Disclosures

Special Enrollment Rights (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

No Guarantee on Tax Consequences

Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of an Employee under any Plan will be excludable from the Employee's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Employee. An Employee shall indemnify and reimburse the Company for any liability it may incur for failure to withhold federal or state income tax or social security tax from such payments or reimbursements.

Newborns & Mothers Health Protection Act

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).

Michelle's Law

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan.

Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

Employee Retirement Income Security Act (ERISA)

Federal law imposes certain requirements on employee benefit plans voluntarily established and maintained by employers. [29 USC §1001 et seq.; 29 CFR 2509 et. seq.] ERISA covers two (2) general types of plans: retirement plans, and welfare benefit plans designed to provide health benefits, scholarship funds, and other employee benefits. As a participant, you are entitled to certain rights & protections under ERISA.

- Examine, without charge, at the office of the Administrator and at other specified locations, such as worksites, all Plan documents and copies of all documents filed by the Plan with the US Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Obtain a statement telling you whether you have a right to receive a benefit at normal retirement age and, if so, what your benefit would be at normal retirement age if you stopped working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing, and no one is required to give such a statement more than once a year. The Administrator must provide the statement free of charge.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to run the Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire your or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you may take to enforce your rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you win the suit, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – for example, if it finds that your claim is frivolous.

If you have any questions about the Plan, you should contact the plan administrator at your Human Resources Department. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Medicare Part D Notice of Creditable Coverage

Written notice stating whether or not the expected amount of paid claims under a group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the standard drug benefit under Medicare Part D. Must be sent to participants and beneficiaries eligible for Medicare Part D.

The notice must be provided by (1) October 15th each year; (2) prior to an individual's individual enrollment period for Part D; (3) prior to the effective date of coverage for any Part D eligible individual who enrolls in the employer's prescription drug coverage; (4) when the plan no longer provides drug coverage or when the coverage is no longer creditable; and (5) upon request.

Jenet's Law Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As required by this law, annual notice of the mandated post-mastectomy benefits must be provided to all covered persons. Please review this information carefully. If your spouse is covered under a health plan sponsored by your employer, please make certain that she or he also has the opportunity to review this information.

Disclosures

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for any complications in all stages of mastectomy, including lymphedemas.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided under the plan. The coverage may be subject to annual deductibles and coinsurance provisions.

The Act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage under the plan in order to avoid the requirements of the Act;
- Penalizing, reducing, or limiting reimbursement to the attending provider (e.g., physician, clinic or hospital) to induce the provider to provide care consistent with the Act; and Providing monetary

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
- The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

HIPAA Information Notice of Privacy Practices

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer recognizes your right to privacy in matters related to the disclosure of health related information. The Notice of privacy Practices (provided to you upon your enrollment in the health plan) details the steps your employer has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this Notice is available to you at any time, free of charge, by request through your local Human Resources Department.

Qualified Medical Child Support Order (QMCSO)

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. 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. 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.

Coverage Extension Rights Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

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 (including spouse) for up to 24 months while in the military. Even if you do not 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 for preexisting conditions except for service-connected injuries or illnesses.

Genetic Information Non-Discrimination Act (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1)genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited circumstances.

Can children stay on a parent's plan until age 26?

If a plan covers children, they can be added or kept on the health insurance policy until they turn 26 years old.

Children can join or remain on a plan even if they are:

- married
- not living with their parents
- attending school
- not financially dependent on their parents
- eligible to enroll in their employer's plan

How to get coverage for adult children

Adult child may be enrolled during a plan's open enrollment period or during other special enrollment opportunities. The employer or insurance company can provide details.

Under-26-year-olds can be signed up directly in new Marketplace plans. Be sure to include him or her on the list of people to be covered.

Questions? Call 1-800-318-2596, 24 hours a day, 7 days a week. (TTY: 1-855-889-4325)