Prolifics®

2024 BENEFITS GUIDE

For Employees in MO, TX, OK

EFFECTIVE JANUARY 1, 2024 – DECEMBER 31, 2024

Introduction

Welcome

Prolifics recognizes the importance of having a comprehensive benefits program. Our program is designed to provide you and your family a variety of plans with tools that promote health and wellness. We are committed to making every effort to provide benefits that support the lifestyles and needs of our employees.

Benefit Options for 2024

Review this guide to learn about the benefits available to you. Then choose the options that are best for you and your family.

Below is a list of the generous package available to you:

Medical
- Cigna Open Access Plus (OAP)-PPO - Available in all states
- Cigna Choice Fund HDHP - HSA - Available in all states

Dental
- Cigna HMO - Available in limited areas
- Cigna PPO - Available in all states

Vision
- Cigna Vision (EyeMed Network) - Available in all states

Life & Disability
- New York Life Basic Life/AD&D - 100% company paid benefit
- New York Life Voluntary Life/AD&D - With convenient payroll deductions
- New York Life Short & Long Term Disability - 100% company paid benefit

Flexible Spending Accounts - Igoe Administrative Services

Employee Assistance Program (EAP) - New York Life's Live Assistance - no cost to you!

Cigna One Guide - Cigna Mobile App - Only available for Cigna members

Health Advocate - Confidential help for you and your family -100% company paid benefit!

Voluntary Supplement Benefits
- Cigna Critical Illness
- Cigna Accident coverage

Additional voluntary benefits in our package:
- Nationwide Pet Insurance
- Farmers Auto/Home Insurance

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When To Enroll

You can only sign up for benefits or change your benefits at the following times:

- When you are newly hired as a Prolifics employee, your benefit coverage begins on the first of the month following date of hire.
- During the annual benefits open enrollment period. See page 3.
- Within 30 days of a qualifying life event: See page 3 and contact Prolifics Human Resources Department for more information.

The choices you make at this time will remain in place until the end of your plan year, unless you experience a qualifying life event. If you do not sign up for benefits during your initial eligibility period, you will not be able to elect coverage until the next annual open enrollment period.

Eligibility

Open Enrollment

Open enrollment occurs once a year. During this time, you may add or remove dependents from your coverage, change your coverage level, or change your benefit elections without experiencing a qualifying event. The benefits and coverage you select during this open enrollment period will remain in effect from January 1, 2024 until December 31, 2024, unless you experience a qualifying life event and submit plan changes.

Eligibility

Employees:
Full-time employees working 30+ hours per week are eligible to participate in the Prolifics benefit plan.

Dependents:
As an eligible employee, you may cover your legal spouse or domestic partner (with proper documentation), and dependent child(ren) up to the age of 26 (regardless of their student status). See page 22 for guidelines on working spouse and domestic partner.

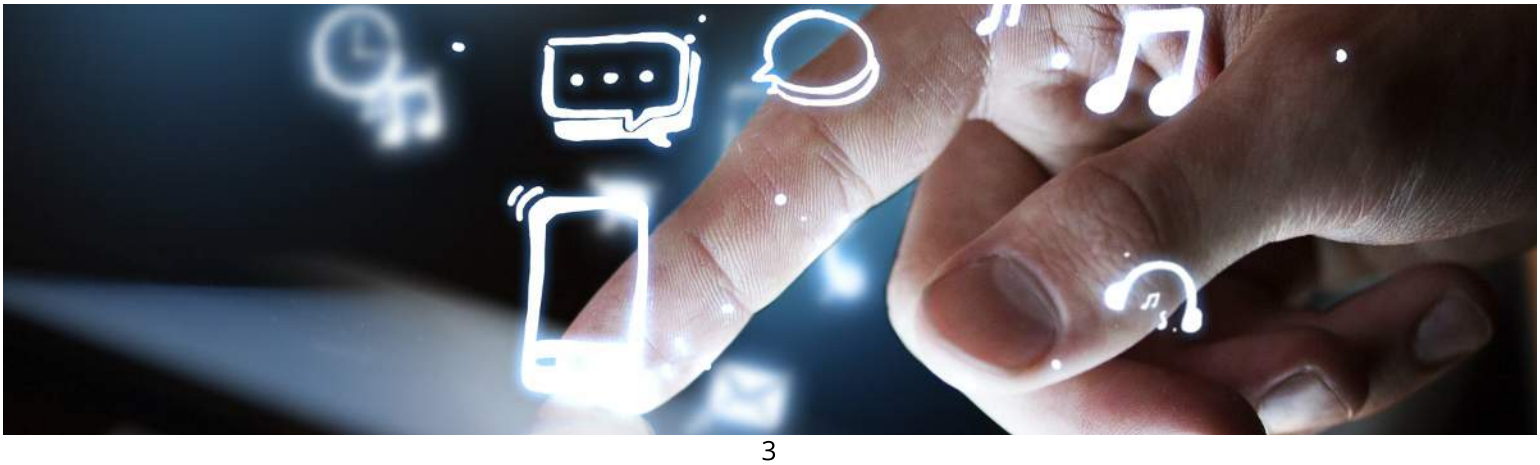
Qualifying Events for Changing Benefits

If you waive coverage at this time, you cannot enroll in the Prolifics Health Plan until the next open enrollment period, unless you have a qualifying event. You have 30 days from the time of the qualifying event to notify Human Resources to change your benefits. Examples of qualifying events include:

- Change in marital status
- Birth or adoption of a child
- Death of a covered dependent
- Loss of eligibility status by a covered dependent
- Change in employment status that affects eligibility for coverage
- Losing or gaining healthcare coverage eligibility under Medicare or Medicaid

CA Individual Mandate

- Effective January 1, 2020, California has an individual healthcare mandate in effect.
- This mandate will tax CA residents (including dependents) who do not have health insurance.
- This state mandate serves to ensure stability in California's individual healthcare market by increasing participation of those who are "young and healthy".
- Tax penalties are determined by the California Franchise Tax Board (FTB) and may be a flat dollar amount per person, or a percentage of the gross annual income. Penalty amounts may change annually.
- For more information and guidance on your personal situation and potential exemption options, please consult with a tax professional.



Insurance Basics

Medical HMO (Health Maintenance Organization)

An HMO is a plan that offers coverage within a specific network of doctors and hospitals. Coverage under an HMO is only available through providers and facilities that are in-network. If you visit a doctor that is not in the HMO network, you are responsible for 100% of the cost of services.

What kind of person should opt for a HMO?

Someone who is looking to pay reduced premiums, lower copays, and no coinsurance for in-network and covered services. HMOs are also great for patients who want a doctor dedicated to coordinating their care. Under an HMO plan your primary care doctor (also called a primary care provider) will provide referrals when a specialist visit is necessary. An HMO could be a good option if your providers are contracted in the HMO network. An HMO plan may limit your ability to see doctors that you've seen in the past if they're not in-network.

Medical PPO (Preferred Provider Organization)

PPO plans typically have premiums and deductibles that are higher compared to HMO plans. They also offer greater flexibility, such as expanded networks and no referral requirements.

What kind of person should opt for a PPO?

If you are looking for greater flexibility to book appointments with providers who are in the PPO network (as well as those out-of-network) without a referral. It's important to note that you may pay a higher rate if you choose to go out-of-network. If you travel often, a PPO plan might be a better fit since they tend to be more flexible– which can be especially helpful if something unexpected happens and you need urgent care.

Medical HDHP (High Deductible Health Plan)

A High-Deductible Health Plan allows you the flexibility to go both in-network or out-of-network. This plan has a significantly higher deductible than the PPO plan but is lower in premium. The coinsurance for in-network under this plan is 90%, meaning you will be responsible for 10% of costs after deductible has been met. Prescriptions are subject to a copay after the deductible has been met. There are no copays for medical or prescriptions services until the deductible has been met. The only exception is preventive care, which is covered at 100% - no cost to you.

What kind of person should opt for a HDHP?

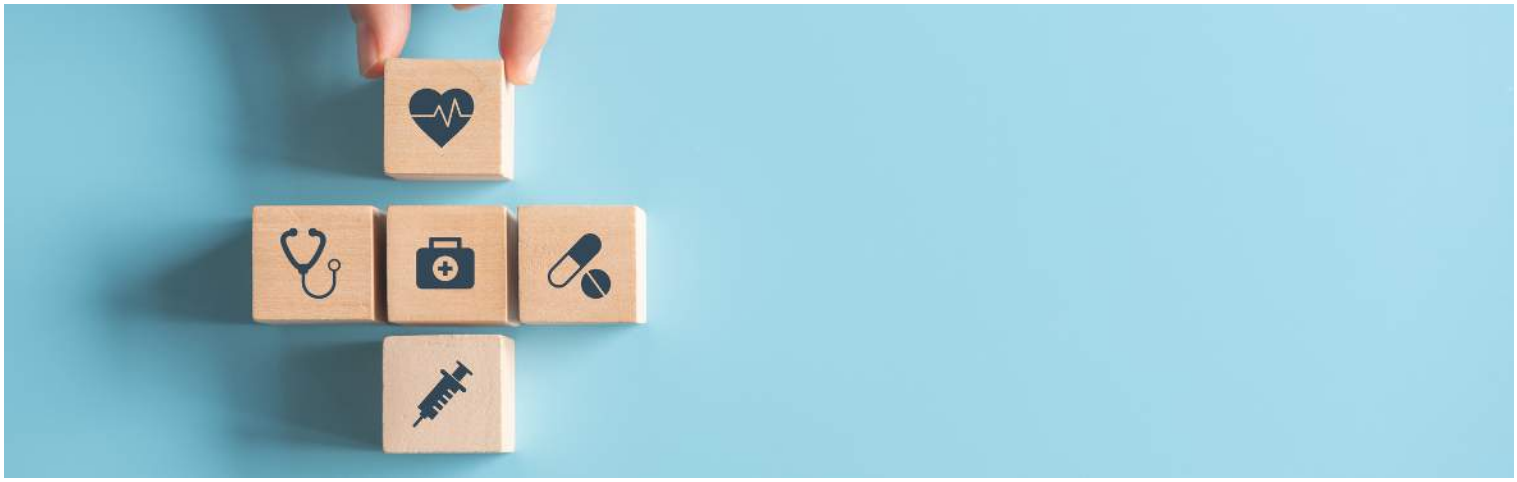
Someone who is healthy and doesn't expect to use many health care services within the next year. You want the cheapest premiums and don't mind having to pay a high deductible if you need a lot of care.

Dental DHMO (Dental Health Maintenance Organization)

If you elect coverage in this plan, you must select a primary care dentist from the DHMO contracted provider list. All care must be provided by the primary dentist. A referral is required in order to visit a specialist. You may change dentists once each month. Changes made prior to the 15th of the month will take effect on the first of the following month.

Dental DPPO (Dental Preferred Provider Organization)

Similar to a medical PPO plan, a dental PPO allows you to choose an in-network or out-of-network provider. Remember, going out-of-network will be more costly than visiting an in-network dentist. If you need services or treatments that will cost $300 or more, it is strongly recommended to ask for a predetermination of benefits from your dentist to understand the cost of services. Please be advised that ID cards are not necessary, and DPPO members may not receive ID cards.



Find a Provider

How To Find a Cigna Medical Provider

You can register online at mycigna.com to see the doctors and hospitals that accept your selected plan, or you can perform a general search.

- Visit www.cigna.com and click on “Find a Doctor." Indicate that you are covered by "Employer or School." Add your zip code, select type of doctor, then press "Continue as guest." Select the "Open Access Plus, Open Access Plus Tiered" network.

You can search by provider name, geographic location, or specialty

Important Information about electing a PCP in Network (HMO) plans

- All HMO enrollees must select a PCP and designate their PCP #. If you enter an invalid PCP # or leave this blank, you will be auto assigned to a provider based on your home zip code. If you receive an ID with an incorrect PCP listed, please contact your carrier member services to correct.
- If you decide to change your PCP at any time, you can do this by phone or online.

Information about the PPO plan

- You have the option of choosing a primary care provider (PCP) to guide your care (it is recommended but not required). You can see a specialist without a referral.
- Using in-network doctors and health care facilities may keep your costs lower.
- You can choose out-of-network doctors or facilities, but your costs may be higher.
- You’ll pay an annual amount called a deductible before the plan begins to pay for covered costs. Once you meet your deductible, you pay a copay or coinsurance amount and the plan pays the rest of covered costs.
- Once you meet an annual limit on your payments called an out-of-pocket maximum, your plan pays 100% of covered costs.

Finding a Dentist:

You can register online at mycigna.com to see the doctors and hospitals that accept your selected plan, or you can perform a general search:

- Visit www.cigna.com
- Start by clicking on“Find a Doctor.” Choose how you are covered "Employer or School"
- Add in zip code and select "dentist" under "Doctor Type" then select "Continue as guest"
- Once promoted, select from the following:
  - DHMO Network: "Cigna Dental Care Access"
  - DPPO Network (High or Low Plan): "Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)"

Finding a Vision Doctor:

You can register online at mycigna.com to see the doctors and hospitals that accept your plan, or you can perform a general search:

- Visit www.cigna.com
- Start by clicking on “Find a Doctor” and choose how you are covered "Employer or School"
- Add in zip code and select "Optometrist" or "eye doctor" under "Doctor Type"
- Once the doctor type is selected, a pop up should appear on your screen.
- Select "Cigna Vision Directory" to be automatically routed
- You will then be able to can search for a Vision provider by "Location/Services" or "By Eye Care Professional or Office Name"

Frequently Asked Questions

What is a Deductible?

A deductible is the amount of money you or your dependents must pay toward a health claim before your organization's health plan makes any payments for health care services rendered.

What is Coinsurance?

Coinsurance is a provision in your health plan that describes the percentage of a medical bill that you must pay and that which the health plan must pay.

What is the Out-of-Pocket Maximum?

The maximum amount (deductible and coinsurance) that an insured will have to pay for covered expenses under a plan. Once the out-of-pocket maximum is reached, the plan will cover eligible expenses at 100%.

What is a Copay?

A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

What is a Health Maintenance Organization (HMO)?

An HMO gives you access to certain doctors and hospitals within its network. A network is made up of providers that have agreed to lower their rates for plan members and also meet quality standards. But unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.

What is a Preferred Provider Organization (PPO)?

A PPO is a group of hospitals and physicians that contract on a fee-for-service basis with insurance companies to provide comprehensive medical service.

What is In-Network?

Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Coverage to services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

What is Out-of-Network?

Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

What is an Explanation of Benefits (EOB)?

An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment.

Medical Coverage: OAMC/PPO Medical Option (All States)

The following chart summarizes the benefits for the medical plan offered to all eligible employees of Prolifics. As an eligible employee, you may choose from the following plan.

LEARN MORE: Please note that the chart below is intended for comparison purposes only. For a comprehensive listing of what is covered and not covered under each plan, please refer to the Evidence of Coverage booklet.

	Cigna Open Access Plus (OAP) - PPO	
	Open Access Plus	
	In-Network	Out-of-Network^
Annual Deductible Calendar Year	$500 Individual $1,500 Family	$750 Individual $2,250 Family
Annual Out-of-Pocket Max. Calendar Year	$3,000 Individual $6,000 Family	$9,000 Individual $18,000 Family
Physicians Services		
Primary Care	$20 Copay	40%*
Specialist Visits	$20 Copay	40%*
Preventive Care	No charge	40%*
Hospital Services		
Inpatient Hospitalization	$250 copay/admit + 20%*	$500 copay/admit + 40%*
Outpatient Surgery	$125 copay/admit + 20%*	$250 copay/admit + 40%*
Tests		
Advanced Imaging	20%*	40%*
Diagnostic X-ray/Lab	20%*	40%*
Urgent / Emergency Care Visits		
Urgent Care	$25 Copay	Same as In-Network
Emergency Room (Waived if admitted)	$150 Copay	Same as In-Network
Prescriptions (Retail 30-day supply)		
Brand Name Rx Deductible	None	None
Generic	$10 Copay	50%
Preferred Brand Name	$20 Copay	50%
Non-Preferred Brand Name	$40 Copay	50%
Mail Order (90-day supply)	$25 / $50 / $100	50%

* After Deductible

^Out-of-Network providers may charge in excess of allowable charges and the excess charges are the responsibility of the member. Additional copays and benefit limitations may also apply to out-of-network services.

Medical Coverage: HDHP/HSA Options (All States)

The following chart summarizes the benefits for the medical plans offered to all eligible employees in all U.S. locations. As an eligible employee, you may elect one (1) of the High Deductible Health Plans (HDHP) with the choice to open a Health Savings Account (HSA) with HSA Bank (See page 11 for more details on HSAs.) The HSA is only available if you enroll in one of the Cigna HDHP plans.

LEARN MORE: Please note that the chart below is intended for comparison purposes only. For a comprehensive listing of what is covered and not covered under each plan, please refer to the Evidence of Coverage booklet.

	Cigna Choice Fund 3500 HDHP - HSA		Cigna Choice Fund HDHP 1600 - HSA	
Network	In-Network	Out-of-Network^	In-Network	Out-of-Network^
Annual Deductible Calendar year	$3,500 Individual $7,000 Family	$7,000 Individual $14,000 Family	$1,600 Individual $3,200 Individual in Family $3,200 Family	$3,000 Individual $3,200 Individual in Family $6,000 Family
Annual Out-of-Pocket Max Calendar year	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family	$2,700 Individual $3,200 Individual in Family $6,000 Family	$9,000 Individual $9,000 Individual in Family $18,000 Family
Physicians Services				
Primary Care	30%*	50%*	10%*	30%*
Specialist Visits	30%*	50%*	10%*	30%*
Preventive Care	No Charge	50%*	No Charge	30%*
Hospital Services				
Inpatient Hospitalization	30%*	50%*	10%*	30%*
Outpatient Surgery	30%*	50%*	10%*	30%*
Tests				
Advanced Imaging	30%*	50%*	10%*	30%*
Diagnostic X-ray/Lab	30%*	50%*	10%*	30%*
Urgent / Emergency Care Visits				
Urgent Care	30%*	Same as In-Network	10%*	Same as In-Network
Emergency Room (Waived if admitted)	30%*	Same as In-Network	10%*	Same as In-Network
Prescriptions (Retail 30-day supply)				
Brand Name Rx Deductible	Integrated Medical & Rx Deductible	Integrated Medical & Rx Deductible	Integrated Medical & Rx Deductible	Integrated Medical & Rx Deductible
Generic	$15 Copay*	50%	$15 Copay*	50%
Preferred Brand Name	$40 Copay*	50%	$40 Copay*	50%
Non-Preferred Brand Name	$60 Copay*	50%	$60 Copay*	50%
Mail Order (90-day supply)	$30/$80/$120*	50%	$37.50/$100/$150*	50%

*After Deductible

Please note, you are responsible for the full price of the prescription drug until the medical/Rx deductible is met. Then Rx copays apply until the medical out-of-pocket maximum is met. Once the out-of-pocket maximum is met, all covered expenses (including prescription drugs) are covered at 100%.

^Out-of-Network providers may charge in excess of allowable charges and the excess charges are the responsibility of the member. Additional copays and benefit limitations may also apply to out-of-network services.

Health Savings Account (HSA)

For employees who enroll in the Cigna HDHP health plan, Prolifics will contribute up to $500 for individual coverage ($20.83 per pay cycle) and $1,000 for family coverage ($41.66 per pay cycle) annually to the HSA account.

2024 IRS defined Health Savings Account maximum contributions:

- Maximum annual contribution for individual (including employer contribution) is $4,150
- Maximum annual contribution for family is $8,300
- Individuals age 55 and over are allowed an additional $1,000 "catch-up" contribution annually

Please note the maximum contribution amounts above are inclusive of the company contribution, so your maximum annual contribution is limited to the difference between the IRS limit and the company contribution.

What is a Health Savings Account (HSA) Plan?

- Combines a Qualified High Deductible Health Plan (HDHP) compatible with a Health Savings Account
- Members can deposit money into a Health Savings Account, pre-taxed
- The funds may be used for qualified medical expenses (IRS rules apply)
- Withdrawals for qualified medical expenses are tax-free
- The funds not used roll over year-to-year ("use it or lose it" rule does not apply)
- The account is portable and yours to keep
- Individuals/HSA Account Holders have the option to invest the money into interest-bearing investment vehicles. Interest on these investments is also not taxable.

Who is Eligible to Participate in an HSA Plan?

- Must be enrolled in a qualified High Deductible medical plan
- Cannot have any other health coverage
- Not covered by a spouse, Medicare, Veterans Administration plan, Flexible Spending Account
- Cannot be claimed as a dependent on another person's tax return

What is considered an HSA eligible expense?

Some examples of eligible expenses:

- Health plan deductibles and copays
- Prescription drugs and medications
- Dental, orthodontia, vision care, corrective lenses, and chiropractic services
- Other typical out-of-pocket health care expenses
- Health care continuation (COBRA premiums)

Refer to IRS Publication 969 for more details.

Health Savings Account (HSA)

How to enroll in the Health Savings Account:

- Enroll in the Cigna HDHP medical plan by logging into ADP during Open Enrollment or your initial eligibility period
- Once Cigna has processed your enrollment, Cigna will automatically transfer your data to HSA Bank to open your account (Note: this step is not applicable if you already have an account with HSA Bank)
- HSA Bank will perform an Identification Verification Process to open an account on your behalf
- Once enrolled, you will receive a welcome kit with all the information on your newly established account along with your HSA debit card
- Once you have established an account, the company will make contributions of $500 or $1,000 over the course of the plan year, per pay cycle to your Health Savings Account
- During Open Enrollment or your initial eligibility period, please determine if you'd like to contribute your own money into the HSA in addition to the Company's contribution, and make an election in ADP to establish a per payroll pre-tax deduction into your HSA account
- Please note: you must complete an HSA election form for a one time lump sum contribution if desired. ADP will not accommodate this type of request

Who is eligible to participate in the Health Savings Account:

- Because Health Savings Accounts (HSAs) have special tax advantages, the IRS defines specific rules on participation.
- To be eligible to contribute toward a Health Savings Account, the IRS requires that individuals:
    - Must be enrolled in a qualified High Deductible medical plan
    - Cannot have any other health coverage:
        - Not covered by a spouse's medical or pharmacy plan
        - Not covered through any Parts of Medicare
        - Not covered through a general-purpose Flexible Spending Account (FSA) plan (either Employer's or Spouse's)
    - Cannot be claimed as a dependent on another person's tax return
- You cannot contribute to the HSA if you are enrolled in any Parts of Medicare:
    - Medicare enrolled participants are not eligible to contribute to an HSA account but they can receive the employer funding. For Medicare eligible, but not enrolled in Medicare participants, Prolifics will provide the employer contribution for those that choose to enroll in the HDHP plan on a quarterly basis during the plan year and through Accounts Payable.
        - $500 for individual coverage ($125 per quarter)
        - $1,000 for family coverage ($250 per quarter)
- Funding is pro-rated for new hires during the course of the year to their Medical plan effective date

IMPORTANT: Medicare eligible who are interested in contributing to the HSA account, should first consult with Social Security/Medicare to discuss details on delaying enrollment in any or all parts of Medicare.

Dental Coverage

The following chart summarizes the benefits for the dental plan(s) offered to all eligible employees of Prolifics. As an eligible employee, you may choose from one of the following plans. The DHMO is ONLY available to employees living in CA, CO, CT, FL, GA, IL, KY, MA, MI, MO, NC, NJ, NY, OH, OR, PA, RI, TN, TX, VA, WI.

LEARN MORE: Please note that the chart below is intended for comparison purposes only. For a comprehensive listing of what is covered and not covered under each plan, please refer to the Evidence of Coverage booklet.

	Cigna Dental Care DHMO P6XV0	Total Cigna PPO		
		DPPO Advantage	In-Network*	Out-of-Network*
Benefit Description & Procedure Code				
Annual Deductible Individual/Family	None	$75 / $225	$100 / $300	$100 / $300
Annual Maximum Benefit** Per Enrolled Member	None	$3,000 per Enrolled Member		
Preventive & Diagnostic Services				
Periodic Oral Evaluation D0120	No Charge	Plan 100%; You 0%	Plan 100%; You 0%	Plan 100%; You 0%^
Prophylaxis (Cleaning) D1110, D1120	No Charge	Plan 100%; You 0%	Plan 100%; You 0%	Plan 100%; You 0%^
Bitewing X-rays D0272	No Charge	Plan 100%; You 0%	Plan 100%; You 0%	Plan 100%; You 0%^
Basic Services				
Amalgam Restoration (Filling) one surface D2140	No Charge	Plan 90%; You 10%	Plan 80%; You 20%	Plan 80%; You 20%^
Gingivectomy per quad (1 to 3 teeth) D4211	$90 Copay	Plan 90%; You 10%	Plan 80%; You 20%	Plan 80%; You 20%^
Root Canal D3310	$90 Copay	Plan 90%; You 10%	Plan 80%; You 20%	Plan 80%; You 20%^
Major Services				
Porcelain Crown D2750	$230 Copay	Plan 60%; You 40%	Plan 50%; You 50%	Plan 50%; You 50%^
Orthodontic Benefits				
Orthodontic Benefits - Child and Adult	$1,464 / $2,160	Plan 50%; You 50%	Plan 50%; You 50%	Plan 50%; You 50%^
Orthodontic Lifetime Maximum Benefit	N/A	$1,000 per Enrolled Member		

* Only partial coverage details provided above. For full in-network and out-of-network plan details, please review the benefit summaries and Evidence of Coverage booklets.
** Annual Maximum is based on the calendar year.
^ Members are subject to charges above the allowed OON reimbursable charge since services are rendered by non-contracted providers. This is called balance billing.

Dental HMO (DHMO)
If you elect DHMO coverage, you must select a contracted dentist from the DHMO Provider list. All care must be provided by the primary dentist.

Dental PPO (DPPO)
The out-of-network benefits on the DPPO for TX residents will mirror the DPPO Advantage Network benefits. However, please note that Out of Network providers may charge for balance that exceeds Cigna's allowable amount. Texas residents should refer to the full summary of benefit and EOC for more details.

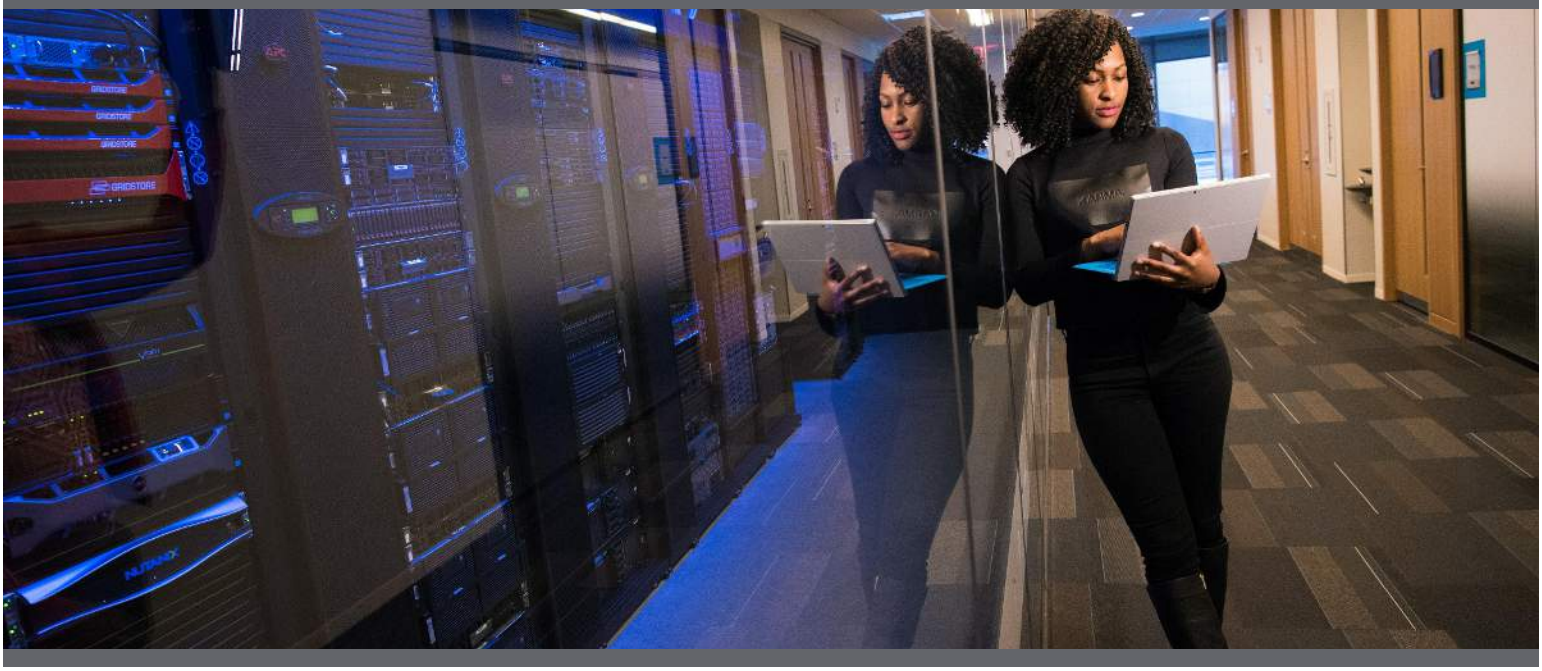
Vision Coverage

The following chart summarizes the benefits for the vision plan offered to all eligible employees of Prolifics in all U.S. locations.

LEARN MORE: Please note that the chart below is intended for comparison purposes only and provides only a brief overview of the most common benefits covered under your plan. For a comprehensive listing of what is covered and not covered (limitations and exclusions) under each plan, please refer to the Evidence of Coverage booklet.

	Cigna Vision - EyeMed Network	
	In-Network	Out of Network
Basic Eye Exam	$20 Copay	Plan pays up to $45
Frames	$130 Allowance + 20% off the remaining balance	Plan pays up to $71
Single Vision Lenses	$30 Copay	Plan pays up to $32
Bifocal Lenses	$30 Copay	Plan pays up to $55
Trifocal Lenses	$30 Copay	Plan pays up to $65
Medically Necessary Contacts (in lieu of frames)	Covered 100%	Plan pays up to $210
Elective Disposable Contact Lenses (in lieu of frames)	$130 Allowance	Plan pays up to $105
Eye Exam Benefit Frequency	Once every 12 months	Same as In-Network
Frame Benefit Frequency	Once every 24 months	Same as In-Network
Lenses Benefit Frequency	Once every 12 months	Same as In-Network

Life and AD&D Coverage



Basic Life and AD&D Coverage

Prolifics provides all active employees with basic life insurance and accidental death and dismemberment (AD&D) coverage through New York Life. This benefit provides valuable income protection in the event that you suffer a severe accident or loss of life. An accelerated death benefit is also included in this policy. You must name a beneficiary for your Life and AD&D benefits. Beneficiary changes can be done at any time during the plan year.

Benefit	Benefit Details
Life/AD&D Benefit Amount	1x Basic Annual Earnings up to $300,000
Accidental Dealth & Dismemberment (AD&D) Amount	1x Basic Annual Earnings up to $300,000
Accelerated Death Benefit	If you are terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum
Life/AD&D Age Reduction Benefit Amount	Benefit reduces to 65% at age 70; 52% at age 75; 44% at age 80; and 40% at age 85

You must name a beneficiary for your life and AD&D benefits. Beneficiary changes can be done at any time during the plan year.

Voluntary Life Coverage

Voluntary Life and AD&D Coverage

As an employee of Prolifics, you have the option of purchasing additional life and AD&D coverage through New York Life. This voluntary policy enables you to purchase coverage for yourself, and qualified dependents. When you enroll yourself and your dependents in this benefit, you pay the full cost through post-tax payroll deductions.

	Employee	Spouse/Domestic Partner	Child(ren) 6 months to 26 yrs*
Coverage Option	$10,000 Increments	$5,000 Increments	$1,000 Increments
Guarantee Issue Amount	$100,000	$25,000	$10,000
Maximum Amount	7x annual salary up to maximum of $500,000	$250,000 maximum, not to exceed 100% of employee amount	$10,000

*Coverage for children from birth to six (6) months old equals $500. Full elected coverage goes into effect after six (6) months from date of birth.

New Hires: Newly hired eligible employees and their eligible dependents may elect Voluntary Life and AD&D up to the Guaranteed Issue (GI) maximum and within the policy limitations, without the evidence of insurability (EOI) requirement. Elections for coverage must be submitted within the new hire eligibility period.

To apply for amounts that exceed the Guaranteed Issue maximums, employees and dependents must complete an evidence of insurability form and submit it to New York Life for review and determination. Underwriting will provide the final determination on the benefit amount and/or the acceptance or denial of the amounts applied for over the GI maximum.

- Please contact HR directly if you would like to apply for Voluntary Life/AD&D benefits
- You must complete an evidence of insurability form if you elect amounts over the Guarantee Issue amount. Guarantee issue does not apply to Voluntary AD&D.

Annual Enrollment Period: During the Annual Open Enrollment Period, employees who are currently enrolled in Voluntary Life may elect up to two (2) units of $10,000 of additional life coverage (up to $20,000 max), as long as the total benefit (current election plus additional election) does not exceed the guaranteed issue limitation, without satisfying the EOI requirement. Spouses or Domestic Partners currently enrolled in Voluntary Life may elect up to two (2) units of $5,000 of additional life coverage (up to $10,000) as long as the total benefit does not exceed the guarantee issue limitation and the employee's election amount, without satisfying EOI requirement.

Eligible employees and spouses who are not currently enrolled in Voluntary Life and have never previously enrolled in Voluntary Life, may elect up to two (2) units of $10,000 of additional life coverage (up to $20,000 max) without satisfying the EOI requirement.

Any amounts currently carried plus the additional elected during the annual Enrollment period must not exceed the guaranteed issue limitations and policy maximums.

- To apply for amounts that exceed the Guaranteed Issue maximums, employees and dependents must complete an evidence of insurability form and submit it to New York Life for review and determination.

Disability Benefits

Disability Coverage

Prolifics provides all eligible employees with a 100% employer-paid Short Term Disability and Long Term Disability plan through New York Life. These coverages provide financial assistance if you are unable to work for an extended period of time due to an illness or injury. Short Term Disability benefit is reduced by any state disability income received. Below are key highlights of the plan.

	STD Plan Highlights	LTD Plan Highlights
Coverage Option	Up to 66.67% of weekly covered earnings	Up to 60% of monthly covered earnings
Elimination Period	7 Days	90 Days
Maximum Benefit	$1,000 Weekly (Less any amount payable by Social Security Income (SSI) or State Disability Income (SDI)	Class 1: $15,000 Monthly Class 2: $10,000 Monthly
Maximum Benefit Duration	13 Weeks	SSNRA – Social Security Normal Retirement Age
Pre-existing Conditions	Does Not Apply	3 month look back; 12 month exclusion of pre-existing condition found during the 3 month look back

Voluntary Products

Voluntary Products

At Prolifics, eligible employees are offered the option to enroll in two additional benefits; Critical Illness and Accidental Injury coverage. Both benefits offer portability options. In the event of serious illness or accident, Cigna gives you more ways to protect yourself, your family, and your assets. Below is a brief summary of the plans. Please review the full benefit summaries and plan documents for more detailed information.

Critical Illness Coverage

The **Critical Illness** plan is designed to help employees offset the financial impact of a catastrophic illness with lump sum benefits if an insured is diagnosed with a covered critical illness. All employees are eligible to enroll with no Evidence of Insurability (EOI). The benefit amount is based on the coverage in effect on the date of diagnosis, or the date treatment is received according to the terms and provisions of the policy. Thus, please refer to the full benefit summary for examples of covered illness & payouts.

Voluntary Benefit Amounts:

Employee: $10,000, $20,000, $30,000
Spouse/Domestic Partner: 50% of Employee Benefit Amount
Dependent Child: 25% of Employee Benefit Amount

Coverage Pay Out Examples:

Heart Attack: 100% of elected amount
Stroke: 100% of elected amount
Diagnosis of Invasive Cancer: 100% of elected amount

Accident Coverage

The **Accidental Injury** plan is designed to help covered employees meet their out-of-pocket expenses and extra bills caused by an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to the employee and their covered spouse and/or children based on the amount of coverage listed in the schedule of benefits.

Coverage Amounts:

Employee: 100% of Benefit Amount
Spouse/Domestic Partner: 100% of Benefit Amount
Dependent Child: 100% of Benefit Amount

Coverage Pay Out Examples:

Emergency Room: $200
Hospital Admission: $1,000
Hospital Stay: $200/day
Concussion: $150
Fracture: Non-Surgical: $100-$4,000

YOUR APP JUST GOT AN UPGRADE

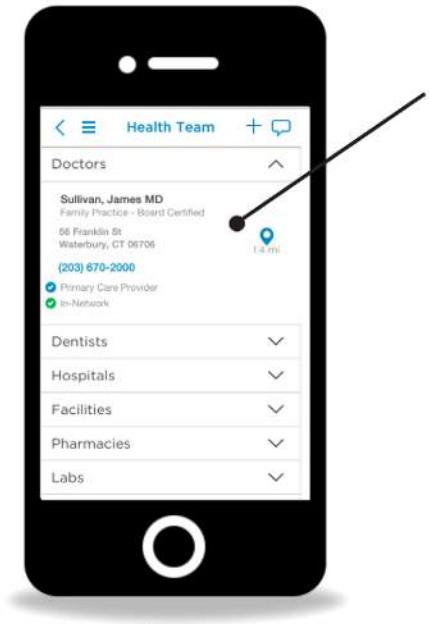
Now it's even easier to take control of your health and health spending

The myCigna℠ app now includes a Cigna One Guide® service upgrade with even more tools and support.

The myCigna app still uses information specific to your plan so you can easily:

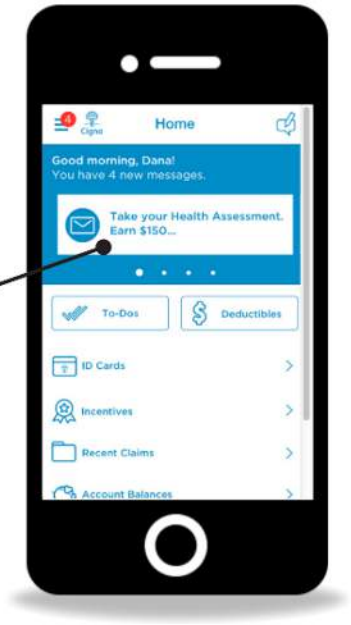
- Find in-network doctors, labs and hospitals
- Get cost estimates for care
- Compare prescription prices
- Manage and track claims
- Access your ID cards to print, fax or email

But the One Guide service now lets you do so much more.



Build your custom health team – a personal list of the in-network doctors, dentists and facilities you use to keep track of their information all in one place.

Sign up for messages that can guide you to savings, coaching opportunities and more (if offered by your employer).



For illustrative purposes only.

Together, all the way.®

Cigna®

904129 07/17

Get tips and reminders to help you stay on track with appointments and preventive care.

Access support quickly. You can chat online or by phone with a personal guide who can answer your questions and help you make the most of your plan.

Get started with the new One Guide service today.

Download the latest myCigna app.*

Or call the number on the back of your ID card.

Download on the App Store | GET IT ON Google play | Available at amazon

Cigna.

Additional Benefits

Our benefit package also includes:

Cigna One Guide

Cigna One Guide service offers Cigna members the convenience of an app with the personal touch of live service to help your employees engage in their health and get the most value from their health plan.

It delivers proactive, personalized support to help your employees navigate health care at every opportunity. Powerful data analytics guide them to the programs and resources that are most relevant to them - like incentives and coaching. By anticipating their needs and turning into their communication preferences, the One Guide service helps your employees take control of their health on their terms.

Technology powers the experience.

Personalized Opportunities

- Pre-enrollment guidance on choosing the right plan
- A highly personalized experience
- Thorough support to help use the plan
- Proactive messaging based on individual health needs

Quick Access to finding and getting care

- Guidance in finding the right doctor, lab, pharmacy, or convenience care center
- Easy connection to health coaches, pharmacists and other resources

One-Click Access to one guide support

- Dedicated one-on-one support in complex situations, for those who need it most
- Access to personal guides by phone or click to chat

Education on plan features, ways to maximize benefits and search incentives

Employee Assistance Program

New York Life's Live Assistance EAP is available to help you and your family find a solution and restore your peace of mind:

- Basic clinical work/life support by phone or web
- Unlimited access to online research and qualified referrals
- 24/7 phone consultation with New York Life licensed clinicians
- Up to 3 face-to-face counseling sessions with a New York Life network licensed behavioral clinicians

Phone Number: 800-538-3543
Login Online: www.guidanceresources.com
Web ID: NYLGBS

Health Advocate Assistance

Health Advocate is a highly personalized program staffed by health advocates that help you navigate healthcare and insurance related issues, such as:

- Help you find the best doctors or schedule appointments
- Help resolve insurance claim issues
- Assist with eldercare and help explain Medicare choices
- Work with insurance carriers
- Answer questions
- Locate and research the newest treatments
- Assist with finding qualified wellness programs

Please read the supporting material on this great benefit.
Phone Number: 866-695-8622

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSA)

Prolifics is pleased to offer employees a Flexible Spending Account (FSA) program. FSAs allow staff or faculty members to set aside pre-tax dollars for qualified healthcare and/or dependent care expenses. The money that is deposited into your FSA comes directly from your gross pay, which reduces your taxable income. Enrollment in one or both of these accounts is optional. Benefit-eligible staff or faculty members have the option to set aside funds into the following types of FSA:

General Purpose Healthcare FSA:

A Healthcare FSA allows you to use pre-tax dollars from your paycheck for eligible medical, dental and vision expenses incurred by you, your spouse and your tax dependents. In order for your expenses to qualify for reimbursement from your FSA they must be considered "qualified expenses" as deemed by the IRS. IRS publication 502 lists all qualified expenses including things such as; office visit copays, coinsurance payments, braces, eye exams, and much more. Please note cosmetic procedures are not considered FSA-qualified expenses. Paying for qualified medical expenses using this tax-free money can save you money! For 2023, the maximum amount you can contribute is $3,200.

Dependent Care FSA:

Dependent care expenses that enable you (and your spouse, if applicable) to go to work and/or school full-time are eligible for reimbursement using tax-free money from your Dependent Care FSA (DCFSA). For expenses to qualify under this FSA, they must be related to the custodial care of your dependent(s) and must be incurred in order for you/your spouse to work. Schooling/tuition or the expenses for sending your child to an overnight camp are not reimbursable through the account. Additionally, payments made to one of your tax dependents, including your spouse or dependent child under the age of 19, are not reimbursable. For the 2024 plan year, the maximum amount you can contribute into your dependent care FSA is $5,000 per household (or $2,500 if married and filing separately).

Reimbursement from your DCFSA is easy! Download a reimbursement request form from www.goigoe.com and complete all sections. When complete, attach your back up documentation and send your request to Carrier. Once approved, reimbursement will be issued up to the available cash balance in your DCFSA. Reimbursements are released on specific dates scheduled by your employer. Please review your Plan Highlights for more specific information on reimbursement release dates. Please note: If you are not able to use all of the money you set aside, it cannot be returned to you at the end of the plan year. How do you avoid that? It's simple! Set your election by only putting aside enough money to cover expected day care expenses.

Who qualifies as a dependent?

- Your federal tax dependent who is under the age of 13 (i.e. age 12 and under)
- Your federal tax dependent (including your spouse) who is physically or mentally incapable of caring for him/herself

Transit & Parking Benefit Program

This program allows you to redirect a portion of your paycheck to pay for Transit Passes and Parking expenses on a pre-tax basis through the FSA plan. (Toll road, Fastrak and express lane expenses are not eligible)

- Mass Transit/Vanpooling: $315 per month
- Qualified Parking: $315 per month

Details about the Prolifics FSA plans:

- Plan year is from January 1, 2024 through December 31, 2024.
- Healthcare FSA and Limited Purpose FSA – Employees have until December 31 of every year to incur claims. Remaining balance of up to $640 at the end of the plan year will be rolled over into the following plan year. Employees have until March 31 of the following year to submit claims or 90 days after termination date.
- Dependent Care FSA – Employees may incur and submit claims through March 15 of the following year (2.5 months of Grace period).
- Parking and Transit Accounts are considered rolling accounts. You have 180 days from the date of service to submit claim.
- You must actively re-enroll every year if you would like to participate in the Healthcare FSA, Limited Purpose FSA, Dependent Care FSA, and Parking/Transit.

Voluntary Benefits

Voluntary Benefits - Direct Bill Option Only

Nationwide Pet Insurance

Nationwide provides insurance for unexpected veterinary expenses including:

- Accidents, Injuries
- Illness and Disease
- Spaying, Neutering
- Vaccinations
- Hereditary Conditions
- Dental Cleanings

Reimbursement plan with easy one page claim form.

Phone: 888-899-4874
Website: www.petinsurance.com

Farmers Insurance Choice - Auto and Home

The Farmers Auto & Home Group Insurance Program provides qualified employees with access to personal lines of property and casualty insurance. Our products provide the coverage members need with attractive group savings. Many valuable discounts are available. The following are some examples:

Auto	Home / Condo
Boat insurance	Landlord's rental dwelling
Flood	Mobile home
Motorcycle	Renters
Personal excess liability	Recreational vehicle

For additional information, please call Farmers Group Select at 800-438-6381

ADP Enrollment

Enrollment Instructions - ADP

Before you enroll, please follow these important steps:

- All employees must re-elect, waive, or confirm changes to their medical, dental, vision, and FSA choices every year during Open Enrollment via ADP Self-Service portal.
- Add Your Dependents - Add any dependents you wish to cover by clicking on Add Spouse and/or Add Dependent.
- If your spouse or domestic partner is eligible for group health insurance coverage through their employer's plan he/she must participate in that group coverage. In order to enroll your spouse or domestic partner for Prolifics coverage or maintain your spouse's/domestic partner's current Prolifics coverage you must complete the Prolifics Spousal/Domestic Partner Coverage Affidavit available on the ADP enrollment portal.
- If you elect to enroll your spouse or domestic partner into the Prolifics plan in addition to their employer's plan, coordination of benefits will apply. Coordination of benefits determines which health plan will be the primary payer and which will be secondary to ensure the provider of care or treatment receives payment up to the plan limits designated in both plans. Any excess amount above plan limits will become the patient responsibility. If a dependent child is covered under two or more plans, the plan of the member covering the child whose birthday occurs earlier in the calendar year will be deemed primary (known as the birthday rule). Other rules and limitations also apply. Refer to the summary plan description for more details.
- All life insurance coverage will remain the same as current. There is no need to re-elect the company-paid coverages or the voluntary coverages that you may have previous elected.
- Log in to ADP and confirm your information. If you have lost/misplaced your password, please send an email to **hrdept@prolifics.com** for help.
- Update your address and other personal information - Once you have logged in, click on your name to verify the personal information on your record. BE VERY SURE to input your full address, home and work phone and e-mail address.
- Change your User Name/Password - You are encouraged to change your username and/or your password to protect your privacy.
- Click Proceed on OPEN ENROLLMENT LINK on Welcome page of ADP OR Select 'Review and Change Benefits from the Benefits Tab on the ADP site.
- Scroll down to each benefit and enroll/decline by selecting an option from the Manage Benefit menu.
- Make sure you are enrolled in the plans you wish to participate in for the new plan year.
- Enroll or re-enroll in the FSA plans that you would like to participate in for the new plan year.
- If you want your premium contributions from your Medical, Dental and Vision elections made pre-tax from your paycheck, a form is required! The pre-tax premium form is available at the ending page of the Open Enrollment process or through the HR Department. Completed forms should be submitted to **hrdept@prolifics.com**. If you already have this form on file with HR from previous years, we do not need another this year. Your premiums will continue to be taken pre-tax.
- Once enrolled in the HDHP with Cigna, you will be able to establish your HSA Bank banking account if you are enrolling in the HSA account for the first time this year.
- Make sure to print out a copy of your benefit elections in ADP so you have record of your elections.
- Make a note to check all deductions for accuracy.

Provider Directories, Plan Summaries and many other useful forms and links to websites can be accessed year round on the Prolifics benefit site.

401(k) - Principal

The Prolifics 401(k) plan is a voluntary profit sharing plan for Prolifics employees. Regular full, four day week or part-time employees may join at any 1st of the month following their date of hire. For new participants, payroll deductions will begin on the payroll following the employee's enrollment date into the plan.

Participants in the 401(k) plan may elect to contribute between 1% and 75% of annual gross pay. These contributions are automatically deducted from each payroll and deposited into tax-deferred investment accounts. Employees are permitted to direct the investment of such funds into any one or more of a wide range of investment alternatives (current information regarding investment alternatives is included in your orientation materials).

The amount that an employee can contribute in a calendar year follows the schedule below per federal law. As well, employees turning 50 years old in a given year may contribute additional contributions (called catch-up contributions) to the plan as per the schedule below:

Year	Younger than 50 years	50 Years and older
2024	$23,000	Additional $7,500/year

Prolifics offers a company match of 20% up to 6% of what that employee contributes to the plan on a per payroll basis. Ex: If an employee contributes 6% of their gross pay, Prolifics will put in 20% of what the employee contributes. Participating employees are 100% vested in employee contributions. Company matching funds are vested under the following schedule:

Years of Service	Vesting Percentage
Less than 2 years	0% vested
2 years	20%
3 years	50%
4 years	60%
5 years	80%
6 years	100%

Our 401(k) trustee and administrator is Principal, which offers many investment programs and services, allowing you to be a fully active participant in the direction of your retirement earnings investments. Here are some of the programs they offer:

- TMR (Target my Retirement), a fee based investment advisory service offered through Morningstar using the Core Funds in the plan.
- Core Funds Selection
- Mutual Fund Window Option - gives you access to invest in many non-core funds with no trading fees
- Automatic Rebalancing - elect to have Principal automatically re-balance your investments on a regular periodic basis
- Target Date Funds - you select a target date that matches your anticipated retirement date, and the portfolio is actively managed to maintain an appropriate level of risk. The portfolio is routinely re-balanced to become incrementally more conservative.
- Self-Managed Account - there is a fee/year to participate and your trades are subject to regular brokerage fees. Please call 800-547-7754 to participate.
- Roth 401(k) - after tax savings

How to register and access your account:

- 24-hour access to your account and services via a voice line at 1-800-547-7754.
- Account access online at: **https://principal.com.** To register for online access, you'll initially need to enter your first name, last name, your social security number, date of birth and mobile phone number. From there, you will create a unique login and password for account access

Helping you manage your retirement goals

With 24/7 account access

Principal®

Planning for retirement doesn't have to be complicated. Set up your account to stay on track with your retirement savings goals. And since your life is busy enough, we've made getting to your information simple and convenient. Use these resources to access your account when and how you want.

Online

First-time users

Go to **principal.com/Welcome**

- Select **Get Started**
- Enter your first name, last name, date of birth, mobile phone number (this is the quickest way to verify your identity), and your ID number (this is either your Social Security number or a specific ID provided by your employer) or ZIP code
- Agree to do business electronically and click **Continue**
- If you don't provide your mobile phone number, you'll need to answer a few personal questions as an alternative way to confirm it's really you
- Create a **unique username**, set a secure **password** and add your **email address**
- Select and answer **three security questions** to use if you need to call us
- You now have access to your online account, and you'll get a confirmation email within a few minutes
- The first time you log in, you'll need to choose where we send you **verification codes** (text message, voice call, or authentication app) and how often you want to use them

Ongoing account access

Go to **principal.com**

- Click **Log In**
- Enter your **username** and **password** (click **Forgot Username or Forgot Password** if you need to reset) and click **Log In**
- If you're logging in from a new device, resetting your username or password, or you've opted to use verification codes every time you log in, you'll receive a security code via text message, voice call, or authentication app
- Enter the security code and click **Verify**

Questions?

Having trouble setting up your login? Give us a call at **800-986-3343.**

Stay up to date!

Keeping your email address current helps you stay in the know with communications tailored to you.

- Click on the **Retirement Plan** link of the account you want to access. Use the tabs at the top of the page to navigate the website.

	Your account	Education Hub
Available options include: Not all options are available for certain plans. Check with your human resources contact to find out what is available.	› Plan info & forms › Statements › Contributions › Investments › Loans & withdrawals › Rollovers › Retirement Wellness Planner	› Overview › My Virtual Coach › Monthly webinars › Retirement planning › Managing money › Life event planning › Calculators & tools

Mobile

Check your account balance and rate of return on the go.

› Principal® App — Available for iPhone® and Android™* › Text message › Email

Phone

First-time users	Ongoing account access
Call **800-547-7754**	Call **800-547-7754**
› Enter your **Social Security number** when prompted › Listen to the menu and select an option › When prompted, establish your **personal identification number (PIN)** using your **Account/Contract Number**	› Enter your **Social Security number** when prompted › Listen to the menu and select an option › If prompted, enter your **(PIN)** *(Note: Some options do not require you to enter your PIN.)*

Follow the prompts to:

(Not all options are available for certain plans. Check with your human resources contact to find out what is available.)

- › Check your account balance
- › Check investment performance
- › Request or review loan information
- › Review investment options
- › Manage your rollover funds
- › Transfer retirement funds between available investment options
- › Hear information regarding an expected Form 1099-R

* The mobile application offered by Principal® to view account information is currently supported on iPhone® (operating systems 11.0 or higher) and Android™ (operating systems 6.0 or higher).

Principal®

principal.com

Employee Contributions

	Semi-Monthly Payroll Deductions (MO, TX, OK)			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical				
Cigna 1600 HDHP/HSA Plan	$176.37	$354.13	$318.64	$549.21
Cigna 1600 HDHP/HSA Plan - Limited	$175.30	$352.05	$316.76	$545.97
Cigna 3500 HDHP/HSA Plan	$100.28	$201.24	$181.07	$312.08
Cigna 3500 HDHP/HSA Plan - Limited	$99.67	$200.02	$179.98	$310.20
Cigna HSA Admin Fee	$0.68	$0.68	$0.68	$0.68
Cigna Open Access Plus OAP/PPO Plan	$247.35	$493.87	$441.19	$765.13
Cigna Open Access Plus OAP/PPO Plan - Limited	$245.90	$490.97	$438.59	$760.64
Dental				
Cigna DHMO (Not available in OK)	$2.39	$4.38	$4.88	$6.91
Cigna DPPO	$7.99	$14.15	$15.59	$24.41
Vision				
Cigna Vision	$1.14	$2.29	$1.93	$3.19

For benefit questions not related to actual claim status or processing, you may reach out to Bolton & Company via email: Prolifics@boltonco.com

PEP Health & Wellness

Carrier Contact Info

Benefit	Administrator	Group ID#	Phone	Website
Medical HDHP & OAP/PPO	Cigna	3332476	800-244-6224	www.mycigna.com
Dental HMO & PPO	Cigna	3332476	800-244-6224	www.mycigna.com
Vision PPO	Cigna	3332476	877-478-7557	www.mycigna.com
Life and AD&D	New York Life	FLX967240	800-362-4462	www.newyorklife.com
Disability	New York Life	SHD962815-STD LK964973-LTD	800-362-4462	www.newyorklife.com
Flexible Spending Account Admin	IGOE	Prolifics, Inc.	800-633-8818	www.goigoe.com
Pet Insurance	Nationwide	Prolifics, Inc.	888-899-4874	www.petinsurance.com
Auto/Home Insurance	Farmers Group Select	Prolifics, Inc.	800-438-6381	www.farmers.com
Employee Assistance Program (EAP)	New York Life's Live Assistance EAP	FLX967240	800-344-9752	www.guidanceresources.com
Health Advocate	Health Advocate	Prolifics, Inc.	866-695-8622	www.healthadvocate.com/members
Voluntary Worksite Benefits	Cigna		800-754-3207	www.cigna.com

This newsletter highlights the main features of the Prolifics benefit plan. It is intended to help you choose the benefits that are best for you. This newsletter does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this newsletter and the legal plan documents, the plan documents are the final authority. Prolifics reserves the right to change or discontinue its benefit plans at any time.

Important Notices

Notice: 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 enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

Notice: The Newborns' and Mothers' Health Protection Act (NMHPA)

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

Notice: Woman's Health and Cancer Rights Act (WHCRA)

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

Notice: Consolidated Omnibus Budget Reconciliation Act (COBRA)

Introduction

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

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

You may have other options available to you when you lose group health coverage.

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Continuation Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the contact person shown at the end of these notices.

How is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

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

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

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

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact information at the end of these notices. 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.

Notice: Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under the Uniformed Services Employment Reemployment Rights Act of 1994 (USERRA), employees are provided with broad protection in terms of their reemployment upon completion of military service.

REEMPLOYMENT RIGHTS

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

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

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

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- **Are a past or present member of the uniformed service;**
- **Have applied for membership in the uniformed service; or**
- **Are obligated to serve in the uniformed service;**

then an employer may not deny you:

- **Initial employment;**
- **Reemployment;**
- **Retention in employment;**
- **Promotion; or**
- **Any benefit of employment**

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

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

Notice: 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, **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 **(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 **(866) 444-EBSA(3272)**.
If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – MEDICAID
WEBSITE: http://www.myalhipp.com **PHONE: (855) 692-5447**	**WEBSITE:** **HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM** **http://dhcs.ca.gov/hipp** **PHONE: (916) 445-8322** **Fax: (916) 440-5676** **EMAIL: hipp@dhcs.ca.gov**
ALASKA – Medicaid	**COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)**
El Programa de Pago de Alaska primas del seguro médico **WEBSITE: http://myakhipp.com/** **PHONE: (866) 251-4861** **EMAIL: CustomerService@MyAKHIPP.com** **MEDICAID ELIGIBILITY:** **WEBSITE: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	**Health First Colorado Website: https://healthfirstcolorado.com/** **Health First Colorado Member Contact Center:** **(800) 221-3943 / State Relay 711** **CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** **CHP+Customer Service: (800) 359-1991 / State Relay 711** **Health Insurance Buy-In Program (HIBI):** **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program** **HIBI Customer Service: (855) 692-6442**
ARKANSAS – MEDICAID	**FLORIDA – MEDICAID**
WEBSITE: http://myarhipp.com/ **PHONE: (855) MyARHIPP (855-692-7447)**	**WEBSITE:** **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** **PHONE: (877) 357-3268**
GEORGIA – MEDICAID	**LOUISIANA – MEDICAID**
GA HIPP WEBSITE: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** **PHONE: (678) 564-1162, Press 1** **GA CHIPRA WEBSITE:** **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra** **PHONE: (678) 564-1162, Press 2**	**WEBSITE: www.medicaid.la.gov or www.ldh.la.gov/lahipp** **MEDICAID HOTLINE: (888) 342-6207** **LAHIPP PHONE: (855) 618-5488 (LaHIPP)**

INDIANA – MEDICAID	MAINE – MEDICAID
HEALTHY INDIANA PLAN FOR LOW-INCOME ADULTS 19-64 WEBSITE: http://www.in.gov/fssa/hip/ PHONE: (877) 438-4479 ALL OTHER MEDICAID WEBSITE: https://www.in.gov/medicaid/ PHONE: (800) 457-4584	ENROLLMENT WEBSITE: https://www.maine.gov/dhhs/ofi/applications-forms PHONE: (800) 442-6003 TTY: Maine Relay 711 PRIVATE HEALTH INSURANCE PREMIUM WEBPAGE: https://www.maine.gov/dhhs/ofi/applications-forms PHONE: (800) 977-6740 TTY: Maine Relay 711
IOWA – MEDICAID AND CHIP (HAWKI)	**MASSACHUSETTS – MEDICAID AND CHIP**
MEDICAID WEBSITE: https://dhs.iowa.gov/ime/members PHONE: (800) 338-8366 HAWKI WEBSITE: http://dhs.iowa.gov/hawki PHONE: (800) 257-8563 HIPP WEBSITE: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	WEBSITE: https://www.mass.gov/masshealth/pa PHONE: (800) 862-4840 TTY: (617) 866-8102
KANSAS – MEDICAID	**MINNESOTA – MEDICAID**
WEBSITE: https://www.kancare.ks.gov/ PHONE: (800) 792-4884	WEBSITE:https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp PHONE: (800) 657-3739
KENTUCKY – MEDICAID	**MISSOURI – MEDICAID**
KENTUCKY INTEGRATED HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (KI-HIPP) WEBSITE: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx PHONE: (855) 459-6328 EMAIL: KIHIPP.PROGRAM@ky.gov KCHIP WEBSITE: https://kidshealth.ky.gov/Pages/index.aspx PHONE: (877) 524-4718 KENTUCKY MEDICAID WEBSITE: https://chfs.ky.gov	WEBSITE: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm PHONE: (573) 751-2005
MONTANA – MEDICAID	**NORTH DAKOTA – MEDICAID**
WEBSITE: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP PHONE: (800) 694-3084 EMAIL: HHSHIPPProgram@mt.gov	WEBSITE: http://www.nd.gov/dhs/services/medicalserv/medicaid/ PHONE: (844) 854-4825
NEBRASKA – MEDICAID	**OKLAHOMA – MEDICAID AND CHIP**
WEBSITE: http://www.ACCESSNebraska.ne.gov PHONE: (855) 632-7633 LINCOLN: (402) 473-7000 OMAHA: (402) 595-1178	WEBSITE: http://www.insureoklahoma.org PHONE: (888) 365-3742
NEVADA – MEDICAID	**OREGON – MEDICAID**
MEDICAID WEBSITE: https://dhcfp.nv.gov/ MEDICAID PHONE: (800) 992-0900	WEBSITE: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html PHONE: (800) 699-9075
NEW HAMPSHIRE – MEDICAID	**PENNSYLVANIA – MEDICAID**
WEBSITE: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program PHONE: (603) 271-5218 TOLL FREE NUMBER FOR THE HIPP PROGRAM: (800) 852-3345 Ext. 5218	WEBSITE: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx PHONE: (800) 692-7462
NEW JERSEY – MEDICAID AND CHIP	**RHODE ISLAND – MEDICAID AND CHIP**
MEDICAID WEBSITE: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ MEDICAID PHONE: (609) 631-2392 CHIP WEBSITE: http://www.njfamilycare.org/index.html CHIP PHONE: (800) 701-0710	WEBSITE: http://www.eohhs.ri.gov/ PHONE: (855) 697-4347 or (401) 462-0311 (Direct Rite Share Line)

NEW YORK – MEDICAID	SOUTH CAROLINA – MEDICAID
WEBSITE: https://www.health.ny.gov/health_care/medicaid/ **PHONE: (800) 541-2831**	**WEBSITE: https://www.scdhhs.gov** **PHONE: (888) 549-0820**
NORTH CAROLINA – MEDICAID	**SOUTH DAKOTA - MEDICAID**
WEBSITE: https://medicaid.ncdhhs.gov/ **PHONE: (919) 855-4100**	**WEBSITE: http://dss.sd.gov** **PHONE: (888) 828-0059**
TEXAS – MEDICAID	**WASHINGTON – MEDICAID**
WEBSITE: http://gethipptexas.com/ **PHONE: (800) 440-0493**	**WEBSITE: https://www.hca.wa.gov/** **PHONE: (800) 562-3022**
UTAH – MEDICAID AND CHIP	**WEST VIRGINIA – MEDICAID AND CHIP**
MEDICAID WEBSITE: https://medicaid.utah.gov/ **CHIP WEBSITE: http://health.utah.gov/chip** **PHONE: (877) 543-7669**	**WEBSITE: https://dhhr.wv.gov/bms/** **http://mywvhipp.com/** **MEDICAID PHONE: (304) 558-1700** **CHIP PHONE: (855) MyWVHIPP (699-8447)**
VERMONT– MEDICAID	**WISCONSIN – MEDICAID AND CHIP**
WEBSITE: http://www.greenmountaincare.org/ **PHONE: (800) 250-8427**	**WEBSITE:** **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** **PHONE: (800) 362-3002**
VIRGINIA – MEDICAID AND CHIP	**WYOMING – MEDICAID**
WEBSITE: https://www.coverva.org/en/famis-select **https://www.coverva.org/hipp/** **MEDICAID PHONE & CHIP PHONE: (800) 432-5924**	**WEBSITE: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** **PHONE: (800) 251-1269**

To see if any other States have added a premium assistance program since July 31, 2022, 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

OMB Control Number 1210-0137 (Expires: 1/31/2023)

Notice (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection –Primary Care Designation (HMO)
Your group health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your health insurer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see the contact information at the end of these notices.

For more information, contact:
Name: Michele Turko
Title: Senior Human Resources Business Partner
Address: 111 N. Magnolia Ave., Suite 1550
Telephone Number: Orlando, FL 32801
Other contact information: 646-825-4092

Notice: HIPAA Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights	**You have the right to:** • Get a copy of your health and claims records • Correct your health and claims records • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated
Your Choices	**You have some choices in the way that we use and share information as we:** • Answer coverage questions from your family and friends • Provide disaster relief • Market our services and sell your information
Our Uses and Disclosures	**We may use and share your information as we:** • Help manage the health care treatment you receive • Tun our organization • Pay for your health services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests and work with a medical examiner or funeral director • Address workers' compensation, law enforcement and other government requests • Respond to lawsuits and legal action

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. • We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 9. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what to share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information.
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your Plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect or domestic partner • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	• For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective date of this Notice

January 1, 2022