Employer Guide to Annual Notices and Other Required Employee Benefit Disclosures

Benefit Year: 2027

***NOTE**: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the MEDICARE PART D NOTICE in this booklet for more details.*

This package contains important information about your employee benefit plans. The notices included in this package describe certain rights, protections, and responsibilities that may apply to you and your eligible dependents under federal law and the terms of the plans.

Topics addressed in these notices may include health plan enrollment rights, privacy practices, wellness program information, prescription drug coverage, and other benefit-related provisions. Please review these materials carefully and keep them for future reference.

Following please find an index of the notices and disclosures incorporated below:

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PLAN ADMINISTRATOR CONTACT INFORMATION

Many of the notices contained in this package describe rights, protections, enrollment opportunities and other actions that may require you to contact the Plan Administrator identified below. If you have questions regarding any notice contained in this package, would like additional information about your benefit plans, or wish to exercise any rights described in these notices, please contact:

Plan Administrator:
City of Chattanooga
101 East 11th Street, Suite 201| Chattanooga, TN 37402
The Human Resources Department
(423) 643-7220 | Benefits@chattanooga.gov

NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS

If you are eligible for coverage under the plan but decline enrollment for yourself or your dependents (including your spouse) because of other 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 sponsoring the other coverage stops contributing toward the cost of that coverage). You must request enrollment within 30 days after the loss of coverage or cessation of employer contributions.

In addition, if you acquire a new dependent through marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the plan. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You may also have a special enrollment right if you or your dependent loses eligibility for Medicaid or a Children's Health Insurance Program (CHIP) plan or becomes eligible for a state Medicaid or CHIP premium assistance subsidy. In these circumstances, you must request enrollment within 60 days of the applicable event.

To request special enrollment or obtain more information, contact your plan administrator.

NEWBORNS' AND 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 insurance carriers may not, under Federal law, require that a provider obtain authorization from the plan or the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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). 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 lymphedema.

These benefits will be provided subject to the same deductibles, copayments and coinsurance applicable to other medical and surgical benefits provided under this plan. These benefits will be provided in accordance with federal law.

HIPAA NOTICE OF AVAILABILITY OF THE NOTICE OF PRIVACY PRACTICES

Federal law requires certain health plans and health insurance issuers to maintain and provide a HIPAA Notice of Privacy Practices that describes how protected health information may be used and disclosed, as well as the rights individuals have regarding their health information.

The Notice of Privacy Practices is available upon request. To obtain a copy of the Notice of Privacy Practices applicable to your health coverage, contact the Plan Administrator, your employer's Human Resources Department, or your health insurance carrier, as applicable.

You may also have the right to receive a paper copy of the Notice of Privacy Practices at any time, even if you have previously agreed to receive the notice electronically.

If you have questions regarding the Notice of Privacy Practices or your privacy rights, please contact the appropriate Plan Administrator or insurer.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ **Phone: 1-855-692-5447**	**The AK Health Insurance Premium Payment Program** **Website: http://myakhipp.com/** **Phone: 1-866-251-4861** **Email: CustomerService@MyAKHIPP.com** **Medicaid Eligibility:** **https://health.alaska.gov/dpa/Pages/default.aspx**
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ **Phone: 1-855-MyARHIPP (855-692-7447)**	**Health Insurance Premium Payment (HIPP) Program** **Website:** **http://dhcs.ca.gov/hipp** **Phone: 916-445-8322** **Fax: 916-440-5676** **Email: hipp@dhcs.ca.gov**
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: **https://www.healthfirstcolorado.com/** **Health First Colorado Member Contact Center:** **1-800-221-3943/State Relay 711** **CHP+: https://hcpf.colorado.gov/child-health-plan-plus** **CHP+ Customer Service: 1-800-359-1991/State Relay 711** **Health Insurance Buy-In Program** **(HIBI): https://www.mycohibi.com/** **HIBI Customer Service: 1-855-692-6442**	**Website:** **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** **Phone: 1-877-357-3268**
GEORGIA – Medicaid	**ILLINOIS – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp **Phone: 678-564-1162, Press 1** **GA CHIPRA Website:** **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra** **Phone: 678-564-1162, Press 2**	**Illinois Medicaid Premium Assistance Information** **Medicaid application website: https://abe.illinois.gov** **HIPP Hotline Number: 217-524-8268** **HIPP Email: hfs.boc.hipp@illinois.gov**
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**

Health Insurance Premium Payment Program **All other Medicaid** **Website: https://www.in.gov/medicaid/** **http://www.in.gov/fssa/dfr/** **Family and Social Services Administration** **Phone: 1-800-403-0864** **Member Services Phone: 1-800-457-4584**	**Medicaid Website:** **Iowa Medicaid | Health & Human Services** **Medicaid Phone: 1-800-338-8366** **Hawki Website:** **Hawki - Healthy and Well Kids in Iowa | Health & Human Services** **Hawki Phone: 1-800-257-8563** **HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)** **HIPP Phone: 1-888-346-9562**
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ **Phone: 1-800-792-4884** **HIPP Phone: 1-800-967-4660**	**Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:** **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** **Phone: 1-855-459-6328** **Email: KIHIPP.PROGRAM@ky.gov** **KCHIP Website: https://kynect.ky.gov** **Phone: 1-877-524-4718** **Kentucky Medicaid Website:** **https://chfs.ky.gov/agencies/dms**
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: **https://www.ldh.la.gov/healthy-louisiana** **Medicaid Customer Service Line: 1-888-342-6207** **Louisiana Medicaid email: healthy@la.gov** **Louisiana Health Insurance Premium Program (LaHIPP) Website:** **https://www.ldh.la.gov/lahipp** **LaHIPP phone: 1-877-697-6703** **LaHIPP email: La.HIPP@la.gov** **LaHIPP fax: 1-888-716-9787** **LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084**	**Enrollment Website:** **https://www.mymaineconnection.gov/benefits/s/?language=en_US** **Phone: 1-800-442-6003** **TTY: Maine relay 711** **Private Health Insurance Premium Webpage:** **https://www.maine.gov/dhhs/ofi/applications-forms** **Phone: 1-800-977-6740** **TTY: Maine relay 711**
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa **Phone: 1-800-862-4840** **TTY: 711** **Email: masspremassistance@accenture.com**	**Website:** **https://mn.gov/dhs/health-care-coverage/** **Phone: 1-800-657-3672**
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** **Phone: 573-751-2005**	**Website:** **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** **Phone: 1-800-694-3084** **Email: HHSHIPPProgram@mt.gov**
NEBRASKA – Medicaid	**NEVADA – Medicaid**

Website: http://www.ACCESSNebraska.ne.gov **Phone: 1-855-632-7633** **Lincoln: 402-473-7000** **Omaha: 402-595-1178**	**Medicaid Website: http://dhcfp.nv.gov** **Medicaid Phone: 1-800-992-0900**
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program **Phone: 603-271-5218** **Toll free number for the HIPP program: 1-800-852-3345, ext. 15218** **Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov**	**Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/** **Phone: 1-800-356-1561** **CHIP Premium Assistance Phone: 609-631-2392** **CHIP Website: http://www.njfamilycare.org/index.html** **CHIP Phone: 1-800-701-0710 (TTY: 711)**
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ **Phone: 1-800-541-2831**	**Website: https://medicaid.ncdhhs.gov/** **Phone: 919-855-4100**
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare **Phone: 1-844-854-4825**	**Website: http://www.insureoklahoma.org** **Phone: 1-888-365-3742**
OREGON – Medicaid and CHIP	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx **Phone: 1-800-699-9075**	**Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html** **Phone: 1-800-692-7462** **CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)** **CHIP Phone: 1-800-986-KIDS (5437)**
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ **Phone: 1-855-697-4347, or** **401-462-0311 (Direct RIte Share Line)**	**Website: https://www.scdhhs.gov** **Phone: 1-888-549-0820**
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov **Phone: 1-888-828-0059**	**Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services** **Phone: 1-800-440-0493**
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) **Website: https://medicaid.utah.gov/upp/** **Email: upp@utah.gov** **Phone: 1-888-222-2542** **Adult Expansion Website:** **https://medicaid.utah.gov/expansion/** **Utah Medicaid Buyout Program Website:** **https://medicaid.utah.gov/buyout-program/** **CHIP Website: https://chip.utah.gov/**	**Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access** **Phone: 1-800-250-8427**

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs **Medicaid/CHIP Phone: 1-800-432-5924**	**Website: https://www.hca.wa.gov/** **Phone: 1-800-562-3022**
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ **Medicaid Phone: 304-558-1700** **CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)**	**Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** **Phone: 1-800-362-3002**
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **Phone: 1-800-251-1269**	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 5/31/2029)

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 may 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 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 care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following 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.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059 or visit the CMS No Surprises website at www.cms.gov/nosurprises for more information about your rights under federal law.

Note: For insured medical plans, additional state law balance billing protections may apply. For details, please visit the insurance carriers web page or refer to a recent Explanation of Benefits for more information.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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

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

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

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

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

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

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

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

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

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

- ***Disability extension of 18-month period of COBRA continuation coverage.*** If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- ***Second qualifying event extension of 18-month period of continuation coverage.*** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still 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, or https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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.

MEDICARE PRESCRIPTION (PART D) CREDITABLE NOTICE

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 to demonstrate whether you have maintained creditable coverage and, whether you are required to pay a higher premium (a penalty) as a consequence thereof.

Important Notice 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 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. Your employer has determined that the prescription drug coverage's offered by BlueCross BlueShield of Tennessee 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 15 to December 7.

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 prescription drug coverage through the employer will not be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that 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 nineteen

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 your employer for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage 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
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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.ssa.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 2027

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WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you may be unable to meet a standard for a reward under this wellness program, you may qualify for an opportunity to earn the same reward by different means. Contact your plan administrator and we will work with you (and, if you wish, with your physician) to find a reasonable alternative standard or waiver that is right for you in light of your health status. If your physician states that a recommended wellness activity or standard is not medically appropriate for you, the Plan will work with you to develop another way to qualify for the reward.

ADA NOTICE REGARDING WELLNESS PROGRAM

The group provides a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment (HRA) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include a blood test.

You are not required to complete the HRA or to participate in the blood test or any other medical examinations. However, employees who choose to participate in the wellness program may receive an incentive for participation. You are not required to complete the HRA or participate in the biometric screening, but only employees who do so receive an incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your plan administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a medical professional, such as a **registered nurse, doctor, or a health coach** associated with the program to provide services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against because of medical information you provide while a participant in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your plan administrator.