The 2022-2023 Benefits and Workplace Rights & Protections *Information*

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Atrium Health

ABOUT THIS BROCHURE

This brochure contains important notices that Atrium Health is required to send to teammates that describe many of your 2022-2023 Atrium Health benefit plans and workplace rights and protections. Every effort has been made to report information accurately, but the possibility of error exists. The Atrium Health program is governed by the official plan documents. In case of any conflict between this brochure and an official plan document, the plan document will be the final authority. Please read this information carefully and keep it where you can find it for future reference.

Please refer to your plan documents or Summary Plan Descriptions for resources that provide a full explanation of covered services, exclusions and limitations. Plan documents and Summary Plan Descriptions related to the information included in this brochure are available on **Teammates.AtriumHealth.org**.

MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Health Care Reform requires employers to provide a minimum level of coverage at an affordable price. Atrium Health already does this – and pays a majority of the health care costs for benefits-eligible teammates and their family members. **Since the LiveWELL Health Plans are considered comprehensive and affordable based on the requirements of the law, and the majority of the cost of the plan is covered by Atrium Health, benefits-eligible teammates will probably not have a better plan option available at a lower cost through the Health Insurance Marketplace.**

Benefits-eligible teammates can always compare the LiveWELL Health Plans to other plans in the Marketplace to see how coverage and costs compare. Just keep in mind that benefits-eligible teammates will NOT qualify to receive a tax credit/subsidy to help pay for your coverage through the Marketplace.

GENERAL INFORMATION

When key parts of the health care law took effect in 2014, there was 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 is November 1, 2022 – January 15, 2023.

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. 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.

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 available at **Teammates.AtriumHealth.org** or **Medcost.com**, or contact Atrium Health Benefits.

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.

INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health		4. Employer Identification Number (EIN) 56-0529945
5. Employer Address 4435 Golf Acres Drive, Building P, Suite 300		6. Employer Phone Number 704-631-1500
7. City Charlotte	8. State North Carolina	9. Zip Code 28208
10. Who can we contact about employee health coverage at this job? Atrium Health Benefits		
11. Phone number (if different from above)		

Here is some basic information about health coverage offered by this employer:

As your employer, we offer two health plan options to:

- [ ] All employees.
- [X] Some employees. *Eligible employees are:*
  Active teammates with standard hours of at least 24 hours per week in 2022, and at least 20 hours per week beginning January 1, 2023.

With respect to dependents:

- [X] We do offer coverage. *Eligible dependents include:*
  Spouse; children up to age 26; unmarried children covered under the Plan at the time they reach age 26 who are incapable of self-support due to a mental or physical disability, and who are primarily dependent upon you for maintenance and support.
- [ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. The information provided above is the employer information you will enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

EQUAL EMPLOYMENT OPPORTUNITY STATEMENT

Atrium Health recruits, hires and promotes qualified candidates for employment opportunities without regard to race, color, age, religion, gender, national origin, veteran status, disability, genetic information, sexual orientation, gender identity or any factor prohibited by law; and as such affirms its policy and practice to support and promote the concepts of equal employment opportunity and diversity and inclusion in accordance with all federal, state and municipal laws.

HIPAA SPECIAL ENROLLMENT NOTICE

If you decline enrollment in the LiveWELL Health Plans for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Atrium Health plans if you or your dependents lose eligibility for that other coverage (or if the employer has a material reduction in or stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 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 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information due to a qualifying life event (marriage, divorce, birth, adoption), go to **Teammates.AtriumHealth.org**.

UPDATING DEMOGRAPHIC INFORMATION

IAnnually, Atrium Health teammates are asked to update their contact information and other important data using CORE Connect. Through this process, teammates ensure personal information is up-to-date, including demographic profile, race/ ethnicity, military and/ or veteran and disability status. Teammates may also check that they decline to disclose specific demographic information. As a business that interacts with the United States government and regulated contract activities, it is essential for us to be compliant and have updated information regarding teammate demographics.

NOTICE CONCERNING THE LIVEWELL HEALTH PLANS

Under Federal law, wellness programs that are part of group health plans and provide for an award related to certain health/wellness factors must meet certain requirements:

- The total reward for the LiveWELL Health Plans wellness program is limited and cannot exceed a certain percentage of teammate-only coverage under the plan.
- The wellness program is designed to promote health and prevent disease.
- The program provides individuals who are eligible to participate the opportunity to qualify for the reward at least once per year.
- The reward is available to all similarly situated individuals. The program allows reasonable alternatives (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard.
- The plan discloses in all materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard).

If it is unreasonably difficult, due to a medical condition, for you to achieve the standards for the reward under the wellness program, or if it is medically inadvisable for you to attempt to achieve the standard for the reward under this program, you may contact LiveWELL and request that they work with you to develop another way to qualify for the reward.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Atrium Health and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare and is available through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. Atrium Health has determined that the prescription drug coverage offered by the LiveWELL Health Plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay, and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year beginning October 15th to December 7. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Information on the LiveWELL Health Plans prescription drug benefits can be found in the Atrium Health Benefits Guide on Teammates.AtriumHealth.org, or by visiting the prescription benefits website at www.CarolinaCareRx.org. You have the option to retain your existing coverage under the LiveWELL Health Plans and choose not to enroll in a Medicare Part D prescription plan.

In addition to prescription drugs, LiveWELL Health Plans coverage pays for other health expenses. If you decide to enroll in a Medicare drug plan, your LiveWELL Health Plans coverage will not be affected. If you drop your health coverage and enroll in Medicare prescription drug coverage, you must wait until the next Open Enrollment period or qualified status change, if earlier, to re-enroll in the LiveWELL Health Plans, if you are still eligible.

You also should know that if you drop or lose your coverage with the LiveWELL Health Plans and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium may always be at least 19% higher than what many other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage:

Contact the Atrium Health Benefits Service Center for further information at 704-631-1500, option 1. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Atrium Health changes. You also may request a copy 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. If Medicare eligible, you will receive a copy of the handbook in the mail every year from Medicare, and you may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized helpThe program provides individuals who are eligible to participate the opportunity to qualify for the reward at least once per year.
- Call **800-MEDICARE** (800-633-4227); TTY users should call 877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213** (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to enroll in Medicare prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you have maintained creditable coverage and that you should not be required to pay a higher premium (a penalty).

Revised:	October 2022
Name of Entity/Sender:	Atrium Health
Contact – Position/Office:	Plan Administrator for LiveWELL Health Plans
Address:	PO Box 32861, Charlotte, NC 28232-2861
Phone Number:	704-631-1500, option 1

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 are 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 are not eligible for Medicaid or CHIP, you will not 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 in this section, you can 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, you can contact your State Medicaid or CHIP office or dial **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 are not 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, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free **866-444-EBSA (3272).**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2022. You should contact your State for further 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: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any more States have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, you can contact either:

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

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

NORTH CAROLINA HEALTH CHOICE HEALTH INSURANCE PROGRAM FOR CHILDREN

Blue Cross Blue Shield of North Carolina offers a free or reduced-price comprehensive health care program for children of families that do not qualify for Medicaid, but are unable to afford health insurance premiums.

The North Carolina Health Choice Program only covers children between the ages of 6 and 18 who do not qualify for Medicaid, Medicare or other Federal government- sponsored health insurance.

Services include:

- Case management and care coordination services
- Dental services
- Durable medical equipment and disposable medical supplies
- Emergency services
- Family planning services
- Hospice care
- Home health care
- Immunizations (shots)
- Inpatient and outpatient substance abuse treatment
- Laboratory and radiological services
- Mental health services (inpatient and outpatient)
- Physician and clinic services (well-child and sick visits)
- Physical therapy, occupational therapy and therapy for individuals with speech, hearing and language disorders
- Prescription drugs
- Substance abuse services (inpatient and outpatient)
- Surgical services

ELIGIBILITY

You must apply each year and you must be disqualified for Medicaid. Your family's monthly income must be more than 133%, but equal to or less than 211% of the federal poverty income limits. Once a child has been covered under the plan, if your family's economic conditions change and the child is no longer eligible, but you want the child to continue in the program, you may be allowed to purchase the plan at full premium cost for one year.

To apply for the program, visit the Department of Social Services (DSS) in the county where you live, or you can apply via mail by sending a completed Medicaid and Health Choice Application to your local DSS office. Other eligibility parameters may apply. Check the NC applicable website.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

All medical plan options provide coverage for mastectomies and provide certain mastectomy-related benefit services to plan participants and beneficiaries. These benefits are outlined in a federal law known as the Women's Health and Cancer Rights Act of 1998 (Women's Health Act of 1998). This law provides participants who receive benefits in connection with a mastectomy to be entitled to the following coverage:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema (swelling associated with removal of lymph nodes).

Coverage will be provided in a manner determined in consultation between the attending physician and the patient. The coverage is subject to the same deductibles, copayments or coinsurance limitations, if any, that apply for other benefits from the medical option you select.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

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.

"We" refers to the LiveWELL Health Plans. The plans contain several component benefits that are administered by MedCost Benefit Services, Carolina Behavioral Health Alliance, CarolinaCARE, OptumRx, Delta Dental, Bank of America and Castlight. Collectively they will be referred to as "Plan." "You" or "yours" refers to individual participants in the Plan.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of your 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 healthcare operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a healthcare provider, a healthcare 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 any of the following:

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

If you have any questions about this Notice or about our privacy practices, please contact the Plan Administrator, as designated in your Summary Plan Description.

OUR RESPONSIBILITIES

We are required by law to:

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

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

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information.

For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students or other hospital personnel who are involved in taking care of you. For example, we may share your protected health information with a utilization review or precertification service provider.

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 healthcare 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. 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 Healthcare 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.

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.

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 protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to 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.

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

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

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

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information 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 protected health information 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 protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, 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 protected health information for public health activities. These activities generally include the following:

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

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

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request or other lawful process by someone 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 protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process;

- to identify or locate a suspect, fugitive, material witness or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- and about criminal conduct.

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

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

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

Research. We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

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

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

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

OTHER DISCLOSURES

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/ authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. In most situations, we send mail to the employee/ member. 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 protected health information 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 protected health information for marketing; and we will not sell your protected health information, 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.

DISCLOSURES

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

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information 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 protected health information, you must submit your request in writing to the Plan Administrator. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

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

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

To request an amendment, your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

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

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

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

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

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator. 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 protected health information that we use or disclose for treatment, payment or healthcare operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

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.

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 to the Plan Administrator. 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 protected health information.

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.

You may obtain a copy of this Notice by contacting Atrium Health Benefits at 704-631-1500, option 1.

QUESTIONS AND 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 Plan Administrator. 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.

If you have a complaint, question, concern or require a copy of the Privacy Notice, please contact Atrium Health Benefits at 704-631-1500, option 1.

POTENTIAL IMPACT OF STATE LAWS

The HIPAA Privacy Regulations generally do not ‘preempt’ (or take precedence over) state privacy or other application laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV, or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights.

CHANGES TO PENSION PLAN

Effective January 1, 2018

Effective January 1, 2018, participants stopped earning additional benefits under the Pension Plan of The Charlotte-Mecklenburg Hospital Authority, the CMHA Pension Plan for certain former Employees of Cleveland County HealthCare System and the Stanly Health Services, Inc. Employees’ Pension Plan. Effective June 30, 2020, the Cleveland and Stanly pension plans merged into the Pension Plan of The Charlotte- Mecklenburg Hospital Authority. Vested pension plan participants will continue to be eligible to receive benefits from the plan in accordance with its terms.

401(K) RETIREMENT SAVINGS PLAN

Atrium Health offers the 401(k) Retirement Savings Plan to help team members with a retirement option to meet their personal retirement savings goals.

This chart describes the contributions Atrium Health makes to the plan.

Match on Teammate Contributions	75% on first 4% (maximum 3%) 50% on next 2% (maximum 1%) (total maximum match 4%)	Eligibility: auto-enrolled at 3% after 3 months of service To receive full match teammate contributes 6% 100% vested in matching contributions
Basic and Performance Based Contributions	Eligibility: Teammate must complete 1,000 hours of service in a designated 12 month period to meet eligibility for Atrium Health basic and performance- based contributions. Teammate becomes a participant on the last day of the month during which the 12 month period is completed. To receive basic or performance-based contributions for a calendar year a participant must complete 1,000 hours of service during the year and be employed with Atrium Health on the last day of the year (except for participants who complete 1,000 hours of service and terminate employment on or after normal retirement date or because of death or permanent disability).	
Basic Contribution	2% Upon eligibility, basic contributions are made even if the teammate chooses not to make their own contributions to the plan	3-year vesting requirement
Discretionary Performance-Based	Upon eligibility: Upon eligibility, performance-based contributions are made even if the teammate chooses not to make their own contributions to the plan 1% for <10 years of service 1.5% for 10–19 years of service 2% for 20+ years of service	Discretionary contribution based on annual system performance and communicated as part of the Performance Plus Scorecard

INFORMATION, ENROLLMENT OR CHANGES

For more information, to enroll in the Plan or to make changes to your 401(k) contributions or investments, log on to AtriumHealth.org/retirement or call Empower Retirement at 866-247-0970. Changes can be made at anytime during the year.

BENEFITS OF PARTICIPATING IN THE 401(K) RETIREMENT SAVINGS PLAN

- You may make pretax contributions. The more you contribute, the more you reduce your current taxable income. Taxes are deferred on all contributions and earnings until you take a distribution. You may also make ROTH after-tax contributions.
- Atrium Health provides a company matching contribution for each paycheck from which you make a deferral contribution, up to a designated limit. All contributions will be made subject to plan eligibility and IRS annual compensation limits.
- Your contributions, the match dollars made by Atrium Health and any earnings the account generates are 100% vested which means you have immediate ownership.
- You can contribute between 1% and 75% of your pay up to the IRS annual contribution maximum ($22,500 for 2023*) and IRS annual compensation limits.
- If you are age 50 or older and contribute the annual maximum, you may also make additional catch-up contributions of $7,500* for 2023.
- You can increase or decrease your contributions as often as you want during the year.
- Teammates also have the opportunity to receive Basic and Performance-Based Contributions from Atrium Health, upon completing all eligibility requirements.

**Limits may be changed by the IRS and are updated annually.*

SAVING – THE KEY COMPONENT TO MEETING YOUR FINANCIAL GOALS FOR RETIREMENT

Your goal should be to save as much as you can – some experts tell us we should contribute at least 10% or more to meet anticipated retirement goals.

INVESTMENTS – STRATEGIES TO CONSIDER

“Do It For Me” Approach – If you do not make your own active elections, your contributions will be invested in the JPMorgan SmartRetirement Fund that most closely matches your birth date and an estimated retirement age of or near 65.

“Do It Yourself” Approach – The Plan offers investment options that allow you to create your own personal retirement savings strategy. You should consider rebalancing your account investment options at least annually. Contact Empower Retirement about Auto Rebalancing features.

AUTO ENROLLMENT FEATURES OF THE 401(K) RETIREMENT SAVINGS PLAN

Auto Enrollment – New hires, rehires and teammates who move from an ineligible benefit status to an eligible benefit status are automatically enrolled at a 3% contribution rate after three months.

JPMorgan SmartRetirement Investment Fund Default – Unless you make your own investment election choices, your contributions will be automatically invested in the JPMorgan SmartRetirement Fund that most closely matches your birth date and an estimated retirement age of or near 65. Target retirement funds are managed to an approximate retirement date and grow "older" along with you. Generally, target retirement funds include a more conservative asset allocation as the participant ages.

Auto Increase – If you are automatically enrolled and do not make an active contribution election, you also will be affected by the automatic increase program, which automatically increases your contributions to the plan by 1% each year until you reach 6%. Your first increase will occur in July the year after you are auto-enrolled, and then every July thereafter, until you reach the 6%. The Auto Increase program occurs each year; however, you can increase or decrease your contribution at any time, set up different amounts, schedule your own automatic increases or opt out in the future by accessing your account at **AtriumHealth.org/retirement**.

Opt Out – You may change your contribution or opt out of any of the auto enrollment features at any time by calling Empower Retirement at **866-247-0970** or via the website at **AtriumHealth.org/retirement**.

SELF-SERVICE AND CUSTOMER SERVICE FEATURES VOICE RESPONSE UNIT (VRU) OR WEBSITE

Access to your retirement account information is available 24/7 through VRU by calling **866-247-0970**, or via website by logging on to **AtriumHealth.org/retirement**.

Features available allow you to:

- Name or update your beneficiaries
- Change your payroll deduction election percentage
- Check account balance and monthly individual rate of return activity
- Project your account balance at retirement
- Review investment fund information
- Make your own investment choices
- Sign up for statement delivery preferences
- Request an account statement or investment fund prospectus

SPEAK TO A REPRESENTATIVE

Empower Retirement representatives are available at **866-247-0970** each business day from 8 a.m. to 10:00 p.m. Eastern Time, and on Saturdays from 9 a.m. to 5:30 p.m. Eastern Time to assist with payroll deduction percentage changes, investment fund changes, inquiries about loan options, hardship or other in-service withdrawals and other questions you may have.

YOUR RIGHTS UNDER 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 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

Your goal should be to save as much as you can – some experts tell us we should contribute at least 10% or more to meet anticipated retirement goals.

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 service, 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 do not 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.

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 **866-4-USA-DOL** (866-487-2365) or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- 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.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify team members of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for team members.

U.S. Department of Labor: **866-487-2365**

FAIR LABOR STANDARDS ACT (FLSA)

SUMMARY STATEMENT

Atrium Health is committed to properly paying team members in compliance with the FLSA and applicable state and local laws.

APPLICABILITY

All full-time, part-time, temporary, PRN team members.

GENERAL GUIDELINES

- The Fair Labor Standards Act (FLSA) is a federal law that outlines pay requirements of covered team members and sets basic minimum wage and overtime pay standards for non-exempt team members.
- Many states and municipalities have wage and hour laws similar to the FLSA. In cases where a team member is subject to both the FLSA and a state or local wage and hour law, the team member will be entitled to the standards provided by the law most favorable to the team member. For example, where a state or municipality has a higher minimum wage than the FLSA, a non-exempt team member working in that location will receive at least the higher minimum wage rate. Although this guide generally refers to only the FLSA, Atrium Health will also comply with all applicable state and local wage and hour laws
- Atrium Health maintains position classifications according to the provisions of the FLSA. The Department of Labor provides requirements and tests that must be satisfied for exemptions under the FLSA. The Atrium Health Compensation Department uses these tests to determine the status of each position. Each job position is classified as either exempt or non-exempt. Job titles do not determine whether a job is exempt or not.

EXEMPT TEAM MEMBERS

- Under the FLSA, some team members are exempt from the minimum wage and overtime pay standards. A team member is classified as exempt if he or she is in a bona fide executive, administrative, professional or outside sales position. Certain computer jobs are also exempt.
- Exempt team members are generally paid on a salary basis. Salaried team members may not have pay reduced for variations in the quantity or quality of work performed. Subject to the exceptions listed below, a salaried team member must receive the full salary for any workweek in which the team member performs any work, regardless of the number of days or hours worked. Salaried team members do not need to be paid for any workweek in which they perform no work.
- Exempt team members are not eligible under the FLSA for overtime pay or 'comp time' for hours worked in excess of forty (40) per week.

HEALTH INSURANCE PROTECTION

- Deductions in pay for salaried team members cannot be made as a result of absences due to circumstances listed below. Such improper salary deductions are not allowed by Atrium Health, regardless of the circumstances. Leaders violating this policy are subject to investigation of their pay practices and appropriate corrective action may be taken.

- Deductions in pay for salaried team members cannot be made as a result of absences due to circumstances listed below. Such improper salary deductions are not allowed by Atrium Health, regardless of the circumstances. Leaders violating this policy are subject to investigation of their pay practices and appropriate corrective action may be taken.

    - Jury duty, attendance as a witness, or military leave in any week in which a team member has performed any work.
    - Absences on a regularly scheduled workday caused by Atrium Health (for example, absences caused by the operating requirements of the business).
    - Partial day amounts other than those specifically listed below.
    - Unpaid administrative leaves (team member counseling) of less than one day or for reasons that do not involve violations of a written workplace conduct policy that applies to all team members.

- The FLSA permits pay deductions for salaried team members for the following absences from work, consistent with other Atrium Health policies and practices:
    - For absences of one or more full days for personal reasons other than sickness or disability (partial days must be paid).
    - For absences of one or more full days due to sickness or disability if the deduction is made in accordance with a bona fide plan, policy or practice of providing pay for salary lost due to an illness. This exception can apply when the team member is not yet eligible for the short-term or long-term disability policy or has exhausted the paid leave benefits Atrium Health provides.
    - Fees received by a team member for jury duty, witness duty or military leave may be applied to offset the pay otherwise received by the team member for that workweek.
    - Penalties imposed in good faith for violations of safety rules of major significance.
    - Unpaid administrative leaves of one or more full days imposed in good faith, in accordance with the team member counseling policy.
    - Deductions for the first and last week of employment when only part of the week is worked by the team member. This must be a practice consistently applied to all team members in the same circumstances. In these circumstances, either partial days or full days may be deducted.
- Atrium Health may reduce a team member's earned paid time off (PTO) or other forms of paid time off for full or partial day absences for personal reasons, sickness or disability.

Refer to HR Policy 2.04, Timekeeping for requirements regarding record keeping for exempt or salaried team members.

NON-EXEMPT TEAM MEMBERS

- Non-exempt team members are generally paid on an hourly basis.
- All non-exempt team members are to:
    - Be paid at least the higher of the federal government mandated wage rate or the state mandated minimum wage rate.
    - Receive overtime pay at time-and-one-half the regular rate for any hours worked over forty (40) hours in a single workweek. If a team member works at more than one Atrium Health facility, all hours are to be combined for purposes of overtime calculation. Unauthorized overtime and voluntary work are to be recorded and paid; however, team members working unauthorized overtime or volunteer work are subject to team member counseling. For purposes of the FLSA, a "workweek" is a fixed and regularly recurring period of 168 hours – seven (7) consecutive 24 hour periods. The standard Atrium Health workweek begins at 12:01 a.m. Sunday and ends at midnight Saturday.
    - Be paid for all hours worked. This also includes time spent in attending employer sponsored meetings or education sessions. It does not include home to work travel time or travel time from home to a different job site.
- Meal Periods of at least 30 uninterrupted minutes are not counted as worked time and will be unpaid. Meal periods or breaks less than 30 minutes are considered worked time and will be paid. Team members are required to clock in and out for 30-minute meal periods.
- On-call time is not counted as hours worked if the team member is free to use the time as they wish. For example, a team member may be required to carry a beeper while off-duty, but is otherwise free to use their time. However, non-exempt team members must record their on-call time in order to receive on-call pay per Atrium Health policy.
- Atrium Health does not allow any form of retaliation against individuals who make good faith reports of suspected violations of this policy. Team members will not be retaliated against for cooperating in the investigation of such reports, even if the reports do not reveal any errors or wrongdoing. Retaliation is unacceptable. Any form of retaliation is in violation of this policy and will result in team member counseling up to, and including, the end of employment.

TEAM MEMBER RESPONSIBILITIES

- Team members classified as non-exempt or hourly are to accurately record the time worked each day. This includes clocking in or recording the start of work, clocking out or recording the end of work, as well as clocking out and in to record meal period times. Team members are to review each pay statement received to make sure their pay is correct. This review is to include verifying that working time was recorded accurately and that pay is correct for all hours worked. If a team member believes that there is an error in pay, the team member is to promptly report it to the unit or department leader.
- Team members are to report all time worked. Team members are prohibited from working "off the clock" (working without reporting the time or recording the time worked); for example, working during a meal period and not reporting the time worked; working at home or off Atrium Health premises and not reporting the time worked; sending or responding to work-related emails while not on the clock and not reporting the time worked; and working before or after a shift and not reporting the time worked.

- Team members may not instruct or encourage another team member to work without pay ("off the clock"), to incorrectly report hours worked or to alter another team member's time records. If anyone directs or encourages a team member to incorrectly report hours worked or to alter another team member's time records, this is to be reported immediately to the unit or department leader or to Human Resources.
- Non-exempt or hourly team members are to make sure that any work performed is approved by their unit or department leader. Team members may not start work early, finish work late, work during a meal period or perform any other extra or overtime work unless it is approved by a unit or department leader. If a team member has any questions about when or how many work hours are expected, the team member is to contact the unit or department leader immediately.
- Atrium Health is committed to following all requirements of the FLSA. Improper deductions from the salaries of exempt team members will be avoided. If a team member believes that an improper deduction has been made to his/her salary, he/she should report it immediately to the unit or department leader. If the team member does not receive a response within five (5) calendar days, or does not agree with the response, the team member is to contact Human Resources at 704-631-1500. If it is determined that a team member was not properly paid, the pay will be promptly reimbursed. Steps will be taken to prevent a repeat improper deduction.
- Atrium Health does not allow any form of retaliation against individuals who make good faith reports of suspected violations of this policy. Team members will not be retaliated against for cooperating in investigations of such reports, even if the reports do not reveal any errors or wrongdoing. Retaliation is unacceptable. Any form of retaliation is in violation of this policy and will result in team member counseling up to, and including, the end of employment.

EMPLOYER RESPONSIBILITIES

Leaders are expected to know, understand and strictly comply with this policy.

It is the responsibility of all leaders to ensure that Atrium Health is following pay regulations. If a leader is aware or becomes aware of any part of this policy that is not being followed in any situation, it is expected that it be reported immediately to Human Resources.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are getting this notice because you are eligible for the LiveWELL Health Plans (the Plan) which includes LiveWELL On-Site Care, Employee Assistance Program (EAP) and Virtual Visits. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan if you elected coverage. If you did not elect or are not eligible for the LiveWELL Health Plans, you are still eligible for continuation of LiveWELL On-Site Care, Employee Assistance Program (EAP) services and Virtual Visits.

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 Atrium Health Benefits at 704-631-1500, option 1.

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. For more information about the Marketplace, visit www.HealthCare.gov.

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 are a team member, you will 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 are the spouse of a team member, you will 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-team member dies;
- The parent-team member's hours of employment are reduced;
- The parent-team member's employment ends for any reason other than his or her gross misconduct;
- The parent-team member 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 CONTINUATION COVERAGE AVAILABLE?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after 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 team member
- The team member becoming entitled to Medicare benefits (under Part A, Part B or both)

For all other qualifying events (divorce or legal separation of the team member and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify plan administrator within 60 days after the qualifying event occurs. You must provide this notice to 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 team members may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability Extension Of 18-Month Period Of COBRA Continuation Coverage

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

This notice should be sent to:

MedCost Benefit Services, LLC
COBRA Administrator
PO Box 24042
Winston-Salem, NC 27114
336-774-4190 • 1-800-852-7040
www.medcost.com

Second Qualifying Event Extension of 18-Month Period of COBRA 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 team member or former team member dies; becomes entitled to Medicare benefits (Part A, Part B or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

MedCost Benefit Services, LLC
COBRA Administrator
PO Box 24042
Winston-Salem, NC 27114
336-774-4190 • 1-800-852-7040

Atrium Health Benefits
PO Box 32861
Charlotte, NC 28232-2861
704-631-1500, option 1

NONDISCRIMINATION NOTICE

In its relations with patients, family members and the public, Atrium Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, age, religion, gender, sexual orientation, gender identity, national origin, protected veterans, disability, genetic information, or any other legally protected status. Atrium Health does not exclude people or treat them differently because of race, color, age, religion, gender, sexual orientation, gender identity, national origin, protected veterans, disability, genetic information, or any other legally protected status.

Atrium Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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 Human Resources.

If you believe that Atrium Health has failed to provide these services or discriminated in another way on the basis of race, color, age, religion, gender, sexual orientation, gender identity, national origin, protected veterans, disability, genetic information, or any other legally protected status, you can file a grievance with: Human Resources, 4435 Golf Acres Drive, Suite 300, Charlotte, NC 28208, 704-631-1500 or HRServiceCenter@AtriumHealth.org. You can file a grievance in person or by mail. If you need help filing a grievance, Human Resources is available to help you.

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:

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)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-368-1019 (TTY: 1-800-537-7697).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-368-1019 (TTY: 1-800-537-7697)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-368-1019 (TTY: 1-800-537-7697).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-368-1019 (TTY: 1-800-537-7697) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-368-1019 (ATS: 1-800-537-7697).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 800 368 1019 (رقم هاتف الصم والبكم: 1 800 537 7697).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-368-1019 (телетайп: 1-800-537-7697).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-368-1019 (TTY: 1-800-537-7697).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-368-1019 (TTY: 1-800-537-7697).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-368-1019 (TTY: 1-800-537-7697).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-368-1019 (TTY: 1-800-537-7697) まで、お電話にてご連絡ください。

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-368-1019 (TTY: 1-800-537-7697)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-368-1019 (TTY: 1-800-537-7697) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-368-1019 (TTY: 1-800-537-7697).