ep Cares

2024 BENEFITS GUIDE

Health Insurance Solutions for Eligible Entertainment Employees

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Health Insurance Solutions for Eligible Entertainment Employees

DID YOU KNOW your employer pays at least **HALF** of the lowest cost medical premium?

Look for an email from **MyEPCares@ep.com** about when, where and how to enroll.

Didn't see the email? Check your Spam/Junk folder and/or email us at myepcares@ep.com.

Coverage becomes effective

1st day of the month following 30 days of employment

You must be enrolled by the 27th of the prior month to get coverage

If you miss this opportunity to enroll, you will not be able to enroll unless you have a qualifying life event or during open enrollment (typically in November).

Log in to **myepcares.com** to review or change your benefits.

Enrollment Meetings are held on the third Wednesday of each month. Join us via Zoom to learn more about your benefits, ask questions, get answers. **Register** for the meeting now.

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See page 28 for an important notice regarding Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) and page 31 for an important notice regarding your Medicare Part D Coverage.

EP CARES™ QUICK START GUIDE

Step 1

Log on to myepcares.com.

Your **username** and your temporary **password** will be your first name, the first initial of your last name, and the last four digits of your Social Security Number (SSN). For example:

Name: Ashley Smith
SSN: XXX-XX-6789
Username: ashleys6789
Temporary Password: ashleys6789

Please note that first-time users will be prompted to select a new password upon signing in. All passwords will be reset to the default as of 11/10/2023 for Open Enrollment.

Step 2

The EP Cares™ Online Enrollment Portal will list your **Employer's monthly contribution amount** and all plans available to you based on your home zip code. Review each one and pick a plan option that meets your specific needs.

Step 3

Once you complete the enrollment process on the EP Cares™ Online Enrollment Portal, you have the option to send yourself an email from the system documenting your insurance elections and the effective date of your coverage. We highly recommend you document your selections by sending yourself the email or taking a screenshot of your enrollment.

NOTE: **You must still be working for your current Employer as of the coverage effective date or your benefits will not take effect.**

Additional information on plan details, coverage options, and applicable disclosures can be found in the Summary of Benefits and Coverage (SBC) and the Summary Plan Descriptions (SPD). A paper copy is also available upon request by contacting the EP Cares™ Contact Center below.

NEED HELP?

Phone: 855.339.7350 | Email: myepcares@ep.com | Web: ep.com/epc

ID CARDS AND MYCIGNA

Digital ID Cards are available in the myCigna mobile app or at mycigna.com. Click here to learn more. As of November 2023, Cigna will mail physical ID cards upon request only. To request a physical ID card, please contact Cigna at 800.997.1654.

myCigna mobile app

Get the most out of your plan with myCigna.

- Digital ID Cards
- Find doctors, urgent care, hospitals and more
- Manage prescriptions and get them delivered to your home
- Take a health assessment, set goals, and earn incentives
- Set up paperless Explanation of Benefits (EOBs)
- Check on the status of your claims

Once you register for myCigna, you get complete access with easy one-touch, secure sign-on to Cigna.

Download the myCigna mobile app.:

Download on the App Store

GET IT ON Google Play

available at amazon appstore

VIDEO LIBRARY

New to health insurance? Looking for more information? Take advantage of our online video library, available 24/7 at ep.com/epc.

General Benefits Videos

- Clueless About EP Cares?
- What is Open Enrollment?
- Understanding Health Insurance: What is In-and Out-of-Network?
- What is an Employee Assistance Program (EAP)?
- Everything You Need to Know About COBRA

Medical, Dental, and Vision Insurance

- Know Where to Go: Telehealth, Urgent Care, Hospital
- Understanding Health Insurance: Premiums, Deductibles, Copays and Out-of-Pocket Maximums
- What is a Copay?
- What is Coinsurance?
- What is an HDHP?
- What is a PPO?
- What is Dental Insurance?
- What is Vision Insurance?

Specialty Benefits

- My Pet Protection from Nationwide
- Aflac Accident Insurance
- Aflac Hospital Insurance
- Aflac Cancer Insurance
- Aflac Life Insurance
- Aflac Critical Illness Insurance

ELIGIBILITY

Employees

All non-union* Employees classified as benefit eligible by Employers offering EP Cares™ are eligible to enroll in EP Cares™ benefit plans.

Dependents

Eligible Employees may also enroll the following dependents:

- **Legally married spouse**
  This includes registered same-sex and opposite-sex domestic partners
- **Children up to age 26**
  This includes natural children, stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, and children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMCSO)
- **Disabled children over age 26** if unmarried, incapable of self-support, dependent on you for primary support, and the disability occurred before the age of 26

If You Cover a Dependent

To control health care costs and meet health plan contract obligations, your Employer may ask to verify family members' eligibility for enrollment in EP Cares™ benefit plans. Your Employer and the insurance carrier(s) reserve the right to request documentation (e.g., marriage and/or birth certificates) to verify eligibility.

Coordination of Benefits

If you currently receive or are eligible for benefits through your spouse or partner, it is your responsibility to check with that plan for specifics surrounding coordination of benefits.

Waiting Period

New Hires

Coverage takes effect on the first day of the month following the 30-day new hire waiting period. **You must be actively employed on that day for the benefits to take effect.**

To get insurance, you must complete the enrollment process by the 27th day of the month prior to your effective date.*

Example: Michael is hired on January 16. He has until February 27 to enroll in benefits, and his coverage will take effect on March 1.

Re-Hires and Eligibility

The chart in the EP Cares Benefits Guide illustrates break in service scenarios for those Employees who have made benefit elections and are being re-hired **within the same Controlled Group.**

If an Employee leaves one Controlled Group (parent company) and goes to work for another, the Employee would need to re-satisfy the waiting period before becoming eligible for benefits.

Rehired employees are given a specific deadline to enroll in their rehire offer letter from EP Cares.

WORK PERFORMED OUTSIDE OF THE U.S.

Unless otherwise specifically directed by your production company, work performed outside of the U.S. does not count toward your EP Cares eligibility.

* If you are working in a union or "non-affiliate" job code, you are ineligible for EP Cares benefits. If you are currently non-union but later switch to a union or non-affiliate position, your EP Cares benefits eligibility will end on the last day of the month and you will not be eligible for COBRA. See the EP Cares COBRA FAQ for more information and alternative benefits options.

RE-HIRES ELIGIBILITY CHART

WITHIN THE SAME CONTROLLED GROUP (PARENT COMPANY)

Break in Service Length of Time	EE can make new benefit elections?	Waiting Period is triggered?	Eligibility Date?	Example
Break in Service < or = 30 Days	No	No	Reverts to initial Eligibility Date (considered "Continuous Employment")	Date of Hire = 3/5 Termination Date = 5/20 Re-hire = 6/2 **Result:** Benefit coverage will be retroactive to the first of the month in which the Re-hire date occurred. In this example, 6/1.
Break in Service > 30 Days, but < or = 90 Days	Yes. If benefits are desired, EE must re-enroll in benefits after a break in service of more than 30 days.	No	If the re-hire date is between the 1st and 15th of the month, the coverage will commence retroactive to the first of the month in which the re-hire date occurred. If the re-hire date is between the 16th and 31st of the month, the coverage will commence the first of the following month.	**Example One:** Date of Hire = 3/5 Termination Date = 5/20 Re-hire = 8/10 **Effective Coverage Date= 8/1** **Example Two:** Date of Hire = 3/5 Termination Date = 5/20 Re-hire = 8/22 **Effective Coverage Date= 9/1** **Result:** EE can make new benefit elections upon Re-Hire date. No waiting period invoked.
Break in Service > or = 91 Days (ACA 13-Week Break in Service)	Yes. If benefits are desired, EE must re-enroll in benefits.	Yes	Eligibility Date is the new Start Date (Considered "New Hire")	Date of Hire = 3/5 Termination Date = 5/20 Re-hire = 9/15 **Result:** EE can make new benefit elections upon New Hire date, but the waiting period applies. Benefit coverage commences on 11/1. EE can select COBRA for June, July, August, September, and October coverage.

EE = Employee

For more information on COBRA, see page 37.

TERMINATION OF BENEFITS

Your benefits may be terminated, either voluntarily or involuntarily under specific circumstances. The table below gives some common examples. Please contact EP Cares at **855.339.7350** or myepcares@ep.com if you have questions.

Scenario	Coverage End Date	Eligible for COBRA* benefits continuation?
You are reported as terminated, wrapped, etc. by your Employer (for any reason other than gross misconduct)	The last day of the month of your termination date	Yes
Your Employer notifies us of a change in status to a non-eligible class (e.g. move from full time to part time)	The last day of the month of your change in status date	Yes
EP is notified that you are working in a union or "non-affiliate" position	The last day of the month of your non-union status	No
You fail to pay your full share of the cost of benefits within the grace period (see page 13)	The last day of the month for which you fully paid for your insurance (may be retroactive to previous month)	No
You notify EP Cares of a Qualifying Life Event and the desire to terminate benefits (see page 14)	The last day of the month following the QLE date	No
Your employer cancels coverage with EP Cares	The last day of the month of the employer's contract with EP Cares	No

For more information on COBRA, see page 37.

WHAT IS COBRA?

COBRA is a federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the Employer used to pay, plus a small administrative fee. For more information, see page 37.

NEED HELP?

Phone: 855.339.7350 | Email: myepcares@ep.com | Web: ep.com/epc

TERMINATION/LAYOFF AND **COBRA**

Frequently Asked Questions

1. I was recently laid off/my project wrapped/ I was terminated. What happens to my EP Cares benefits?

Your Cigna medical, dental, and/or vision insurance will end on the last day of the month in which you stopped working. For example, if your last work date was March 20, your benefits will end on March 31.

Your Aflac and Nationwide benefits will remain in place as long as you continue to make payments directly to those vendors.

2. My benefits with EP Cares are ending. Now what?

You have several options. The involuntary loss of benefits due to a layoff or termination generally qualifies you for a "special enrollment period" with the state/federal health exchanges. You may also be able to enroll in your spouse's health insurance plan or directly with an insurance company.

If you would like assistance selecting a plan, we recommend Mylo. Mylo combines technology and licensed insurance agents to help you find the best plan for your situation. See the attached flyer for details.

Phone: 844-893-9886
Web: **ChooseMylo.com/health-insurance**
Email: **YourChoice@ChooseMylo.com**

In most cases, you are also eligible to continue your medical, dental and vision benefits via COBRA.

3. I lost benefits eligibility because I was hired into a union position. What should I do?

You are not eligible for COBRA because the COBRA laws are very specific. The only qualifying events that would make an employee eligible for COBRA are the termination of employment or the reduction of hours that results in a loss of benefits. Changing to union status does NOT count as a qualifying event for COBRA.

However, all the other options in Q2, including **Mylo**, apply to you. We encourage you to seek insurance through one of those options while you are in the waiting period for union benefits.

4. How does COBRA work?

If you are eligible for COBRA, you can keep the medical, dental, and/or vision insurance you had at the time of your loss of active insurance. You will need to enroll in COBRA and pay the full cost of benefits, plus a 2% administrative fee.

The specific information for your COBRA enrollment will be mailed to the address we have on file at **myepcares.com**. Please watch for an envelope from Wex Health (the COBRA administrator).

5. When does COBRA start?

If eligible, COBRA benefits will be effective on the first day of the month after your active insurance benefits with EP Cares end. For example, if your termination date was March 20, your active benefits will end on March 31. Your COBRA benefits will be effective on April 1 if you choose to enroll – even if you enroll after April 1.

6. When will I receive my COBRA information?

Once your employer advises EP Cares of your termination, the information is processed and sent to Wex health, our third-party administrator for COBRA. The COBRA packet will then be mailed within 14 days to the address we have on file at **myepcares.com**.

continued >>>

TERMINATION/LAYOFF AND COBRA

Frequently Asked Questions (continued)

7. Can EP Cares email me my COBRA packet?

The law says it must be mailed to you. However, if you would also like to request a copy via email, please send your request to **cobraadmin@wexhealth.com**. Be sure to include your full name and the last four digits of your SSN. Please allow a minimum of two weeks of processing time from your last day of work for your information to be live in the Wex system.

8. How much does COBRA cost?

Your exact costs for the plans you have chosen will be mailed to you with your COBRA packet. In general, you will be charged the full cost of benefits (including what your production/studio used to pay), plus a 2% administrative fee. You can get an idea of those costs by reviewing the full rates on pages **15** and **21**

9. How do I enroll in COBRA?

Once you have received your COBRA packet, you can enroll online or by filling out the paper COBRA election form and mailing it as instructed. Note: Online COBRA enrollment requires a unique password (listed on a page toward the end of the packet). **You will not be able to enroll online until you receive this information.**

10. When is my deadline to enroll in COBRA?

Your specific deadline to enroll in COBRA will be listed in your COBRA packet. Generally, you have 60 days from the date of the COBRA notice.

11. I haven't enrolled in COBRA yet, but I need medical coverage now. What do I do?

If you choose to enroll in COBRA, your benefits will be retroactive as described above in Q5, if you meet the enrollment deadlines described in Q10.

If you need to seek medical services before your COBRA enrollment shows as active with the Cigna system, you will be able to submit any expenses that occurred after the COBRA effective date to Cigna for reimbursement.

12. How do I pay for COBRA?

Once you have enrolled in COBRA, you can set up recurring ACH payments through the Wex self-service portal. If you prefer to mail a check or money order, payment coupons are included with your COBRA packet. **Review the payment guide here.**

13. Who do I contact for help?

Wex Health is the COBRA Administrator. Please allow a minimum of two weeks of processing time from your last day of work for your information to be live in the Wex system.

Email: **cobraadmin@wexhealth.com**
Please include your full name and the last four digits of your SSN

Phone: 866-451-3399

14. I need proof of loss of coverage. Can you write me a letter?

The COBRA administrator will provide a COBRA notice, as indicated in Q6.

If you need something sooner than that, the employer (production company/studio) can write a letter on company letterhead, advising that you are losing your medical/dental/vision insurance due to the layoff/termination. The effective date of the loss should be included in the letter. EP Cares cannot provide these letters as we are not the Common Law Employer who offered the health insurance.

MOVING BETWEEN PROJECTS

EP Cares™ is specifically tailored to the needs of non-union employees in the entertainment industry. One of the many advantages of EP Cares™ is that it provides you with consistent access to medical, dental, and vision benefits as you move between different Employers offering EP Cares™. Some geographic restrictions apply and Employer contributions may vary. In most cases, you will have access to the same benefit plan options at the same rates. See the scenarios below for examples.

MOVING BETWEEN PROJECTS: SCENARIOS

SCENARIO 1: Your tenure on a project ends in March and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) within 30 days.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. Upon rehire, your benefits will be reinstated with no lapse in coverage. You will be responsible for your share of premium payments, if any.
SCENARIO 2: Your tenure on a project ends on March 10 and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) in early May.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. You will be offered the opportunity to maintain coverage through COBRA during the period of time you are between jobs. You will receive COBRA information via mail upon termination. Since your next project begins less than 13 weeks after you were terminated from the first project, you will be allowed to re-enroll in your benefits upon your first day of work in May, and your coverage will be effective in accordance with the chart on **page 7**.
SCENARIO 3: Your tenure on a project ends on March 10 and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) in mid-August.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. You will be offered the opportunity to maintain coverage through COBRA during the period of time you are between jobs. You will receive COBRA information via mail upon termination. Since your next project begins more than 13 weeks after you terminated from the first project, you will be required to satisfy a new hire waiting period. If you elect benefits, your coverage will be effective on the first day of the month (in this example, October 1).

PLAN ENROLLMENT

New Hire Enrollment

Coverage takes effect on the first day of the month following 30 days from your hire date. To get benefits, you must complete the enrollment process by the 27th day of the month prior to your effective date.

Example: Libby is hired on March 16. She has until April 27 to enroll in benefits, and her coverage will take effect on May 1.

WARNING:
If you miss the new hire enrollment window, you must wait until the next Open Enrollment period or experience a Qualifying Life Event (see page 14) to enroll.

2024 Open Enrollment

Each year, during Open Enrollment, you can add, drop, or make changes to your benefits. This year, Open Enrollment runs from **November 13 - 28, 2023**.

If you choose not to take any action, then your existing selections (if applicable) will apply to the following year.*

New plans and/or rates will apply as of January 1.

Example: Sam selects or changes insurance coverage during Open Enrollment. His new insurance begins on January 1.

Online Benefit Enrollment Portal

EP Cares™ provides you with the ability to enroll in your benefit plans online at **myepcares.com**.

Before you begin, please make sure you have:

Social Security Number (SSN) for all legal dependents

Date of Birth (DOB) for all legal dependents

Log in to myepcares.com:

Your **username** and your temporary **password** will be your first name, the first initial of your last name, and the last four digits of your Social Security Number (SSN). For example:

Name: Elizabeth Munoz
SSN: XXX-XX-4617
Username: elizabethm4617
Temporary Password: elizabethm4617

Please note that first-time users will be prompted to select a new password upon signing in. All passwords will be reset to the default deach year on the Friday prior to Open Enrollment.

NOTE: **Please be sure to review your confirmation statement carefully.**

Check the plans, prices, and effective dates. You can log back in and make changes at any time within your enrollment window.

PAYING YOUR SHARE OF INSURANCE

Payment for your share of premiums (if any) is due on the first of the month and is your responsibility. EP Cares offers payroll deductions or a billing service (depending on your employer) as a courtesy, but ultimately **it is your responsibility to ensure that your monthly premium is paid in full.**

Employees with paycheck from EP	Employees of projects with payroll outside of EP, COBRA participants
Employees who get payroll checks from EP will be set up with automatic payroll deduction for medical, dental, and vision insurance. Payroll deductions are not available for other policies.*	You are responsible for sending payment for your share of the cost of benefits. Click here for a detailed payment guide. We highly recommend you set up automated payments via checking or savings account so you never miss a month.

* If enrolled in an Aflac or Nationwide policy, you will pay the vendor directly. Payment details provided by vendor upon enrollment.

Grace Period for Late Payment of Premiums

While payments are due on the first of the month, there is an automatic grace period extended through the last day of the month.

If the share of premium you have paid for the month is sufficient to pay for some, but not all of the insurance coverage in which you have enrolled yourself, spouse, and dependents, the premium payments for that month will be applied first to medical insurance, second to dental insurance, third to vision insurance, and then to any additional lines of coverage (if applicable).

WARNING:

Failure to pay your share of premiums will result in the termination of insurance coverage through EP Cares retroactively to the last day of the month for which your share of premiums was fully paid. Full details are provided in the authorization forms you sign during the enrollment process.

If you have questions about your premium, don't see deductions on your paycheck, and/or don't understand how to pay through WEX Health (if your payroll goes through a different company), please contact us.

Similarly, if you normally pay via payroll deduction and are going on hiatus, leave or other break, you must mail or deliver payment to Entertainment Partners, 2950 N. Hollywood Way, Burbank, CA 91505. Checks should be made payable to EP Health Insurance Solutions, LLC. Please include your full name and the last four digits of your SSN on your payment.

You are responsible for making sure payments for your insurance are paid on time. Deliquent accounts are subject to cancellation.

MAKING CHANGES TO YOUR BENEFITS

Annual Open Enrollment

During annual Open Enrollment, you can re-evaluate and make changes to the plans you and your eligible dependents enroll in for the upcoming year. Open Enrollment for EP Cares™ typically begins in November each year.

Learn more about Open Enrollment by watching a short video.

Qualifying Life Events (QLEs)

The federal government has set guidelines, referred to as Qualifying Life Events, for when you are allowed to make changes outside of Open Enrollment. Examples of QLEs are:

- **Involuntary loss of other group coverage (including loss due to reaching age 26)**
- **Marriage, legal separation, or divorce**
- **Birth or adoption of a child**
- **Change in eligibility of a child**
- **Death of a dependent family member**
- **Change in your or your spouse's/registered domestic partner's employment status**
- **Your spouse/registered domestic partner reaches age 65 and is covered by Medicare**
- **Enrollment in another group insurance plan such as a spouse's or parent's plan through their employer**
- **If you are moving to a different county or state, please advise. You may qualify and/or be required to make changes.**
- **FMLA special requirements**
- **HIPAA special enrollment rights**
- **Increase or reduction of hours that changes employment status**
- **Reduction in hours such that you are expected to work fewer than 30 hours per week**
- **You become eligible to enroll in an exchange or marketplace established under §1311 of the Patient Protection and Affordable Care Act**

How to Report a QLE

If you experience a Qualifying Life Event, as specified by the federal government, you may make changes to your benefit elections within 31 days of the date of the QLE. Please note that any changes to the benefit plans must be consistent with the qualifying event.

If you have had a QLE and would like to make changes to your benefits, please email us at **myepcares@ep.com**. Please be sure to include the following information:

- Your first and last name
- Last four digits of your SSN
- The nature of the QLE
- The date of the QLE
- If you have any supporting documentation (birth certificate, marriage certificate, proof of loss of other insurance, etc.), please attach it to the email

MEDICAL BENEFITS AND RATES 2024

PLANS	EPO Plans In-Network Only No PCP[3] Required		HMO Style Plans In-Network Only PCP[3] Required		PPO Plans In-and-Out of Network Coverage No PCP[3] Required		
	Local+ IN 5900 HDHP	Open Access+ IN 5900 HDHP	Local+ IN 3000	Open Access+ IN 3000	Open Access+ 4500 HDHP	Open Access+ 2500	Open Access+ 250
	Same Plan, Different Regions		Same Plan, Different Regions				
AVAILABILITY[1]							
California	✓			✓	✓	✓	✓
California Rural[2]				✓	✓	✓	✓
Georgia		✓	Network determined by home zip code		✓	✓	✓
New York		✓		✓	✓	✓	✓
New Jersey		✓	Network determined by home zip code		✓	✓	✓
Alabama, Arkansas, Oklahoma	State laws prohibit in-network only plans.				✓	✓	✓
Other States		✓	Network determined by home zip code		✓	✓	✓
CALENDAR YEAR DEDUCTIBLE (The amount you pay for covered healthcare services before your benefit plan coverage begins. Not all services are subject to the deductible.)							
In Network Deductible (Single)	$5,900		$3,000		$4,500	$2,500	$250
In Network Deductible (2 Or More)	$11,800		$6,000		$9,000	$5,000	$750
OUTPATIENT (Employee Pays)							
Preventive Benefits	No Copay		No Copay		No Copay	No Copay	No Copay
Office Visits	30%*		$30		20%*	$30	$30
Specialist Visits	30%*		$50		20%*	$50	$50
Urgent Care Facility	30%*		$50		20%*	$50	$50
Emergency Room Facility	30%*		$200		20%*	$500	$250
OTHER SERVICES (Employee Pays)							
Coinsurance	30%*		30%*		20%*	20%*	10%*
Hospital Inpatient Care	30%*		30%*		20%*	20%*	$500 copay, then 10%*
Annual Maximum Out-of-Pocket (single)	$6,550		$6,000		$7,500	$9,100	$5,000
Annual Maximum Out-of-Pocket (2 or more)	$13,100		$12,000		$15,000	$18,200	$10,000
PHARMACY (Employee Pays)							
Deductible	Combined with Med		$0		Combined with Med	$0	$0
Tier 1	30%* max $250		$15		$20*	$20	$20
Tier 2	40%* max $250		$40		$40*	$40	$40
Tier 3	50%* max $250		30% max $100		30%* max $250	30% max $250	30% max $250

Home Delivery Pharmacy benefits available with all EP Cares plans for many common recurring medications. Receive a 90-day supply for 2X the retail co-pay. Contact Cigna for details.

* after deductible

	Local+ IN 5900 HDHP	Open Access+ IN 5900 HDHP	Local+ IN 3000	Open Access+ IN 3000	Open Access+ 4500 HDHP	Open Access+ 2500	Open Access+ 250
TOTAL MONTHLY PREMIUM	Available upon request - please email epcares@ep.com.						
Employee Only	[redacted]						
Employee + Spouse	[redacted]						
Employee + Child(ren)	[redacted]						
Employee + Family	[redacted]						

[1,2,3] See following page for footnotes.

MEDICAL PLAN COMPARISON GRID

PLANS	EPO Plans In-Network Only No PCP[3] Required		HMO Style Plans In-Network Only PCP[3] Required		PPO Plans In-and-Out of Network Coverage No PCP[3] Required		
	Local+ IN 5900 HDHP	Open Access+ IN 5900 HDHP	Local+ IN 3000	Open Access+ IN 3000	Open Access+ 4500 HDHP	Open Access+ 2500	Open Access+ 250
	Same Plan, Different Regions		Same Plan, Different Regions				
AVAILABILITY[1]							
California	✓			✓	✓	✓	✓
California Rural[2]				✓	✓	✓	✓
Georgia		✓	Network determined by home zip code		✓	✓	✓
New York		✓		✓	✓	✓	✓
New Jersey		✓	Network determined by home zip code		✓	✓	✓
Alabama, Arkansas, Oklahoma	State laws prohibit in-network only plans.				✓	✓	✓
Other States		✓	Network determined by home zip code		✓	✓	✓
PLAN TYPE							
PPO - In and Out-of-Network Coverage, No PCP[3]					✓	✓	✓
EPO - In Network Coverage, No PCP[3] Required	✓	✓					
HMO Style- In Network Coverage, PCP[3] Required			✓	✓			
CIGNA PROVIDER NETWORK							
Open Access		✓		✓	✓	✓	✓
Local Plus	✓		✓				
SERVICES AND BENEFITS							
Preventive Care Visits Free[4]	✓	✓	✓	✓	✓	✓	✓
Telemedicine Benefits Available	✓	✓	✓	✓	✓	✓	✓
TalkSpace Available	✓	✓	✓	✓	✓	✓	✓
Health Savings Account ("HSA") Compatible	✓	✓			✓		
Infertility Benefits Available							✓
You can see a specialist without a referral	✓	✓			✓	✓	✓

NEED HELP?

Phone: 855.339.7350

Email: myepcares@ep.com | Web: ep.com/epc

PRO TIP:

Log in to www.myepcares.com. The exact plans and networks available to you will be visible in the medical plan selection area.

[1]EP Cares is not available to Hawaii residents. If you live in HI, please contact us if you have healthcare questions. EP Cares is also unavailable in GU and PR.

[2] CA residents in Los Angeles, Orange Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Contra Costa and Alameda counties have access to the Local+ network, so their lowest cost plan is the Local+ 5900 plan. Outside of those areas, network access varies by zip code. In locations where the Local+ network is unavailable ("CA Rural"), the lowest cost plan available to CA residents is the Open Access+ 4500 HDHP.

[3]PCP = Primary Care Physician. The HMO Style plans require a PCP who will refer you to specialists within the network.

[4]Preventive Care Visits with an in-network provider are covered at 100% as long as you follow the preventive care guidelines. See plan documents for details.

FINDING A DOCTOR

Is your doctor or hospital in your plan's Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

Search Your Plan's Network In Four Simple Steps

Step 1

Go to Cigna.com, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

(If you're already a Cigna customer, log in to myCigna.com or the myCigna® app to search your current plan's network. To search other networks, use the Cigna.com directory.)

Step 2

Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

Step 3

Answer any clarifying questions, and then verify where you live (as that will determine the networks available).

Step 4

Select one of the plans offered by your employer during open enrollment.

Medical Plan Name	Network Name
Local+ IN 5900 HDHP	Local Plus
Open Access+ IN 5900 HDHP	Open Access Plus, Open Access Plus Tiered
Local+ IN 3000*	Local Plus
Open Access+ IN 3000*	Open Access Plus, Open Access Plus Tiered
Open Access+ 4500 HDHP	Open Access Plus, Open Access Plus Tiered
Open Access+ 2500	Open Access Plus, Open Access Plus Tiered
Open Access+ 250	Open Access Plus, Open Access Plus Tiered
Dental Plan Name	**Network Name**
Dental PPO	Cigna DPPO Advantage
Dental HMO	Cigna Dental Care Access (formerly Cigna Dental Care HMO)

* **NOTE!** If you enroll in one of the HMO style plans (Local+ IN 3000 or Open Access+ IN 3000) you must select a Primary Care Physician ("PCP") to coordinate your care. See next page for instructions.

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

QUESTIONS ABOUT IN-NETWORK DOCTORS AND PROVIDERS?

Not yet enrolled in Cigna: 800-564-7624 | Enrolled in Cigna: 800-244-6224

Be sure to reference "EP Cares" if asked for your employer.

PRIMARY CARE PROVIDER (PCP)

How to select or change your Primary Care Provider (PCP)

If you selected an HMO Style plan (Local+ IN 3000 or Open Access+ IN 3000) you must select a Primary Care Physician ("PCP") to coordinate your care.

Here's how to select or change your PCP:

1. Begin by calling **1-800-Cigna24 (244-6224)**
2. Listen to the prompts and select the number that says you are a customer.
3. You will be prompted to enter your Cigna ID or SSN along with your date of birth.
4. You can then tell the automated system that you wish to speak to a Personal Guide. The system will ask you to confirm if you are calling regarding medical, dental or mental health benefits.
5. Once you reach a representative, you can ask for assistance in selecting a Primary Care Provider.
6. At this time if you have a PCP in mind, your representative can help you make that election (and confirm they are in-network). If you do not have a provider in mind, they will help you find one.

You can also update your PCP through myCigna.com:

1. Register/ login to myCigna.com
2. Find your name in the top right corner
3. Click "My Health Team" from the drop-down menu
4. Confirm the provider listed is correct
5. If you would like to change or add a provider to your health team, scroll down the page and select "Search for in-network providers & facilities"
6. Under "Doctor by type" select "Primary Care Physician" or "Doctor by name"
7. Select "See a local provider"
8. Click on your preferred provider and within profile click the "Select PCP" button

UPDATES MADE THROUGH MYCIGNA.COM OR THE MOBILE APP:

If made before the 15th, the system will reflect the new PCP on the 1st of the month. If a change is made after the 15th, the system will update on the 1st of the following month.

Please note that calling in is the fastest way to make a change and select your preferred PCP.

QUESTIONS ABOUT IN-NETWORK DOCTORS AND PROVIDERS?

Not yet enrolled in Cigna: 800-564-7624 | Enrolled in Cigna: 800-244-6224

Be sure to reference "EP Cares" if asked for your employer.

VOLUNTARY BENEFITS

Because you are eligible for EP Cares, you can purchase Aflac and Nationwide policies at discounted group rates.

Aflac

Accident Advantage

includes benefits payable for fractures, dislocations, lacerations, concussions, burns, emergency dental work, and more.

Cancer Protection

includes benefits for covered cancers, including screenings, initial diagnosis, treatment, and more. Please see details for full information.

Critical Care Protection

provides coverage for serious health events like heart attack, stroke, third degree burns, etc.

Lump Sum Critical Illness

benefits are paid for specific illnesses or injuries, such as end-stage renal failure, heart attack, paralysis, organ transplant, or coma. Benefit amounts up to $100,000 available.

Hospital Confinement Insurance

offers hospital-related benefits if a hospital stay of 23 hours or longer is required. Various options available.

Term Life Insurance

provides a lump-sum benefit to your loved ones if something happens to you. Guaranteed-issue policies up to $20,000. Up to $500,000, subject to approval.

To enroll or get more information

Schedule an appointment
Call or Text 818.396.6824
Email our Aflac partner.

Nationwide

Nationwide® pet insurance

Nationwide offers coverage for your pet's injuries, illnesses and preventive care. Plus, you're free to use any vet, anywhere. Plans are available for dogs, cats, birds and exotic pets.

All Nationwide pet insurance members receive free, 24/7 access to vethelpline® ($150 value) for guidance on any pet health concern. This service is available exclusively from Nationwide.

Because you are eligible for EP Cares, you get preferred pricing on coverage for your pets.* Visit benefits.petinsurance.com/ep or call 877-738-7874 for more information or to get a no-obligation quote.

*Preferred pricing applies to base plan only. Please note, your employer's contribution toward health insurance cannot be applied toward Nationwide pet insurance.

NOTE: **Unlike medical, dental and vision insurance, Aflac and Nationwide policies do not automatically terminate when you leave your employer. You make keep these plans with the same terms as long as you continue to pay your monthly premiums. The employer subsidy toward EP Cares benefits does not apply to these voluntary benefits.**

MENTAL HEALTH RESOURCES

IMPORTANT CRISIS PHONE NUMBERS

If you or a loved-one is in crisis, please contact one of the numbers below. Counselors are available to assist you 24/7.

National Suicide Prevention Lifeline: 800.273.8255
National Domestic Violence Hotline: 800.799.7233 or text LOVEIS to 866.331.9474
Crisis Text Line: Text HOME to 741741 from anywhere in the USA.
Cigna Veteran Support Line: 855.244.6211

Cigna customers: You can also call the number on your ID card or contact your Employee Assistance Program (see below).

TRADITIONAL	TELEMEDICINE	TEXTING & ONLINE
Cigna.	MDLIVE	talkspace
All Cigna medical plans through EP Cares include mental health coverage. See the specific plan information for details.	MD Live for Cigna offers private, secure online video therapy with licensed therapists. If you have Cigna medical insurance, MD Live is an "in-network" benefit.	TalkSpace offers therapy via texting, audio, and video messages in a private, text-based chatroom. If you have Cigna medical insurance, TalkSpace is an "in-network" benefit.

Employee Assistance Program (EAP) through Cigna - see page 24

DENTAL BENEFITS AND RATES

Through EP Cares™, your Employer is offering a choice of two dental plans: a Cigna Dental DHMO and a Cigna Dental PPO.

Learn more about Dental Insurance by watching a short video.

Dental Benefit Summaries are available for review at ep.com/epc.

	Dental HMO	Dental PPO		
		Total Cigna DPPO Network		Out-of-Network
Network Options	Cigna Dental HMO	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Orthodontics	Some Coverage	No	No	No
Must select in-network dentist?	Yes	No. PPO plan allows out-of-network coverage at a lower reimbursement rate.		
Calendar Year Benefits Maximum	N/A	$2,000	$1,500	$1,500
ID Cards Issued	Yes	No. Your provider will use your SSN to confirm enrollment.		
Dental Plan Rates*	Available upon request - please email epcares@ep.com.			
Employee	[redacted]		[redacted]	
Employee + Spouse	[redacted]		[redacted]	
Employee + Child(ren)	[redacted]		[redacted]	
Family	[redacted]		[redacted]	

* Figures represent full monthly premiums without Employer subsidy applied.

VISION BENEFITS AND RATES 2024

Cigna's National Vision Plan allows you to seek care or services from either a vision contracted network provider or a non-contracted provider and still receive a benefit. Seeing a contracted provider typically results in a lower out-of-pocket expense to you.

Vision Plan Rates*	
Employee	[redacted]
Employee + Spouse	[redacted]
Employee + Children	[redacted]
Family	[redacted]

* Figures represent full monthly premiums without Employer subsidy applied.

Rates available upon request - please email epcares@ep.com.

Generally, you can get a routine eye exam and an eyeglass lens allowance every 12 months. You can opt for contact lens allowance in lieu of eyeglass lenses and frames. The vision plan covers an eyeglass frame retail allowance every 24 months. See plan summary for more information.

Vision Benefit Summaries are available for review at ep.com/epc.

PHARMACY BENEFITS

All EP Cares medical plans include pharmacy benefits. You can go online to see the current list of medications your plan covers.

myCigna app or myCigna.com

Click on the **Find Care & Costs** tab. Then select **Price a Medication**, and then type in your medication name.

Cigna.com/druglist

Select **Standard 3 Tier** from the dropdown menu. Then type in your medication name or view the ful list.

QUESTIONS?
myCigna.com:
Click to Chat
Monday-Friday
9:00am-8:00pm EST
By phone:
Call the toll-free number on your Cigna ID card.

Generic vs. Brand Name

If you request a brand name drug, you will be charged the brand name drug cost plus the difference between the brand and generic drugs (up to the cost of the brand drug).

To avoid this charge, the prescribing physician must indicate "Dispense As Written" (DAW) on the prescription. When DAW is ordered, you will only be charged the cost of the brand name drug. Generally, generic drugs are Tier 1 and brand drugs are Tier 2. If you have questions, please contact Cigna directly.

Save Time and Money by Using Cigna 90 Now

The Cigna 90 Now program makes it easier and less expensive for you to fill maintenance medications. A maintenance medication is something you take on a regular basis to treat an ongoing health condition like asthma, diabetes, high blood pressure, or high cholesterol.

Cigna 90 Now...

- Provides coverage for 90-day (or 3-month) supplies at select retail pharmacies in your plan's network and through Express Scripts® Pharmacy, Cigna's home delivery pharmacy.
- Provides coverage for 30-day supplies at all pharmacies in your plan's network.
- If you fill a prescription in a 90-day supply, you must use an in-network retail pharmacy that's approved to fill 90-day supplies, or home delivery, to receive coverage.
- Does not include narcotics or specialty medications.

Are there any benefits to filling a 90-day supply?

Yes. You'll make fewer trips to the pharmacy for refills. And you're more likely to stay healthy because with a 90-day supply on-hand, you're less likely to miss a dose.[1]

continued >>>

PHARMACY BENEFITS

Cigna 90 Now Program (continued)

Will I save money by filling a 90-day supply?

Generally, yes. Most 90-day supplies are filled for 2x the cost of a 30-day supply. Check your plan materials for specific details.

Do I need my doctor's approval to switch to a 90-day prescription?

Yes, you'll need a new prescription for a 90-day supply. You may be able to request the switch via a telemedicine visit or via email if you have refills remaining. Check with your doctor.

How do I switch to Express Scripts® home delivery?

Use one of these three options:

1. Log into the myCigna App or **myCigna.com** to move your prescription electronically. Click on the **Prescriptions** tab and select **My Medications** from the dropdown menu. Then click the button next to your medication name to move your prescription(s).
2. Call your doctor's office. Ask them to send a 90-day prescription (with refills)[2] electronically to Express Scripts Home Delivery.
3. Call Express Scripts® Pharmacy at 800-835-3784. They'll contact your doctor's office to help transfer your prescription. Have your Cigna ID card, doctor's contact information and medication name(s) ready when you call.

I have a 90-day prescription but my pharmacy isn't approved to fill 90-day supplies. How do I switch pharmacies?

Once you find a pharmacy that's approved to fill 90-day supplies, here are two easy ways you can move your prescription:

1. Call your doctor's office. Ask them to send your 90-day prescription electronically to your new pharmacy.

Or,

2. If your prescription still has a refill available, ask the pharmacist at your new pharmacy to contact your current pharmacy to help transfer your prescription.

[1] Internal Cigna analysis performed Jan 2019, utilizing 2019 Cigna national book of business average medication adherence (customer adherent > 80% Proportion Days Covered), 90-day supply vs. those who received a 30-day supply stopped taking antidiabetics, blood pressure medications, and statins.

[2] Some medications aren't available in a 90-day supply and may only be packaged in lesser amounts. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.

MDLIVE

MDLIVE provides you with 24/7/365 access to board-certified primary-care doctors and pediatricians by secure video, phone or e-mail. Simply pay the applicable in-network copay, deductible, or coinsurance.

Whether you are at home, at work, traveling, or simply want the most convenient way to see a doctor, MDLIVE is easy to use and available on your schedule anytime, anywhere. Our service is secure, confidential, and compliant with all medical privacy regulations.

To get started and make an appointment, call toll-free 888.726.3171 or visit **mdlive.com/epcares**

When should I use MDLIVE?

If you're considering the ER or urgent care for a non-emergency medical issue

Your primary care physician is not available

At home, traveling or at work

24/7/365, even holidays!

What can be treated?

- Allergies
- Cold and Flu
- Respiratory Infection
- Asthma
- Ear Infections
- Sinus Problems
- Bronchitis
- Joint Aches and Pain
- And More!

Who are our doctors?

Our doctors practice primary care, pediatrics, family and emergency medicine, and have incorporated MDLIVE into their practice to provide convenient access to quality care.

Get Started Today

Register onllne or by phone	Complete medical history	Request a consultation
Register online anytime by visiting mdllve.com/epcares or calling **888-726-3171** You will need to enter your first name, last name, gender, date of birth and your Cigna Customer ID#.	Just complete your medical history during registration.	Simply pay the applicable in-network copay, deductible or coinsurance. MDLIVE staff is available 24/7/365 by online video or phone!

Get Started NOW

mdlive.com/epcares or **888.726.3171**

EMPLOYEE ASSISTANCE PROGRAM (EAP)

When you need some extra support, the Cigna Employee Assistance & Work/Life Support Program is just a call or click away. These services are all **confidential** and available at **no additional cost** to you and your household members.

We're here to listen to your concerns, get you the information you need and guide you toward the right solution. Our licensed professional employee assistance consultants are available for telephonic consultation for routine or urgent concerns. We can also direct you to a variety of helpful resources in your community.

- **Child Care:** We'll help you find a place, program or person that's right for your family.
- **Financial Services Referral:** Free 30-minute financial consultations by phone and 25% off tax preparation.
- **Identity Theft:** Get a free 60-minute expert consultation by phone for prevention or if you are victimized.
- **Legal Consulting:** Get a free 30-minute consultation with a network attorney and 25% off select fees.†
- **Pet Care:** From vets to dog walkers, we'll help you ensure your pets are well taken care of.
- **Senior Care:** Learn about solutions related to caring for an aging loved one.

Take advantage of the convenience of consultation by phone:

- Confidential
- No cost to you or anyone living in your household
- Work with a licensed EAP clinician
- 20 to 30 minutes in length
- Unlimited number of consultations each year

Online Managing Stress Toolkit:

- Self-assessment tools
- On-demand stress reduction seminars
- Mindfulness exercises for free download
- Helpful articles and information

We're here to listen. Contact us any day, any time.

Call 877-622-4327
Or log in to myCigna.com

Employer ID: **epcares**
(for initial registration only)

If already registered on myCigna.com, simply log in and go to the **EAP** link under the **Review My Coverage** tab.

†Legal consultations related to employment matters are not available under this program.

HEALTH SAVINGS ACCOUNT (HSA)

Certain high deductible health plans (designated "HDHP") are designed to be compatible with a Health Savings Account (HSA) to give you more control over how your health care dollars are spent. Federal legislation allows you to reduce your taxable income by contributing funds into an HSA. You may then use the funds to pay for qualified health care expenses. Please refer to the table below for IRS imposed annual maximums. If you do not use all of the money in your HSA in a given calendar year, the remaining money "rolls over" for use in future years.

2024 IRS Maximum Contribution Amounts		
	Individual	**$4,150**
	Family	**$8,300**

Individuals age 55 and over may contribute an additional $1,000 per year in catch-up contributions.

Several of the medical plans offered through EP Cares™ are marked as HDHP. To take advantage of the tax savings available via an HSA, enroll in one of these HDHP plan options.

You may then open an HSA at the bank of your choice, or contribute to an existing HSA account, if you have one in place. Most HSA providers offer a debit card so you can pay for provider services and prescriptions directly from your HSA. Because of the transitory nature of the production workforce, EP Cares does not administer pre-tax deposits into your HSA accounts. You can still recognize the same tax savings by claiming the deduction when filing your annual taxes. It is simple to do, using **Form 8889**, and you don't need to itemize your deductions to take advantage of this great tax-savings opportunity.

Want to learn more? Watch a quick video:
Everything You Need to Know about HSAs

HSA ACCOUNTS

An HSA functions much like a regular bank account, except that the funds in the account can only be used for qualified medical expenses. The money in the HSA is yours to keep. There is no "use it or lose it" timeframe for HSA funds. You may use the funds at any time for qualified medical expenses. Just like a regular bank account, you can contribute funds to the HSA throughout the year, so long as you are enrolled in a qualified High Deductible Health Plan (HDHP).

IMPORTANT!
SAVE YOUR RECEIPTS

Be sure to save all of your receipts for expenses related to your HSA account in case you are later asked by the IRS to justify your expenses.

CONTACT INFORMATION

EP Cares Contact Center

M-F, 5:00 AM - 8:00 PM (Pacific Time)
855.339.7350
myepcares@ep.com

- General information
- Password resets
- Inquiries about how much your employer pays toward the cost of benefits
- Address changes (see below)

Cigna Pre-Enrollment Line

800.564.7642

- Specific information on medical, dental, or vision plan details
- Questions about doctors, networks
- Questions about what is covered under the plans

WEX Health

866.451.3399
cobraadmin@wexhealth.com

Aflac

818.396.6824
russell_nakamura@us.aflac.com

Nationwide

877.738.7874
benefits.petinsurance.com/ep

WHEN CONTACTING EP CARES

Please provide:

- **Full name (as it appears on payroll)**
- **Last four digits of SSN**
- **Project/Show**

WHEN CONTACTING AN OUTSIDE VENDOR

- **Cigna**
- **WEX Health**
- **Aflac**
- **Nationwide**

Be sure to reference "EP Cares" if you are asked for your "employer."

Benefits highlighted in this guide are governed by EP Cares™ plan contracts and policies, applicable state and federal law, and company policy. In the event of a conflict, the policies, contracts, and applicable laws govern. EP Cares™ reserves the right to alter, amend, or terminate any of the benefits described in this guide at any time.

ADDRESS CHANGES

If you change your address, you must notify EP Cares in writing immediately (myepcares@ep.com). If you are enrolled in COBRA when your address changes, please notify the COBRA administrator (WEX Health) directly.

Note: Updating your address through payroll or at my.ep.com is insufficient. You must also notify EP Cares directly.

REQUIRED NOTICES

See page 28 for an important notice regarding your Medicare Part D Coverage.

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 January 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO
Health First Colorado
www.healthfirstcolorado.com
Member Contact Center: 1-800-221-3943/ State Relay 711
Child Health Plan Plus (CHP+)
https://hcpf.colorado.gov/child-health-plan-plus
Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI)
www.mycohibi.com
Customer Service: 1-855-692-6442

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

U.S. Department of Labor
Employee Benefits
Security Administration
www.dol.gov/agencies/ebsa
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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) CONTINUED

FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
https://in.gov/medicaid
Phone 1-800-457-4584

IOWA – Medicaid
https://dhs.iowa.gov/ime/members
Phone: 1-800-338-8366
CHIP (Hawki)
http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563
HIPP
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
https://kancare.ks.gov
Phone: 1-800-792-4884
HIPP
Phone: 1-800-766-9012

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP
https://kidshealth.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid
https://chfs.ky.gov

LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid Hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
www.mymaineconnection.gov/benefits/
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium
www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
http://dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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

NEBRASKA – Medicaid
http://ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
http://dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
https://dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP
Toll Free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid
http://state.nj.us/humanservices/ dmahs/clients/medicaid/
Phone: 609-631-2392
CHIP
www.njfamilycare.org
Phone: 1-800-701-0710

NEW YORK – Medicaid
https://health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
http://healthcare.oregon.gov
www.oregonhealthcare.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHP
https://dhs.pa.gov/HIPP
Phone: 1-800-692-7462
CHIP
http://dhs.pa.gov/chip/
Phone: 1-800-986-KIDS (5437)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) CONTINUED

RHODE ISLAND – Medicaid and CHIP
http://eohhs.ri.gov/
Phone: 1-855-697-4347
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
http://gethipptexas.com/
Phone: 1-800-440-0493

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

VERMONT– Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-230-8427

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

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

WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/
http://mywvhipp.com
Medicaid
Phone: 304-558-1700
CHIP
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
www.dhs.wisconsin.gov/badgercareplus/hipp.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137 (expires 1/31/2026).

IMPORTANT NOTICE FROM THE COMPANY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE UNDER THE CREDITABLE PLAN(S)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. The Company has determined that the prescription drug coverage offered by the Creditable Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

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 a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty). If after your initial Medicare Part D enrollment period, you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed at the beginning of this document.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Company Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Company Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or Web address listed below.

If you do decide to join a Medicare drug plan and drop your prescription drug coverage with the Company, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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

Contact the Plan Administrator 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 the Company changes. You also may request a copy.

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** (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at **www.socialsecurity.gov,** or call them at 800.772.1213 (TTY 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 whether or not you are required to pay a higher premium (a penalty).

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA NOTICE OF PRIVACY POLICY AND PROCEDURES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and this material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official), and will be posted on any website maintained by the Company that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

TREATMENT

Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

PAYMENT

Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

HEALTH CARE OPERATIONS

The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

TO THE PLAN SPONSOR

The Plan may disclose PHI to the employers (such as the Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department,

HIPAA Notice of Privacy Policy and Procedures CONTINUED

as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.

TO THE PLAN'S SERVICE PROVIDERS

The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.

REQUIRED BY LAW

The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

FOR PUBLIC HEALTH ACTIVITIES

The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

FOR HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

RELATING TO DECEDENTS

The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

FOR RESEARCH PURPOSES

In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

TO AVERT THREAT TO HEALTH OR SAFETY

In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

FOR SPECIFIC GOVERNMENT FUNCTIONS

The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to Have an Opportunity to Object

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES

You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

TO CHOOSE HOW THE PLAN CONTACTS YOU

You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

TO INSPECT AND COPY YOUR PHI

Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

TO REQUEST AMENDMENT OF YOUR PHI

If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

TO FIND OUT WHAT DISCLOSURES HAVE BEEN MADE

You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed on the first page of these notices. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach. If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see first page). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment by the HIPAA Special Enrollment Deadline after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 by the HIPAA Special Enrollment Deadline, after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator. This notice is relevant for health-care coverages subject to the HIPAA portability rules.

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

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

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

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

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

The Company is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Company's plan(s) provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore the deductibles and coinsurance listed in this document apply.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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 coverage would otherwise end because of a life event known as 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 Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within the COBRA Qualifying Event Period from the qualifying event. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage 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. If you believe you are eligible for this extension, contact the Plan Administrator.

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.

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/medicareand-you**

Are there other coverage options besides COBRA Continuation Coverage?

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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