MODEL NOTICES

MAKING MID-YEAR CHANGES

The Internal Revenue Code restricts when you can make changes to your health insurance plan. Typically, you can only make changes to your plan during the open enrollment period, unless you have a qualifying event. The election change you request must be consistent with the qualifying event. The following is a list of qualifying events that would allow you to make a mid-year change to your plan:

- Marriage or divorce
- Death of a spouse or other dependent
- The birth of a child
- Adoption
- Change in employment status for you or your spouse that causes a loss or gain in coverage for you or your dependents
- An open enrollment period for your spouse

If you have had a qualifying event, you will need to complete a change of status form which can be obtained from Human Resources. You will have 30 days from the date of your qualifying event to change your benefit selection. If you miss the 30 day window, your next opportunity to make a change will be during the next open enrollment period.

ADDITIONAL NOTICES

Children's Health Insurance Program and Medicaid Eligibility Changes

If you or your dependents are eligible for medical coverage in this Plan but are not enrolled, you have 60 days to enroll in the Plan in the following two circumstances:

- If you or your eligible dependents' Medicaid coverage or coverage under the state Children's Health Insurance Program (CHIP) is terminated due to loss of eligibility; or
- If you or your dependents become eligible for a premium assistance program in the state in which you reside.

Notice of Women's Health and Cancer Rights Act

This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides group health benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema (swelling caused by the removal of lymph nodes). Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Newborns and Mothers Health Protection Notice

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay for the mother or newborn child in connection with childbirth 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 health care provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, if applicable). In any case, the Health Plan will not require a provider to obtain authorization from the Health Plan for prescribing a length of stay of 48 hours (or 96 hours, if applicable) or less.

Notice of Eligibility for Health Plan Related to Military Leave

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect continuation coverage under USERRA.

Patient Protection Notices

If the Plan provides for or 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator. For children, you may designate a pediatrician as the primary care provider.

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ADDITIONAL NOTICES CONT.

Patient Protection Notices Cont.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

If you have a health emergency, you can go to any emergency room. You don't need to get approval from the plan first – even if the emergency room isn't in your plan's network. However, we do require you or your doctor to notify us of your visit after you go to the emergency room.

Your plan covers both in-network and out-of-network emergency services. Your out-of-pocket costs are the same, but you may pay more for out-of-network care in other ways. For example, an out-of-network provider is allowed to bill you for some things that in-network providers can't bill you for.

HIPAA Notice of Privacy Practices

Your employer is committed to maintaining the privacy of protected health information for participants in the Plan. This is a reminder that in compliance with the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) a Notice of Privacy Practices is available to employees. This notice of Privacy Practices explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. To obtain a copy or for further information regarding the issues covered by this Notice of Privacy Practices, please contact the Plan Administrator.

Notice of Right to Receive a Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) was enacted to help you maintain your health coverage when you need to change jobs. If you lose coverage under the Plan, the Plan will provide you with a certificate that shows how long you had coverage under the Plan. This is your "creditable coverage." Using this certificate of creditable coverage, you will be able to reduce or eliminate any pre-existing condition exclusion imposed by a new employer plan or group insurance policy. You will automatically receive a certificate:

- When you become a qualified beneficiary entitled to elect COBRA coverage.
- When you lose medical coverage, even though you are not entitled to elect COBRA coverage.
- When your COBRA continuation coverage ends.

You may also request a certificate at any time or within 24 months after your medical coverage ends.