Franklin County Fiscal Court

321 W. Main St, Frankfort, KY, 40601
Vicki Webb, Plan Administrator, (502) 875-8754

Effective Date: November 11, 2026

Employee & Eligible Beneficiaries,

As an employee of Franklin County Fiscal Court and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact Vicki Webb, Payroll & Benefits Director, Franklin County Fiscal Court at: (502) 875-8754

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

IMPORTANT INFORMATION

MEDICARE PART D NOTICE

Medical Plan: Anthem Blue Cross and Blue Shield

About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will be affected. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

Visit http://www.cms.hhs.gov/CreditableCoverage/ which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage...
Contact the person listed in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage: Visit www.Medicare.gov or call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 800-MEDICARE (800-633-4227). TTY users should call (877) 486-2048. If you have limited income and resources, extra help paying for Medicare

prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call (800) 772-1213 (TTY 1-800-325-0778).

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

MEDICARE PART D NOTICE
Medical Plan: Anthem Blue Cross and Blue Shield

Important Notice from Franklin County Fiscal Court about Your Prescription Drug Coverage and Medicare
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Franklin County Fiscal Court and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Franklin County Fiscal Court has determined that the prescription drug coverage offered by the Anthem Blue Cross and Blue Shield is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is **considered Non-Creditable Coverage**. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug

coverage from the Anthem Blue Cross and Blue Shield. **This also is important because it may mean you might pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3. You can keep your current coverage from Anthem Blue Cross and Blue Shield. However, because your coverage is **non-creditable**, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare Drug Plan when you first become eligible for Medicare and each year from October 15th through December 7th.

If employer/union sponsored group plan, if you decide to drop your current coverage you may be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Anthem Blue Cross and Blue Shield. Refer to plan documents or contact the plan administrator for additional information.

If your coverage, previous to this coverage, was Creditable Coverage, since you are losing creditable prescription drug coverage under the Anthem Blue Cross and Blue Shield, you may also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. Refer to plan documents or contact the plan administrator for additional information.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

Since the coverage under Anthem Blue Cross and Blue Shield, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have

Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Franklin County Fiscal Court coverage will be affected. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. Guidance at http://www.cms.hhs.gov/CreditableCoverage/, which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Franklin County Fiscal Court coverage, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if the coverage through Franklin County Fiscal Court changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage visit www.Medicare.gov.

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

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

NOTIFICATIONS

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

Notice of Privacy Practices – Business Associates

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

This Notice describes the legal obligations of Franklin County Fiscal Court (the “Business Associate”) and its legal responsibilities regarding protected health information held by the Business Associate of

participants of health plans ("Covered Entities) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"). This Notice has been drafted in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule.

When we refer to participants in this Notice, we are referring to the participants of these Covered Entities.

Among other things, this Notice describes how this protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law on behalf of participants of these Covered Entities.

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

- Past, present or future physical or mental health or condition;
- Provision of health care; or
- Past, present or future payment for the provision of health care.

Contact Person

If you have any questions about this Notice or about our privacy practices, please contact Vicki Webb, Payroll & Benefits Director, (502) 875-8754.

Effective Date

This Notice is effective November 11, 2026.

Our Responsibilities

We are required by law to:

- Maintain the privacy of participant protected health information;
- Inform participants if a breach occurs that may have compromised the privacy or security of the participant's information;
- Provide participants with certain rights with respect to their protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to a participant's protected health information;
- Follow the terms of the Notice that is currently in effect; and
- Not use or share a participant's information other than as described here unless the participant tells us in writing that we can. If a participant tells us we can share information, the participant may change his/her mind at any time and advise us in writing of such change.

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

How We May Use and Disclose Participants' Protected Health Information

Under the law, we may use or disclose participant protected health information under certain circumstances without the participant's permission. The following categories describe the different ways that we may use and disclose a participant's protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

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

For Payment

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

For Health Care Operations

We may use and disclose a participant's protected health information for other covered entity operations. These uses and disclosures are necessary to run the covered entity. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general administrative activities. If use or disclosure of protected health information is made for underwriting purposes, any such protected health information that is genetic information of an individual is prohibited from being used or disclosed.

To Other Parties

We may contract with other individuals or entities to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, these individuals will receive, create, maintain, use and/or disclose a participant's protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding a participant's protected health information. For example, we may disclose a participant's protected health information to a third party to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the third party enters into an agreement with us.

As Required by Law

We will disclose a participant's protected health information when required to do so by federal, state or local law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law. For example, we may disclose a participant's protected health information when required by national security laws or public health disclosure laws.

To Prevent a Serious Threat to Health and Safety.

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

To Plan Sponsors

For the purpose of administering a Covered Entity, we may disclose protected health information to certain employees of an employer. However, those employees will use or disclose that information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless the participant whose PHI is in question has authorized further disclosures. A participant's protected health information cannot be used for employment purposes without a participant's specific authorization.

Special Situations

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

Organ and Tissue Donation

If a participant is an organ donor, we may release a participant's protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

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

Workers' Compensation

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

Public Health Risks

We may disclose a participant's protected health information for public health actions. These actions generally include the following:

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

Health Oversight Activities

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

Lawsuits and Disputes

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

Law Enforcement

We may disclose a participant's protected health information if asked to do so by a law enforcement official:

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

Coroners, Medical Examiners and Funeral Directors

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

National Security and Intelligence Activities

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

Inmates

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

Research

We may disclose a participant's protected health information to researchers when:

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

Required Disclosures

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

Government Audits

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

Disclosures to a Participant

When a participant requests, we are required to disclose to a participant the portion of that participant's protected health information that contains medical records, billing records, and any other records used to make decisions regarding a participant's health care benefits. We are also required, when requested, to provide a participant with an accounting of most disclosures of a participant's protected health information where the disclosure was for reasons other than for payment, treatment or health care operations, and where the protected health information not disclosed pursuant to a participant's individual authorization. Such requests must be made through the Covered Entity.

Participant Choices

For certain health information, participants can tell us their choices about what we share. If a participant has a clear preference for how we share his/her 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, participants have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for a participant's care
- Share information in a disaster relief situation

If a participant is not able to tell us his/her preference, for example if he/she is unconscious, we may go ahead and share the participant's information if we believe it is in his/her best interest. We may also share a participant's information when needed to lessen a serious and imminent threat to health or safety.

Personal Representatives

We will disclose a participant's protected health information to individuals authorized by a participant, or to an individual designated as a participant's personal representative, attorney-in-fact, etc., so long as a participant provides us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- A participant has been, or may be, subjected to domestic violence, abuse or neglect by such person;
- Treating such person as a participant's personal representative could endanger a participant; or
- In the exercise of professional judgment, it is not in a participant's best interest to treat the person as a participant's personal representative.

Fundraising and Marketing

Prior to disclosing a participant's protected health information in the case of fundraising efforts, the participant will be notified prior to receiving such fundraising communications. Such communication will provide the participant with the option of opting-out of receiving such communications. Additionally, uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI will require authorization.

Authorizations

Other uses or disclosures of a participant's protected health information not described above will only be made with a participant's written authorization. Where appropriate, most uses and disclosures of psychotherapy notes will require a participant's authorization.

A participant may revoke written authorization at any time, so long as the revocation is in writing. Once we receive a participant's written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving a participant's written revocation.

A Participant's Rights

A Participant has the following rights with respect to his or her protected health information:

Right to Access

A participant has the right to inspect and copy certain protected health information that may be used to make decisions about a participant's health care benefits. To inspect and copy a participant's protected health information, a participant must submit a participant's request in writing to the Covered Entity. If a participant requests a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with a participant's request.

Additionally, a participant has the right to request electronic copies of certain protected health information in a designated record set. We will provide such information in the electronic form and format requested by the participant, provided it is readily producible. If the requested form and format are not readily producible, we will provide the information in a readable electronic form and format that is mutually agreed upon with the requesting participant. If a participant requests a copy of the electronic information, we may charge a reasonable fee for the labor costs and supplies involved in creating the information.

We may deny a participant's request to inspect and copy in certain very limited circumstances. If a participant is denied access to his or her medical information, a participant may request that the denial be reviewed by submitting a written request to the Covered Entity.

Right to Amend

If a participant feels that the protected health information, we have about that participant is incorrect or incomplete, a participant may ask the Covered Entity to amend the information. A participant has the right to request an amendment for as long as the information is kept by or for the Covered Entity.

To request an amendment, a participant's request must be made in writing and submitted to the Covered Entity. In addition, a participant must provide a reason that supports a participant's request.

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

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

If we deny a participant's request, we will notify the participant in writing within 60 days with an explanation as to why the request was denied. The participant then has the right to file a statement of disagreement with us and any future disclosures of the disputed information will include the participant's statement.

Right to an Accounting of Disclosures

A participant has the right to request an "accounting" of certain disclosures of his or her protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to a participant; (3) disclosures made pursuant to a participant's authorization; (4) disclosures made to friends or family in a participant's presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, a participant must submit the participant's request in writing to the Covered Entity. A participant's request must state a time period of not longer than six years prior to the date the participant asks for the accounting.

A participant's request should indicate in what form the participant wants the list (for example, paper or electronic). The first list a participant requests within a 12-month period will be provided free of charge. For additional lists, we may charge a participant for the costs of providing the list. We will notify a participant of the cost involved and a participant may choose to withdraw or modify a participant's request at that time before any costs are incurred.

Right to Request Restrictions

A participant has the right to request a restriction or limitation on a participant's protected health information that we use or disclose for treatment, payment or health care operations. A participant also has the right to request a limit on a participant's protected health information that we disclose to someone who is involved in a participant's care or the payment for a participant's care, like a family member or friend. For example, a participant could ask that we not use or disclose information about a surgery that a participant had.

If a participant requests a restriction, it is the participant's responsibility to notify any other entity that may be impacted by the requested restriction.

We are not required to agree to a participant's request. However, if we do agree to the request, we will honor the restriction until a participant revokes it or we notify the participant.

To request restrictions, a participant must make a participant's request in writing to the Covered Entity. In a participant's request, the participant must tell us (1) what information a participant wants to limit; (2) whether a participant wants to limit our use, disclosure, or both; and (3) to whom a participant wants the limits to apply—for example, disclosures to a participant's spouse.

Right to Request Confidential Communications

A participant has the right to request that we communicate with a participant about medical matters in a certain way or at a certain location. For example, a participant can ask that we only contact the participant at work or by mail.

To request confidential communications, a participant must make the participant's request in writing to the Covered Entity. We will not ask a participant the reason for the participant's request. A participant's request must specify how or where the participant's wishes to be contacted. We will accommodate all reasonable requests if the participant clearly provides information that the disclosure of all or part of a participant's protected information could endanger a participant.

Right to Receive Notification of a Breach

A participant has the right to receive notification of any breach of your protected health information. Such notice will be provided to participants within sixty (60) days of the breach being identified.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if the participant has agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, contact Vicki Webb, Payroll & Benefits Director, vicki.webb@franklincounty.ky.gov, (502) 875-8754.

Right to Choose Someone to Act for the Participant.

Participants have the right to appoint a personal representative to act on their behalf with respect to their protected health information, such as if a participant has given someone medical power of attorney or if someone is a participant's legal guardian.

To appoint a personal representative to act on a participant's behalf, the participant must make a request in writing to Vicki Webb, Payroll & Benefits Director, vicki.webb@franklincounty.ky.gov, (502) 875-8754. The request must specify who the individual is that the participant is appointing as personal representative, that individual's contact information, and in which matters the personal representative may act on the participant's behalf.

Complaints

If a participant believes that his or her privacy rights have been violated, he or she may file a complaint with covered entity or with the Office for Civil Rights. To file a complaint with the covered entity, contact: Vicki Webb, Payroll & Benefits Director, vicki.webb@franklincounty.ky.gov, (502) 875-8754.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with the covered entity

SPECIAL ENROLLMENT NOTICE

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 stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, 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 or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

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

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

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

Right to Be Free From Discrimination and Retaliation

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 **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. 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.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Michelle's Law

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

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

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

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

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

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.
If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law
The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters
○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters
○ Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

QMCSO (Qualified Medical Child Support Order)
QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

WHCRA
The Women's Health and Cancer Rights Act (WHCRA) 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). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage 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). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

RESCISSIONS

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and

as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

PREVENTIVE CARE

Health plans through Anthem Blue Cross and Blue Shield will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.

WOMEN'S PREVENTIVE HEALTH SERVICES

All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network through Anthem Blue Cross and Blue Shield:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

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FMLA

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

MHPA/MHPAEA

Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

COBRA NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect

the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., $2,550 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

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

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

- The parent-employee dies;

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

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

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), employees must notify the Plan Administrator within 60 days after the qualifying event occurs.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the 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, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. 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.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059 the federal phone number for information and complaints.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.