Foxdale Village
500 E. Marylyn Avenue
State College, PA 16801
814-238-3322

Effective Date: 01/01/2027

Employee & Eligible Beneficiaries,

As an employee of Foxdale Village and a participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. The Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact Mary Jane (MJ) Schreffler, Director of Human Resources, Foxdale Village at: 814-238-3322.

IMPORTANT INFORMATION

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

Medicare Part D Notice

Medical Plan: PPO $750
Insurer: Highmark Blue Shield

About Your Prescription Drug Coverage and Medicare
This notice has information about your current prescription drug coverage 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:

- 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.
- We have determined the prescription drug coverage offered by the Highmark BCBS, Highmark PPO Medical Plan plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore **considered Creditable**

Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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 will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

For more guidance, visit **http://www.cms.hhs.gov/CreditableCoverage/** which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to the plan documents or contact your provider or the plan administrator before making any decisions.

Note: *In general, different guidelines exist for retirees regarding the cancellation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.*

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know if you drop or lose your current coverage 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...
Contact the person listed at the beginning of this notice. You will get this notice each year. You will also get it before the next Medicare Part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
Visit **www.Medicare.gov** or 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 800-MEDICARE (800-633-4227). TTY users should call (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 (800) 772-1213 (TTY 1-800-325-0778).

Remember to 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).

Medical Plan: PPO $1500
Insurer: Highmark Blue Shield

About Your Prescription Drug Coverage and Medicare
This notice has information about your current prescription drug coverage 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:

- 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.
- We have determined the prescription drug coverage offered by the Highmark BCBS, Highmark HDHP Medical Plan plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore **considered Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age

65, are already 65 years old or if they are disabled. 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 will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

For more guidance, visit **http://www.cms.hhs.gov/CreditableCoverage/** which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to the plan documents or contact your provider or the plan administrator before making any decisions.

Note: *In general, different guidelines exist for retirees regarding the cancellation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.*

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know if you drop or lose your current coverage 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...
Contact the person listed at the beginning of this notice. You will get this notice each year. You will also get it before the next Medicare Part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
Visit **www.Medicare.gov** or 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 800-MEDICARE (800-633-4227). TTY users should call (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 (800) 772-1213 (TTY 1-800-325-0778).

Remember to 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).

NOTIFICATIONS

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you have declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

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

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

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

a. Your past, present, or future physical or mental health or condition;
b. The provision of health care to you; or
c. The past, present, or future payment for the provision of health care to you.

I. Contact Information

If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact the individual named at the beginning of this packet.

II. Our Responsibilities

We are required by law to:

a. maintain the privacy of your PHI;
b. provide you with certain rights with respect to your PHI;
c. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
d. follow the terms of the Notice that is currently in effect.

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

III. How We May Use and Disclose Your PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient.

For Treatment. When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is

experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Substance Use Disorder (SUD) Treatment Information. Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

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

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

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

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

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

IV. Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your PHI for public health activities. These activities generally include the following:

a. to prevent or control disease, injury, or disability;
b. to report births and deaths;
c. to report child abuse or neglect;
d. to report reactions to medications or problems with products;
e. to notify people of recalls of products they may be using;
f. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
g. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and

licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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

Law Enforcement. We may disclose your PHI if asked to do so by a law-enforcement official.

a. in response to a court order, subpoena, warrant, summons, or similar process;
b. to identify or locate a suspect, fugitive, material witness, or missing person;
c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
d. about a death that we believe may be the result of criminal conduct; and
e. about criminal conduct.

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

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

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

Research. We may disclose your PHI to researchers when:

a. The individual identifiers have been removed; or
b. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

V. Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

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

Disclosures to You. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most

disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

VI. Other Disclosures

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

a. You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or
b. Treating such person as your personal representative could endanger you; and
c. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

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

Authorizations. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

VII. Your Rights

You have the following rights with respect to your PHI:

Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.
To inspect and copy your PHI, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

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

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

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

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

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

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

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

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

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

VIII. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after the conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free from Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military duty for more than 30 days, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For military service of less than 31 days, you are entitled to your existing employer-based health coverage for you and your dependents as if you were employed continuously and will continue to pay your regular premium.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protection of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats,etc.)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer; and know the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 lymphedemas.

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 at the number listed at the front of this document.

Newborns' and Mothers' Health Protection Act (NMHPA)

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law

generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not over 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

Rescissions

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

Preventive Care

Health plans through the Highmark BCBS, Highmark BCBS plan(s) will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: **https://www.healthcare.gov/coverage/preventive-care-benefits/**. Please check component plan documents for the specific list of preventive coverage services with no cost sharing that are covered by your health plan.

Women's Preventive Health Services

All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network through Highmark PPO Medical Plan, Highmark HDHP Medical Plan :

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)

- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA webpage at **https://www.dol.gov/whd/fmla/**.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. In general, coverage limits (both financial requirements and treatment limits) cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.**

You may request information from your employer-sponsored health plan or your group or individual market insurer regarding treatment limitations that may affect your access to mental health or substance use disorder benefits, including nonquantitative treatment limitation (NQTL) analysis. If you, a family member, or someone you are representing obtains health coverage through a private employer health plan, federal law requires the plan to provide certain plan documents about your benefits, including coverage limitations on your benefits, at your request. For example, you may want to obtain documentation as to why your health plan is requiring preauthorization for visits to a therapist before it will cover the visits. Generally, the plan must provide the documents you request within thirty (30) calendar days of the plan's receipt of your request. To request this information, contact your Plan Administrator.

COBRA Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 (or 31) days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year; (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the

Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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.

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

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

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family 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 continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these

options may cost less than COBRA continuation coverage. You can learn more about many of these options at **https://www.healthcare.gov/**.

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

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

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

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. 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 **https://www.dol.gov/agencies/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.

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services 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.

In addition to the protections of the Federal No Surprises Act, the state in which you receive services may have protections that apply to your visit for emergency or non-emergency services. Additional information is available from your state's department of insurance. Visit ***https://content.naic.org/state-insurance-departments*** *to find the contact information for your state's department of insurance. The Federal protections exceed state protections in almost every state.*

The following states limit the amount an out-of-network provider and out-of-network facility can bill you for emergency services: CA, CT, FL, GA, IA, MD, MI, NJ, NY, OH, PA. The amount is limited to your in-network cost sharing amount. The following states limit the amount an out-of-network provider can bill you for emergency services to your in-network cost sharing amount: DE, IN, IL, MA, OR, OH. Several states have dispute resolution processes (CA, FL, GA, IL, NJ, NY, MI) and several states establish the amounts providers may be paid (CA, CT, DE, FL, GA, MD, MI, OR)

NOTE: The above lists are subject to change pending new state legislative action.

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

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

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

If you believe you've been wrongly billed, you may contact HHS, in coordination with the Department of the Treasury, Department of Labor and the Office of Personnel Management at 1-800-985-3059.

Visit **https://www.cms.gov/medical-bill-rights#:~:text=The%20No%20Surprises%20Act%20is,Emergency%20room%20visits** for more information about your rights under federal law.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.