-8427
PENNSYLVANIA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 800-692-7462 CHIP Website: Children's Health Insurance Program(CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://www.coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://www.coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-hipp-programs Medicaid/CHIP Phone: 800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 888-549-0820	Website: https://dhhr.wv.gov/bms/ https://mywvhipp.com Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 855-MyWVHIPP (855-699-8447)
SOUTH DAKOTA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 800-362-3002
TEXAS – Medicaid	**WYOMING - Medicaid**
Website: Heatlh Insurance Premium Payment (HIPP) Program/Texas Health and Human Services Phone: 800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 800-251-1269

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

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

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

NOTICE FOR PATIENT PROTECTIONS

The following notice is provided for all plans that require or allow for the designation of primary care providers by participants or beneficiaries: You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the insurance carrier or the plan administrator. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, you may contact the insurance carrier or the plan administrator, Your Employer.

WHCRA ENROLLMENT/ANNUAL 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 medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices. Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthese, and complications resulting from a mastectomy, including lyphedema? Call your plan administrator for more information.

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

SPECIAL ENROLLMENT NOTICE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance. To request special enrollment or obtain more information, contact your plan administrator.

PAPERWORK REDUCTION ACT STATEMENT: According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such a collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210, or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0317 (expires 1/31/2026).

HIPAA PRIVACY NOTICE 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. This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information in your company plan (herein referred to as the "Plan") creates or receives about you.

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013.

As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

HOW THE PLAN WILL USE OR DISCLOSE YOUR PHI Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to HHS;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with legal regulations; and
- Uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan, For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.

- The PHI is directly relevant to the family or friend's involvement with your care or payment for thatcare;
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- The PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor'sPHI.

For School Records. The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court ortribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Right to Request Restrictions on PHI Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend. You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, effective January 1, 2013, you can request an accounting of all disclosures by the Plan of your electronic PHI during the three years prior to the date of your request.

Right to Receive Confidential Communications. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this

Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.

- The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of you unsecured PHI.

Your Right to File a Complaint. You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information. If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan.

The information in this Benefit Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Benefit Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefit Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Benefit Summary, contact the Benefits Department.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE
PART A: GENERAL INFORMATION FORM APPROVED OMB NO. 1210-0149

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment- based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer- offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. [1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
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 does not 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."

If the Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to Your Employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of coverage under the Plan.

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;
- If the Plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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. You must provide this notice to the Plan Administrator.

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 the Social Security Administration (SSA) to be disabled and you timely notify the Plan Administrator **in writing**, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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.

In order for this disability extension to apply, you must timely notify the Plan Administrator **in writing** of the SSA disability determination before the end of the 18-month period of continuation coverage and within 60 days after the later of (i) the date of the initial qualifying event; (ii) the date on which coverage would be lost because of the initial qualifying event; or (iii) the date of the SSA disability determination. **This notice must be mailed to Your Employer at the address shown at the end of these notices**. Oral notice, including notice by telephone, is not acceptable. The written notice must include the name and address of the employee covered under the plan; the name of the disabled qualified beneficiary; the date that the qualified beneficiary became disabled; and the date that the SSA made its determination of disability. Your notice must also include a copy of the SSA disability determination. If these procedures are not followed or if written notice is not provided to the Plan Administrator within the required time period, there will be no disability extension of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of any revocation of Social Security disability benefits.

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, 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.

(see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods). 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.

MEDICARE PART D CREDITABLE COVERAGE NOTICE
IMPORTANT NOTICE FROM YOUR EMPLOYER 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 offered by the Your Employer Creditable through Your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Employer has determined that the prescription drug coverage offered by your Employer medical plan is Creditable , 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 through 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 coverage through Your Employer will not be affected. You can keep this coverage if you elect Part D, and this plan will coordinate with Part D coverage. If you decide to join a Medicare drug plan and drop your current group health coverage through Your Employer, be aware that you and your dependents will not be able to get this coverage back. If you are able to get this coverage back, reentry into the plan is subject to the underlying terms of the Plan.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…Contact the Plan Administrator 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 Your Employer changes. You 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).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergecy care or are treated by an out-of-network provider at an in-network hosptial or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and /or deductible.

What is "balance billing " (sometimes called "surprisie billing")

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or 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 provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services 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 can 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 balanced billed.

If you get other types of 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.

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

When balance biling isn't allowed, you also have these protections:

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

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "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-pocket services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1.800.985.3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

For purposes of these notices, the Plan Administrator is:
Lisa Sullivan
Director of Human Resources
Generations Health Assoc., Inc.
406 N. Spring Street, McMinnville, TN 37110
lsullivan@generationsgaither.com
931-507-1212

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefits information. While every effort was taken to report your benefits, discrepancies or errors accurately are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Summary, contact Human Resources.

Generations
Gaither's
Group