Scotland Health Care System

2022 Employee Benefit Guide

SCOTLAND HEALTH CARE SYSTEM
Closer Care. Better by Far.

Provided by March & McLennan Agency

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 19 for more details.

Welcome to Your Benefits Open Enrollment!

Our 2022 Benefits Guide will provide you with an overview of the comprehensive and rewarding benefits package offered by Scotland Health Care System (SHCS). We value your service as an associate and our competitive benefits are one way that we thank you for all that you bring to our team. We are proud to offer you a benefits program designed to protect the health and financial security of you and your family.

Employee Benefit Resources

View a short presentation on our 2022 benefits:

- Visit https://www.brainshark.com/marshmma/Scotland2022OE
- Or scan the QR code to the right

Highlights for 2022

Scotland Health carefully evaluates our employee benefit offerings each year to ensure we are providing our associates a competitive program while also promoting health and wellness within our organization. With these goals in mind, we are pleased to share the following for 2022:

- There will be a slight increase in dental premiums
- We will continue our $50 tobacco surcharge.
- SHCS will continue to make a $100 contribution to your Health Savings Account when you complete your annual health visit/screening.

Eligibility & Enrollment

Benefits Eligibility

If you are a full-time or part-time associate regularly scheduled 20 or more hours per week, you are eligible to enroll in the benefits described in this guide.

Eligible dependents may enroll in medical, dental, vision, supplemental health, and voluntary life insurance. Eligible dependents include your legal spouse, children up to age 26 and unmarried children over age 26 who meet the definition of disability.

How and When to Enroll/Make Changes

1. Review your current benefit elections. Verify your personal information and make changes as needed in Core Connect
2. Evaluate plan options and make your benefit elections and/or changes through our benefit administration systems shown below.

Several benefits may only be elected or changed during open enrollment or with a qualified change in status. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence, commencement or termination of adoption proceedings, change in employment status or change in coverage under another employer-sponsored plan.

SHCS shares the cost of many benefits with you, below is an overview of available plans and where to go to enroll or change your benefit election:

	Employer Paid	Employee Paid	Where to elect coverage
Medical & Pharmacy	✔	✔	Core Connect
Dental		✔	Core Connect
Vision		✔	Core Connect
FSA and HSA		✔	Core Connect
Accident, Critical Illness, Hospital Indemnity, Whole Life		✔	Register (plane.biz) User ID: last name, last 4 of your SSN & date of birth
Long Term Disability	✔		Automatically Enrolled
Voluntary Short Term Disability		✔	Lincoln Financial User id is last 6 digits of your SSN & full year of birth
Basic Life and AD&D	✔		Automatically Enrolled
Dependent Life and Supplemental Life		✔	Core Connect
403(b) Plan	✔	✔	Empower
Diabetes Prevention	✔		omadahealth.com/scotlandhealth
Weight Management	✔		enroll.realappeal.com
Employee Assistance Plan	✔		Automatically Enrolled

Open Enrollment is October 19th - November 2nd

Elections will take effect on Januarv 1. 2022

Medical & Pharmacy Coverage

Traditional Health Plan (PPO)

This is a traditional plan offering copays for doctor visits and prescriptions.

- This plan has lower deductibles and annual out-of-pocket maximums.
- In exchange for lower out-of-pocket costs and standard fees at the doctor, you will pay a higher premium out of your paycheck to enroll in this plan.

Consumer Directed Health Plan (CDHP)

This is a high deductible health plan that is paired with a tax-advantaged health savings account (HSA).

- Pay negotiated rate for doctor visits and prescriptions up to plan deductible
- Plan pays coinsurance for services after you meet your deductible
- Paired with Health Savings Account (HSA) – helps pay for medical expenses pre-tax
- Higher deductible with lower premium from your paycheck

Things to Consider When Choosing a Plan:

- **How much did I spend on health care last year?** Consider your premiums and out-of-pocket expenses.
  → Choose a plan with limits that fit your budget.
- **Do I have major events coming up this year?** This may include planned medical procedures or life events like having a baby.
  → Compare hospital benefits in addition to what you'll pay in plan premiums

Medical Plan Overviews

	Traditional Health Plan			
	TIER 1 Scotland	**TIER 2**	**TIER 3**	**TIER 4**
Deductible Individual Family	 $500 $1,500	 $1,000 $3,000	 $2,000 $4,000	 $2,000 $6,000
Out of Pocket Max Individual Family	 $2,500 $5,000	 $3,500 $7,000	 $6,000 $12,000	 $10,000 $20,000
Preventive Care	Covered 100%	Covered 100%	Covered 100%	50% after Deductible
Primary Care	$20 Copay	$35 Copay	$50 Copay	50% after Deductible
Specialist	$50 Copay	$70 Copay	$100 Copay	50% after Deductible
Inpatient Hospital	$250 per admission then 10% after deductible	$500 per admission then 20% after deductible	$750 per admission then 50% after deductible	$1,000 per admission then 50% after deductible
Outpatient Hospital	$150 Copay then 10% after deductible	$300 Copay then 20% after deductible	$500 Copay then 50% after deductible	$1,000 Copay then 50% after deductible
Urgent Care	$30 Copay	$30 Copay	$30 Copay	$30 Copay
Emergency Room	$150 Copay then 10%	$150 Copay then 10%	$150 Copay then 10%	$150 Copay then 10%
Outpatient Lab & X-Ray	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Retail Pharmacy: **-Generic** **-Preferred Brand** **-Brand**	 $5 copay 10% ($10-$50) 25% ($20-$100)	 $10 copay 25% ($20-$100) 50% ($40-$200)		

The plans encourage employees to utilize SHCS providers, their partners in care, and Aetna network providers by covering services at lower copays, co-insurance, and deductibles. The tiers of coverage are as follows:

- Tier 1: Service at Scotland
- Tier 2: Service is not offered at Scotland
- Tier 3: Service is offered at Scotland, but you choose to receive care elsewhere
- Tier 4: Out-of-Network

	Consumer Directed Health Plan			
	TIER 1 Scotland	TIER 2	TIER 3	TIER 4
Deductible Individual Family	 $1,500 $3,000	 $2,000 $4,000	 $3,000 $6,000	 $4,000 $8,000
Out of Pocket Max Individual Family	 $2,500 $5,000	 $3,500 $7,000	 $6,000 $12,000	 $10,000 $20,000
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	50% after deductible
Primary Care	10% after deductible	20% after deductible	50% after deductible	50% after deductible
Specialist	10% after deductible	20% after deductible	50% after deductible	50% after deductible
Inpatient Hospital	10% after deductible	20% after deductible	50% after deductible	50% after deductible
Outpatient Hospital	10% after deductible	20% after deductible	50% after deductible	50% after deductible
Urgent Care	10% after deductible	20% after deductible	50% after deductible	50% after deductible
Emergency Room	10% after deductible	20% after deductible	50% after deductible	50% after deductible
Outpatient Lab & X-Ray	10% after deductible	20% after deductible	50% after deductible	50% after deductible
Prescription Drugs **-Generic** **-Preferred Brand** **-Brand** **-Specialty**	Covered at Tier 1 deductible & coinsurance	Covered at Tier 2 deductible & coinsurance		

The plans encourage employees to utilize SHCS providers, their partners in care, and Aetna network providers by covering services at lower copays, co-insurance, and deductibles. The tiers of coverage are as follows:

- Tier 1: Service at Scotland
- Tier 2: Service is not offered at Scotland
- Tier 3: Service is offered at Scotland, but you choose to receive care elsewhere
- Tier 4: Out-of-Network

Tips for Keeping Costs Down:

- Choose in-network providers
- Take advantage of preventive care services
- Talk to your medical provider about appropriate substitution of lower cost alternative medications
- Use Urgent Care providers instead of the Emergency Room
- Try a Virtual Visit for non-emergent health consultations
- Take advantage of free mental health counseling services through our EAP

Health Savings Account

If you enroll in the Consumer Directed Health Plan (CDHP), you can open a Health Savings Account (HSA) to help pay for eligible medical expenses.

A HSA is a deposit account that you can use to pay for qualified medical expenses – tax-free. Plus, the account is yours to keep – the money you save will roll over year to year.

→ How can I use a HSA?

A HSA is a great way to save money for future medical expenses like having a baby, planned surgeries, or unexpected hospital visits. Many people also save money in a HSA for medical expenses during retirement.

→ Who is eligible to open a HSA?

To open a HSA, you must be enrolled in a qualified CDHP plan. You cannot be a dependent on another person's tax return, be enrolled in Medicare if you're over 65, or have received Veterans Affairs medical benefits at any time over the past three months.

→ What is the tax benefit associated with a HSA?

The money you contribute to your HSA is tax-deductible and can be used for expenses for yourself and your dependents. You can maximize your tax savings by contributing up to the maximum annual amount allowed by the Internal Revenue Service (IRS). Your HSA balance plus investment earnings carry over from year to year – tax-free. Plus – your HSA funds are yours to keep – even if you switch health plans, change jobs, or retire.

HSA Limits	Total for 2022 *
Individual	$3,650
Family	$7,300

***SHCS will contribute $100 to your HSA upon completion of your annual wellness visit.**

→ What are qualified medical expenses?

The IRS maintains a list of all eligible medical expenses, common qualified expenses include:

- Prescription drug expenses
- Inpatient/Outpatient out of pocket expenses
- Doctor's fees
- Acupuncture
- Ambulance services
- Dental treatment
- Contact lenses
- Hearing aids

Additional Health-Related Benefits

Virtual Visits

SHCS partners with Atrium Health to bring you Virtual Visit services. Take advantage of 24/7 access to doctors over the phone or video chat. Virtual Visits can help with many conditions including

- Sore throat
- Headache
- Fever
- Stomachache
- Cold and Flu
- Allergies

Visits are low-cost – just **$30**

Register online to be ready when you need it: https://atriumhealthvirtualvisit.org/landing.htm

Tobacco Cessation

SHCS strives to create an environment that is supportive of your health and well-being. We want to provide you with the resources and support necessary to reach your best health. To sign up for the FREE Scotland Health Care Tobacco Cessation Course, enroll through Aetna. Non-tobacco users and tobacco users who complete the course, will earn the non-tobacco medical premiums.

Diabetes Management

Diabetes continues to be a concern at SHCS and in our community. For 2022, SCHS will continue to offer diabetes prevention and diabetes management programs through Omada, which will include connected health devices, professional health coaching, group coaching, and interactive lessons. These programs are designed to improve blood glucose control, encourage lifestyle change to lose weight, and promote regular check-ups.

Weight Management – New for 2022!

We will roll out a new program for 2022 – Real Appeal. The online weight management program will be available on December 1st. Real Appeal will be available as a benefit and will be covered through Scotland's health plan at 100%. Once you qualify for the program, you will receive a success kit with great tools to assist you in your weight management journey. You have the opportunity for group and/or individual health coaching. Stay tuned for more information on this exciting program.

Supplemental Health Benefits

SHCS understands you value the opportunity to customize your insurance coverage to best fit your individual needs. We are pleased to offer you the ability to add-on any of the following supplemental health programs to complement your medical plan coverage. Find more information about this benefit and how to file a claim at www.unum.com.

Critical Illness Insurance

Critical Illness insurance helps guard against financial hardship if you or a dependent is diagnosed with a covered condition. Some of the expenses this benefit can help pay include initial diagnosis, treatment, and follow-up care. You can choose between a $5,000, $10,000, $15,000 or $20,000 benefit. See benefit summary for all covered conditions. This plan also features a **$50 annual health screening benefit** per covered member.

Covered Illnesses Include:

- Invasive cancer
- Heart attack
- Stroke
- Paralysis
- End-stage kidney failure
- Major organ transplant

Accident Insurance

Accident insurance can help protect you, your spouse, or your children from the unexpected expense of an accident. Some of the common reasons for claims under this plan include broken bones, burns, and sports related injuries – including kids organized sports.

This plan includes a **$100 annual health screening benefit** per covered member.

Plan Highlights	
Injury or Treatment	**Cash Benefit**
ER treatment	$150
Ambulance	$400
Fracture	Up to $7,500
Concussion	$150

Hospital Indemnity

The Hospital Indemnity plan provides a benefit for hospital admission ($1,000) and confinement ($100/day) for an illness or injury. Benefit is paid directly to you and can be used however you need. Plan includes benefit for initial admission, intensive care stay, and hospital confinement – including for maternity stays.

Dental

Our dental plan, administered by MetLife, allows you and your dependents to visit the dentist of your choice. Preventive services are covered by the plan at 100% and other services are covered with coinsurance.

See an overview of the coverage below and view full details in your dental summary of benefits.

Services	Core Plan In-Network Benefit	Buy-Up Plan In-Network Benefit
Deductible Applies to basic and major services only	N/A	Individual: $50 Family: $150
Preventive Services Exams, cleanings, x-rays, fluoride, sealants	Covered 100%	Covered 100%
Basic Services Fillings, crowns, extractions, denture repair	Covered at 50%	Covered at 80%
Major Services Oral surgery, root canal	Covered at 50%	Covered at 50%
Orthodontic Services	Covered at 50%* $2,000 lifetime maximum *Children up to age 19 only*	Covered at 50% $2,000 lifetime maximum
Annual Maximum	$1,500	$1,500

Find a Dentist

Visit www.metlife.com for a list of dentists near you.

Vision

Our vision plan with Community Eye Care covers eye exams and helps offset the cost of corrective eyewear.

An overview of the plan is provided below; please see your summary of benefits for complete details.

Services	Benefit	Frequency
Vision Exam	$10 copay	Once every 12 months
Lenses	$10 copay	Once every 12 months
Eyewear Allowance	$150 allowance Most in-network providers offer discounts over allowance: 20% on glasses and 10% on contacts	Once every 12 months
Contact Lenses	$10 copay	Once every 12 months

Flexible Spending Accounts

SHCS provides you the opportunity to pay for out-of-pocket medical, dental, vision, and dependent care expenses with pre-tax dollars through a Flexible Spending Account (FSA).

Contributions to your FSA are deducted from your paycheck before any taxes are taken out. **You should contribute the amount of money you expect to spend on eligible expenses for the year. Up to $500 can roll over to the following year.**

Health Care FSA

The maximum you can contribute to a health care FSA for 2022 is $2,750. The full amount you elect is available at the beginning of the plan year.

Examples of qualified expenses include:

- Prescriptions
- Doctor visit copays
- Contact lenses
- Dental care

Health Care Tax Savings Example	
Prescription drugs	$225
Doctor co-pays	$80
Orthodontia (braces)	$1,500
Suggested Plan Year Election	**$1,805**
Taxes (30%)	x 0.30
Estimated Annual Savings	**$541.50**

Dependent Care FSA

The maximum you can contribute to the dependent care FSA is $5,000 if you are a single employee or married filing jointly, or $2,500 if you are married and filing separately. Funds are available only after they are deducted from your paycheck.

Examples of qualified expenses include:

- Child-care
- Before or after school program
- Elder care

Dependent Care Tax Savings Example	
Day care for child	$3,500
Summer child care	$1,500
Suggested Plan Year Election	**$5,000**
Taxes (30%)	x 0.30
Estimated Annual Savings	**$1,500**

*Tax savings examples are for illustrative purposes only and are not intended to reflect actual costs of care. 30% tax rate is used for illustration only and may be different than your rate.

Disability Income Benefits

Should you become unable to work due to an illness or injury that is not work-related, disability coverage acts as income replacement to protect you and your family from serious financial hardship.

Short-Term Disability Coverage

Short-term disability coverage is available to you on a voluntary basis through Lincoln Financial. You may choose from the following coverage options:

	11 Week Option	13 Week Option
Benefits Begin	Begins on the 15th day	Begins on the 8th day
Benefits Payable	Up to 11 weeks	Up to 13 weeks
Percent of Income Replaced	60%	60%
Maximum Benefit	$1,500 per week	$1,500 per week
Your Cost	$0.40 per $10 of weekly benefit	$0.70 per $10 of weekly benefit

Long-Term Disability Coverage

SHCS provides all full-time associates with long-term disability through Lincoln Financial coverage at no cost to you.

Long-Term Disability	
Benefits Begin	91st day
Benefits Payable / Duration	To Social Security Normal Retirement Age
Percentage of Income Replaced	60%
Maximum Benefit	$10,000 per month

Life Insurance

Basic Life and AD&D Insurance

SHCS provides all benefit eligible associates with Basic Life and Accidental Death & Dismemberment (AD&D) Insurance through Lincoln Financial at no cost to you. Associates are covered at 1x your annual base salary up to $200,000. Please make sure Human Resources has your designated beneficiary for this plan.

Supplemental Life and Dependent Life Insurance

You are also eligible to elect Supplemental Life and Dependent Life Insurance for yourself and your dependents. Associates pay the full cost for this plan; premiums will be deducted from your paycheck.

Associate Coverage

- Elect $10,000 increments of coverage up to a maximum of $200,000 or 5X salary, whichever is less.

Associates who enroll in the supplemental plan can also elect dependent life coverage for their dependents. You can select a benefit of $5,000 or $10,000.

Whole Life Insurance

SHCS also offers Whole Life Insurance from UNUM as a complement to the Basic & Voluntary Term Life plans.

In addition to a death benefit, Whole Life Insurance builds cash value while you're living that you can use in times of need.

- Associate coverage is available starting at a $2,000 benefit.
- Spousal coverage is available from $2,000 to $50,000 in $1,000 increments. Coverage for your spouse can be purchased without electing associate coverage.
- Child coverage is also available up to $25,000. Child coverage can be purchased without electing associate or spousal coverage.

Key Terms

- The **guarantee issue** amount is the minimum amount a policy will pay on an insured person's claim regardless of health status
- **Evidence of insurability** is an application process detailing your health condition that is required for certain types of insurance coverage
- An insurance plan that is **portable** gives the insured person the right to retain their coverage when switching employers

Employee Bi-Weekly (24) Contributions in 2022

Your premium for elected plans will be deducted pre-tax from each paycheck.

MEDICAL	Associate Only	Associate + Spouse	Associate + Child	Associate + Child(ren)	Associate, Spouse & Children
CDHP- Non-Tobacco	$12.95	$90.27	$56.19	$64.77	$115.59
CDHP- Tobacco	$62.95	$140.27	$106.19	$114.77	$165.59
Traditional- Non-Tobacco	$77.87	$231.62	$160.82	$181.98	$292.22
Traditional - Tobacco	$127.87	$281.62	$210.82	$231.98	$342.22

DENTAL	Associate Only	Associate + Spouse	Associate + Child(ren)	Associate, Spouse & Children
Core	$7.49	$20.78	$14.73	$28.33
Buy up	$14.75	$34.88	$29.28	$49.39

VISION	Associate Only	Associate + One	Family
Vision	$5.50	$10.45	$15.95

OTHER PLANS	
Basic Life Insurance	Employer Paid
Supplemental Life Insurance	Varies depending on age and coverage amount
Dependent Life	$.98 per pay period for $5,000 in coverage; $1.97 per pay period for $10,000 in coverage
Accident, Critical Illness, Hospital Indemnity & Whole Life Insurance Plans	Rates vary depending on coverage elected. You can visit the links below to enroll in these plans
Short Term Disability	Rates vary depending on coverage elected. You can visit the links below to enroll in these plans
Long Term Disability	Employer Paid after 60 days of employment
Employee Assistance Plan (EAP)	Employer Paid

Additional Benefits

Employee Assistance Program

The Employee Assistance Program (EAP) offers confidential resources and referral services. This program is provided to you at no cost by SHCS.

The EAP provides assistance to you and your dependents on a variety of issues including:

- Relationship counseling
- Financial and legal counseling
- Mental health counseling including depression and anxiety
- Work/life balance resources
- Family assistance including help finding childcare or elder care

Associates can take advantage of this resource with the full confidence that all information discussed with Atrium EAP will be kept confidential.

403(b)

Associates may choose to deduct 1-25% of their gross earnings up to $19,500, plus an additional $6,500 for catch up contributions for those age 50 or older, totaling $26,000. After one year of employment, SHCS matches associate deductions $.50 per $1.00 up to an associate's 4% investment. Associates with one year of service who work 1,000 hours during a calendar year and are employed on December 31st of that year will receive an additional 2% contribution to their plan. The annual contribution is not contingent on the associate's participation.

Contact Information

Benefit	Provider	Phone	Website
Medical	Aetna	866-925-0995	www.aetna.com
Virtual Visits	Atrium Health	855-438-0010	https://atriumhealthvirtualvisit.org/landing.htm
Pharmacy	OptumRx	800-334-8134	www.Optumrx.com
Dental	MetLife	800-438-6388	www.metlife.com
Vision	Community Eye Care	888-254-4290	www.cecvision.com
Supplemental Health Critical Illness Accident Hospital Indemnity Whole Life	UNUM	800-635-5597	www.unum.com
Health Savings Account	Bank of America	800-718-6710	https://healthaccounts.bankofamerica.com/index.shtml
Flexible Spending Account	Bank of America	800-718-6710	https://healthaccounts.bankofamerica.com/index.shtml
Basic Life, AD&D Supplemental Life, Dependent Life	Lincoln Financial	800-423-2765	www.lfg.com
Short-Term & Long-Term Disability	Lincoln Financial	800-423-2765	www.lfg.com
Employee Assistance Program	Atrium Health	800-384-1097	www.atriumhealth.org
Diabetes Prevention	Omada		omadahealth.com/scotlandhealth
Weight Management	Real Appeal		enroll.realappeal.com
403(b)	Empower		Empower

Important Notices

For the January 1, 2022 to December 31, 2022 Plan Year

Dear Valued Associate:

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law for the 2022 plan year.

Enclosures:

- Medicare Part D Creditable Coverage Notice
- HIPAA Special Enrollment Rights Notice
- HIPAA Notice of Privacy Practices
- Children's Health Insurance Program (CHIP) Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice
- Newborns' Mothers Health Protection Act (NMHPA) Notice
- General Notice of COBRA Continuation Rights

Scotland Health Care System will herein be referred to as "Employer" or "Entity"

Scotland Health Care System will herein be referred to as "Plan Administrator"

January 1, 2022- December 31, 2022 will herein be referred to as "Plan Year"

Should you have any questions regarding the content of the notices, please contact Kelvin D Oxendine, VP, HR, at Kelvin.Oxendine@ScotlandHealth.org.

IMPORTANT NOTICE FROM YOUR EMPLOYER ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered by the Medical Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in your Employer's coverage as an active employee, please note that your Employer's coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in your Employer's coverage as a former employee.

You may also choose to drop your Employer's coverage. If you do decide to join a Medicare drug plan and drop your current your Employer's coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – 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://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392

Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx; http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	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
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

HIPPA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment in your Employer's group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPPA NOTICE OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

The Employer's Group Health Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact your Plan Administrator.

WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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

HIPAA WELLNESS PROGRAM REASONABLE ALTERNATIVE STANDARDS NOTICE

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your Plan Administrator and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

HIPAA NOTICE OF PRIVACY PRACTICES

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

The Employer sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Employer, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

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

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

Note: If you are covered by one or more fully-insured group health plans offered by they Employer, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Employer's HIPAA Privacy Officer

Effective Date

This Notice as revised is effective January 1, 2022

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. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

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 protected health information will fall within one of the categories.

For Treatment

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

For Payment

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

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage;

submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement 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 Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

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

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

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

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

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

Health Oversight Activities

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

Lawsuits and Disputes

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

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

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

National Security and Intelligence Activities

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

Inmates

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

Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

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

Government Audits

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

Disclosures to You

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

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

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;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or 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 protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your 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. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

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

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. 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 have a right to request that the denial be reviewed and you will be provided with details on how to do so.

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 Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

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

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

Right to an Accounting of Disclosures

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

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

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

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. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. 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 to the Privacy Officer at the address provided above under Contact Information. 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 if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

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. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may

qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Scotland Health Care System

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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[1] 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/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**.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Keep your Plan informed of address changes

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

Plan contact information

See the contact information provided at the beginning of this notice to inquire *about the Plan and COBRA continuation coverage, which can be obtained on request.*