Employee Benefits Guide

January 1, 2026—December 31, 2026

HEALTH |HRA | DENTAL | LIFE| VOLUNTARY LIFE | STD | LTD | VISION | FSA | EAP | EDU ASST | 403B

North Country Hospital

Where caring runs deep.

Benefits Guide is intended for summary purposes only

Employee Cost (26 deductions)

Welcome to Open Enrollment 2026!

North Country Hospital is committed to providing you and your family with quality insurance coverage. This guide will help you select the best options for your specific situation and provide you with helpful tips to maximize your benefits.

During our Annual Open Enrollment Period, you have the opportunity to enroll in one of the benefit plans if you have previously waived coverage, change election choices, or you may enroll eligible dependents not currently enrolled.

Please Remember ~ The elections you make during open enrollment will remain in effect until next year's open enrollment (unless you have a qualifying event; see Special Open Enrollment Rights).

This booklet will provide you with a brief overview of all benefits offered to you this plan year:

January 1, 2026- December 31, 2026

Please make sure you complete your enrollment elections no later than the date designated by your HR Department.

Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract. Should there be any discrepancies between this summary and the actual insurance policy or plan documents, the insurance policy or plan documents will govern in all instances. Nothing contained herein should be construed as a guarantee of coverage or benefits.

Welcome to your 2026 Employee Benefits Guide

We are committed to providing employees with a benefits program that is both comprehensive and competitive. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist you in providing for the health, well–being and financial security of you and your covered dependents. Helping you understand the benefits North Country Hospital offers is important to us. That is why we have created this Employee Benefits Guide.

Benefits Guide Overview

This guide provides a general overview of your benefit choices to help you select the coverage that is right for you. Be sure to make choices that work to your best advantage. Of course with choice, comes responsibility and planning. Please take time to read about and understand the benefit plan thoroughly, and enroll on time.

Included in this guide are summary explanations of the benefits and costs as well as contact information for each provider.

It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you. We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable co-payments and deductibles, how to file claims, preauthorization requirements, networks and services that may be limited or not covered (exclusions). **This guide is not an employee/employer contract. It is not intended to cover all provisions of all plans but rather is a quick reference to help answer most of your questions. Please see your Summary Plan Description for complete details.** We hope this guide will give you a clear explanation of your benefits and help you be better prepared for the enrollment process.

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At Your Service...

Employee Advocate

Employees occasionally need assistance in resolving issues with insurance carriers, such as unpaid or denied claims on medical insurance, referral questions, and prescription coverage issues. Our goal is to provide truly expert personalized service, as well as assist employees of North Country Hospital.

We ask that employees and/or dependents contact the carrier at least once to resolve their issue. If assistance is still needed, please contact our Employee Advocate, Sara Closson, whose services are provided at no cost.

Having spent her career working in claims resolution for a major insurance carrier, Sara has an excellent understanding of insurance and what is required to "work within the system" to obtain timely resolution to problems. Sara is totally dedicated to resolving the claims issues of our customers employees and their families.

Contact Information:

You will need to complete a carrier release form in order for Sara to assist you.

Email: **sclosson@acadiabenefits.com**
Phone: **207.523.0065**
Toll-Free: **866.761.2426**
Fax: **207.761.0976**

Eligibility Details

Are you eligible for benefits?

To determine the benefits for which you may be eligible, please refer to the chart below. You are eligible to participate in these plans upon meeting each plan's eligibility requirements. You also have the option to enroll your eligible dependents in these plans.

Eligible dependents may include:

Medical, Dental, Vision: Your Lawful spouse; or your Domestic Partner and any child of yours who is less than 26 years old. Benefits for a dependent child will continue until the last day of the calendar year in which the limiting are is reached.

Benefit Plan	Eligibility	New Hire Waiting Period
Medical	Full time employee	First of the month, after date of hire
Dental	Full time employee	First of the month, after date of hire
Life/AD&D	Full time employee	First of the month, after date of hire
Short Term Disability	Full time employee	First of the month, after date of hire
Long Term Disability	Full time employee	First of the month, after date of hire
Vision	Full time employee	First of the month, after date of hire

Employee Responsibilities

Life Events

It is the employee's responsibility to report any dependent changes which result in loss of or entitlement to eligibility and any other "life" events to the Human Resources Department for COBRA purposes, within 30 days of the event in order to make any changes to your plan elections.

Marriage

You are required to report a marriage to your employer within 30 days in order to add your spouse to your insurance plans. A copy of the marriage license and insurance company applications will be required to change your name, beneficiary, address, or to add or delete dependents from the benefit plans.

Birth/Adoption:

If you are enrolling a new dependent, you have 30 days from the date of birth or acquisition to complete the required enrollment forms. A copy of the Birth Certificate or Court document is required.

Court Orders:

If you are enrolling a dependent child(ren) whose coverage might be governed by a divorce decree or other support order, please look at your documents carefully. Depending upon how your divorce or court order was written, the dependent may NOT be eligible for this plan. A copy of the court documents or Medical support Notice is required to enroll a dependent child(ren).

Different last name for spouse or children:

Insurance companies or your employer may require proof such as a marriage license, birth certificate, court documents, or recent tax form, to show that dependents with different names are your legal dependents. Enrollment or payment of claims may be pended until proof is received. Please be prepared to submit this documentation if requested by the insurance carrier or your employer. Your dependent may not be enrolled if documentation is not received when requested.

Divorce or Legal Separation:

If you become legally separated or divorced, it is your responsibility to notify your employer of your status change within 30 days of the event in order to make any changes to your plan elections. You may be required to provide a copy of the appropriate finalized court paper to verify the event date. Please contact Acadia Benefits, Inc. at 207-761-2426 if you would like further explanation.

Health Insurance Definitions

Copayment (co-pay)

A Copayment is a fixed dollar amount you must pay for certain Covered Benefits. The Copayment is due at the time of service of when billed by the Provider. You may have to pay a set amount every time you have an office visit, a different amount for lab work, and various amounts for different types of prescription drugs.

Deductible:

A specific dollar amount that you pay for most Covered Benefits each calendar year before any benefits subject to the Deductible are payable by the Plan.

Coinsurance:

A percentage of the allowed amount for certain Covered Benefits that must be paid by the Member. Coinsurance amounts applicable to your plan are stated in your Schedule of Benefits.

Covered Benefit(s):

The products and services that a Member is eligible to receive, or obtain payment for, under the Plan.

Out-of-pocket Maximum:

Money you pay toward the cost of healthcare services. It generally is the deductible and the coinsurance amount added together. In some cases it may also include the co-pays you have for medical services. Plans vary widely in the amount of out-of-pocket costs you pay.

Plan Year:

The one-year period for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Plan Year. Generally, the Plan year begins on the Plan's Anniversary Date. Benefits under your Plan are administered on a Calendar Year basis. Please refer to your Schedule of Benefits for details.

Premium:

The cost of a health plan. Your employer may pay part of your premium if you get your health benefits through your company.

Health Reimbursement Arrangement (HRA)

Employees enrolled in Medical Plan A, B or C will have an HRA available to them to help with medical expenses. The HRA will offset eligible in-network deductible and co-insurance expenses:

	Employee	Family
Base	$600	$1,200
Incentive	$600	$1,200
Carryover	$2,200	$4,400
Total	**$3,400**	**$6,800**

HRA Wellness Incentive Menu:

	Category Cap.
Complete Health Risk Assessment &/or Biometric Screening	**$150**
Biometric Screening Outcomes	**$150**
❑ Achieve target blood pressure, BMI, total cholesterol, etc.	
Preventive Care	**$200**
❑ Annual Physical, pap smear, mammogram, colon screening/ stool test, prostate cancer (PSA), bone density test, etc.	
Wellness Activities	**$200**
❑ Movement goals (track steps or activity minutes), view daily content cards, track healthy habits, complete a nicotine-free agreement, nutrition & calorie tracking, sleep tracking, digital coaching journeys, well-being challenges, weight loss attestation, etc.	

Medical– Plan A

administered by CIGNA

Benefit	North Country Hospital Network	Cigna network
Annual Deductible	$1,250 Individual $2,500 Family	$2,250 Individual $4,500 Family
Your Coinsurance After Deductible	20% member responsibility	30% member responsibility
Out of Pocket Annual Maximum	$2,500 Individual $5,000 Family	$3,000 Individual $6,000 Family
Non-Preventive Office Visits	PCP- $25 copay Specialist-20% coinsurance after deductible	30% coinsurance after deductible
Inpatient/ Outpatient	20% coinsurance after deductible	30% coinsurance after deductible
ER and Urgent Care	20% coinsurance after deductible	20% coinsurance after deductible
Prescriptions Generic/Name Brand	Copays $10/$20/$40 Specialty drug: You pay 50%	50% coinsurance

Medical– Plan B

administered by CIGNA

Benefit	North Country Hospital Network	Cigna network
Annual Deductible	$1,750 Individual $3,500 Family	$2,750 Individual $5,500 Family
Your Coinsurance After Deductible	20% member responsibility	30% member responsibility
Out of Pocket Annual Maximum	$3,000 Individual $6,000 Family	$3,500 Individual $7,000 Family
Non-Preventive Office Visits	PCP- $35 copay Specialist-20% coinsurance after deductible	30% coinsurance after deductible
Inpatient/ Outpatient	20% coinsurance after deductible	30% coinsurance after deductible
ER and Urgent Care	20% coinsurance after deductible	20% coinsurance after deductible
Prescriptions Generic/Name Brand	Copays $10/$20/$40 Specialty drug: You pay 50%	50% coinsurance

Medical– Plan C

administered by CIGNA

Benefit	North Country Hospital Network	Cigna network
Annual Deductible	$2,250 Individual $4,500 Family	$3,250 Individual $6,500 Family
Your Coinsurance After Deductible	20% member responsibility	30% member responsibility
Out of Pocket Annual Maximum	$3,500 Individual $7,000 Family	$4,000 Individual $8,000 Family
Non-Preventive Office Visits	PCP- $35 copay Specialist-20% coinsurance after deductible	30% coinsurance after deductible
Inpatient/ Outpatient	20% coinsurance after deductible	30% coinsurance after deductible
ER and Urgent Care	20% coinsurance after deductible	20% coinsurance after deductible
Prescriptions Generic/Name Brand	Copays $10/$20/$40 Specialty drug: You pay 50%	50% coinsurance

Medical– Plan D (HSA Plan) administered by CIGNA

Benefit	North Country Hospital Network	Cigna network
Annual Deductible	$2,250 Individual $4,500 Family	$3,250 Individual $6,500 Family
Your Coinsurance After Deductible	20% member responsibility	30% member responsibility
Out of Pocket Annual Maximum	$3,500 Individual $7,000 Family	$4,000 Individual $8,000 Family
Non-Preventive Office Visits	20% coinsurance after deductible	30% coinsurance after deductible
Inpatient/ Outpatient	20% coinsurance after deductible	30% coinsurance after deductible
ER and Urgent Care	20% coinsurance after deductible	20% coinsurance after deductible
Prescriptions Generic/Name Brand	Deductible, then co-pays $10/$20/$40 Specialty drug: You pay 50%	50% coinsurance

Medical Plan Bi-Weekly Premium Schedule (per pay period)

FULL TIME EMPLOYEE				
Tier	**HRA A**	**HRA B**	**HRA C**	**HSA D**
Employee	$57.13	$26.38	$11.56	$11.56
Employee & Spouse	$182.93	$126.06	$81.64	$81.64
Employee & Children	$105.17	$71.84	$46.53	$46.53
Family	$210.33	$143.68	$93.04	$93.04

PART TIME EMPLOYEE				
Tier	**HRA A**	**HRA B**	**HRA C**	**HSA D**
Employee	$99.92	$64.90	$40.18	$40.18
Employee & Spouse	$299.49	$205.33	$132.97	$132.97
Employee & Children	$176.83	$118.32	$75.50	$75.50
Family	$353.66	$236.63	$150.99	$150.99

Dental

administered by Delta Dental

Delta Dental PPO + Premier		
	Core Plan	Buy-Up Plan
Deductible	N/A	N/A
Preventive	100%	100%
Basic	80%	85%
Major	50%	50%
Orthodontics (Child)	N/A	50%
Annual Max. Benefit	$1,500 per person	$2,000 per person
Lifetime Benefit (Ortho)	N/A	$1,500 per person
Cleanings	4 times in 12 months	4 times in 12 months
Fluoride	2 times in 12 months	2 times in 12 months

FULL TIME EMPLOYEE (BI-WEEKLY RATES)		
Tier	Core Plan	Buy-Up Plan
Employee	$3.91	$5.69
Employee + 1	$6.55	$10.07
Employee + 2	$15.38	$24.68

PART TIME EMPLOYEE (BI-WEEKLY RATES)		
Tier	Core Plan	Buy-Up Plan
Employee	$7.34	$9.12
Employee + 1	$12.58	$16.10
Employee + 2	$21.24	$30.54

Vision

administered by VSP

VSP	In-Network
Exam	$10 Copay
Prescription Glasses - $10 Copay	
Frames	$180 Allowance for a wide selection of frames
Lenses (single vision, bi-focal and tri-focal)	Included in prescription glasses
Contacts (instead of glasses)	$180 Allowance (copay does not apply)

FULL TIME EMPLOYEE	
Tier	**BI-WEEKLY RATES**
Employee	$5.68
Employee + 1	$8.23
Employee + 2	$14.76

PART TIME EMPLOYEE	
Tier	**BI-WEEKLY RATES**
Employee	$5.68
Employee + 1	$8.23
Employee + 2	$14.76

Group Life / AD&D Insurance

administered by Voya

Group Life/AD&D Policy	
Eligibility	All eligible Full-Time Hourly Employees
Who pays the cost of coverage?	Your employer pays the cost of your insurance.
Life Benefit Amount	2x annual earnings (subject to maximums)
Portability	If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may be eligible to elect portable coverage and continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.
Benefit Reduction Schedule	Your insurance will reduce by: 35% at age 70, 50% at age 75.

Voluntary Life / AD&D Insurance

administered by Voya

LIFE/AD&D AMOUNT	<5X salary or $500,000 - $10,000 increments
BENEFIT MAXIMUM	<5X salary or $500,000
GUARANTEE ISSUE	<2X salary or $100,000
DEPENDENT LIFE	
SPOUSE	$5,000 increments
MAXIMUM	100% employee coverage
CHILD	Increments of $2k to $10k or 100% employee coverage

Short Term Disability Insurance

administered by Prudential

100% Employer PAID

WEEKLY BENEFIT	60% of EARNINGS
ELIMINATION PERIOD	
ACCIDENT	7 DAYS
SICKNESS	7 DAYS
MAX BENEFIT PERIOD	13 WEEKS

Long Term Disability Insurance

administered by Prudential

MONTHLY BENEFIT	60% or 66 & 2/3% of Earnings (Dependent on Coverage)
ELIMINATION PERIOD	90 DAYS
MAX. MONTHLY BENEFIT	$10,000 or $20,000 (Dependent on Coverage)
DURATION	Own OCC to Age 65, Own Specialty, or 2 Year Own OCC (Dependent on Coverage)

Flex Spending Account (FSA)

North Country Hospital provides you with an opportunity to participate in two different Flexible Spending Accounts (FSAs) administered through Voya

FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income tax, Social Security tax, and Medicare tax.

Health Care FSA

For 2026 you may contribute up to $3,400 to cover eligible health care expenses incurred by you, your spouse, and your children up to age 26. For a complete list of eligible health care expenses, visit www.irs.gov/pub/irs-pdf/p502.pdf.

Dependent Care FSA

For 2026, you may contribute up to $7,500 (per family) to cover eligible dependent care expenses ($3,750 if you and your spouse file separate tax returns). For a complete list of eligible dependent care expenses, visit www.irs.gov/pub/irs-pdf/p503.pdf.

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules, so please plan carefully:

- Health Care FSA: Unused funds remaining at the end of the plan year will be forfeited.
- Dependent Care FSA: Unused funds will NOT be returned to you or carried over to the following year.
- You must file your 2025 claims by March 31, 2026.

NCH 403B Retirement Plan Highlights

ELIGIBILITY

- For making pre-tax and/or Roth salary deferral contributions and NCH Matching: date of hire
- For Discretionary, Non-Elective Employer Contributions: first day of the quarter following completion of 2 Years of Service (during which employee worked at least 1000 hours)

CONTRIBUTIONS

Employee

Pre-tax and/or Roth contributions through payroll deduction

- Contributions up to the maximum amount permitted by law for the year, the limits are $24,500 for 2026; $32,500 for those who are age 50 (reach age 50 anytime in 2026) or older.

Rollover assets accepted from certain former plans and IRAs

NCH

Matching contributions of 50% of the first 5% of base pay, which you contribute
The maximum amount of the employer match is 2.5% of your base pay for the year.
At its discretion the Hospital may make a non-elective contribution to your account. The current formula is based on your Years of Service:

Years of Service	Contribution as % of Base Pay
2 or more but less than 5	1.5%
5– 8	3.0%
9 – 19	4.5%
20 or more	5.0%

Base Pay which is considered for the discretionary contribution is base pay for the calendar quarter for the current year for which the contribution is made. Years of Service are determined as of the first day of the current year. To complete a year of service you must have worked 1,000 hours of service during an eligibility period. The first eligibility period is the 12-month period beginning on your date of hire. Subsequent eligibility periods are based on the Plan Year.

Participants must be employed on the last day of the quarter to receive the discretionary contribution for that quarter if declared.

NCH 403B Retirement Plan Highlights

TAX CREDIT

- You may be eligible to receive a "non-refundable" tax credit for making contributions to this plan. This credit is subtracted directly from your calculated "taxes due" on your return. The credit will not increase any refund you may be due; it will only reduce an amount you may owe in taxes. The credit amount is linked directly to your Adjusted Gross Income (AGI) on your tax return as follows:

AGI Married Filing Joint	AGI Head of Household	AGI Single	TAX CREDIT
0-$39,500	0-$29,625	0-$19,750	50% of Contribution
$39,501-$43,000	$29,626-$32,250	19,751-$21,500	20% of Contribution
$43,001-$66,000	$32,251-$49,500	$21,501-$33,000	10% of Contribution

The maximum tax credit that may be claimed cannot exceed $2,000. These rates reflect income limits for tax year 2021.

WITHDRAWALS

In-Service hardship withdrawal

- To pay necessary uninsured medical expenses for you, your spouse or your dependent
- Any other emergency which the Plan Committee determines has produced an immediate and heavy financial need for which hardship withdrawals are permitted under this type of retirement plan
- The amounts available for withdrawal are your cumulative salary deferral contribution (without earnings)

Other In-Service Withdrawal

After age 59 ½ your vested account balance is available for withdrawal

LOANS

- Loans can be taken from employee contributions only
- Minimum loan amount - $1000
- Maximum loan amount - 50% of your balance (employee and rollover contributions only) up to $50,000
- Maximum term is 5 years for normal loan, and 10 years for loan to purchase primary residence
- Only one outstanding loan can be had at any one time

NCH 403B Retirement Plan Highlights

TAXES AND PENALTIES

- Taxes will be due on the taxable portion of any withdrawal and certain amounts may be required to be withheld at the time of the withdrawal
- Participants under the age of 59 ½ generally owe a 10% tax penalty on the taxable portion of a withdrawal when filing their income taxes; this penalty tax is not due if you receive your distribution on account of termination of employment after age 55.

BENEFIT PAYMENTS

- Upon termination, vested account balance is payable to you
- Upon retirement after age 55, or upon death or total disability, account balance is payable to you or a named beneficiary
- Flexible pay-out options that include: Lump sum, installments, single requests or purchase of an annuity

VESTING

- All contributions are 100% vested at all times

The Summary Plan Description has more details about your plan. The above information cannot change the terms or conditions of the plan. If there is a discrepancy between the Summary Plan Description and this Plan Highlights sheet, the Summary Plan Description governs.

Investments are provided through Transamerica Retirement Solutions

NCH Educational Assistance Program

MINI GRANTS

North Country Hospital has budgeted funds to assist employees in the pursuit of educational goals, whether for career or personal satisfaction. These funds may be issued in the form of Mini Grants to assist with tuition for approved courses.

All Full-Time and Regular Part-Time employees are eligible to apply for a Mini Grant, with the exception of persons intending a leave of absence for educational purposes. Applications for financial assistance will be considered provided the applicant is actively employed at the time of application. Employees should complete the "Mini-Grant Request" available through the Human Resources Department before the course begins. Proof of registration is required.

Employees must have completed their introductory employment period to be eligible to receive a grant. Mini-grants will be awarded based on the following schedule:

Completed Years of Service	Cumulative Amount Eligible for
End of Introductory Period through year 4	$100
Year 5 through year 9	$250
Year 10 and greater	$400

Applications will be reviewed on an individual basis. Persons awarded a Mini Grant will receive one-half of the grant on enrollment and the final half upon the successful completion of the course provided the applicant is still actively employed at North Country Health System. If a course is under $100.00, the full amount can be paid in advance.

A lifetime maximum of $750.00 has been established for Mini-Grants.

TUITION REIMBURSEMENT

Full-Time employees may apply for tuition reimbursement of 50% for career-oriented education.

Application should be made through the Human Resources Department prior to the beginning of the course. Reimbursement is made upon successful completion of the course as long as the applicant is still an NCH employee. An employee may receive 50% reimbursement upon enrollment. Or an employee may receive 100% of the tuition costs by electing payroll deductions to pay back the hospital within one year. 50% of the costs will be forgiven when the person successfully completes the course with the remainder (if any) continuing to be paid through payroll deductions.

Part-Time employees may receive tuition reimbursement of 25% or 50% by electing payroll deductions to pay back 25% to the hospital within one year.

If the employee withdraws from, fails the course, or is not employed at NCH when the course is completed, the amount previously issued is due immediately and may be deducted from final wages and accruals, in accordance with Vermont Wage and Hour Laws, if employee has terminated employment.
NOTE - Tuition Reimbursement excludes any scholarships or grants received by the employee and will not be included in the calculation of the tuition reimbursement granted to the requesting employee.

TIMELY APPLICATION

Application for Mini-Grant or Tuition Reimbursement funds should be submitted for approval at least (2) weeks before the start of a given course of program.

NCH Employee Assistance and Work-Life Program

A free, confidential program for employees and adult household members. Here's how we can help:

EMOTIONAL HEALTH	PARENTING	ELDERCARE	LEGAL
Counseling, Consultations & Referrals Alcohol & Drug Anxiety Chronic Illness Depression Eating Disorders Family & Relationship Gambling Meditation Mindfulness Partner Violence Smoking Cessation Sleep Issues Stress Management	**Childcare Consultation & Referrals** Back-up Care Before/After School Childcare Centers Family Day Care Nannies & In-home Care Summer Camps **Information & Support** Adolescence Adoption Child Development College Planning New Parents Pregnancy Special Needs	**Consultation & Referrals** Assisted Living Facilities Caregiver Support Community Services Home Health Care Hospice Medicare/Medicaid Nursing Homes Respite Care Social Security Transportation	**Consultation & Referrals** Bankruptcy Child Custody & Support Consumer Issues Elder Law Estate Planning Immigration Landlord Tenant Disputes Real Estate Concerns Restraining Orders Separation & Divorce Wills & Trusts

FINANCIAL	WORK	CONVENIENT SERVICES	NUTRITION
Consultation & Referrals Budgeting Credit Problems Debt Management Financial Wellbeing Homebuying Information Insurance Planning Retirement Planning Tax Resources	**Consultation & Referrals** Career Exploration Interest Testing Job Performance Concerns Job Search Strategies Resume Review Time Management Work-life Integration Work Stress	**Information & Referrals** Community Education Fitness Programs/Trainers Home Cleaning Home Repair Services Moving Services Organizer Services Pet Care Relocation Information Yoga Classes	**Consultation & Information:** Child Friendly Meals Diabetes Food Allergies Gastrointestinal Problems Healthy Eating High Blood Pressure High Cholesterol Lactation Weight Management

Initial COBRA Notification (Continuation Coverage Rights Under COBRA)

Introduction
This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive 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 additional 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." 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 under the employer's plan must pay for COBRA continuation coverage.

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.

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, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

Initial COBRA Notification (Continuation Coverage Rights Under COBRA)

You Must Give Notice of Some Qualifying Events
For the 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: Human Resources in written form, along with supporting documentation of event.

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 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 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.

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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**.

Initial COBRA Notification (Continuation Coverage Rights Under COBRA)

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.

For the 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: Human Resources in written form, along with supporting documentation of event.

Health Insurance Marketplace Coverage Options & Your Health Coverage

Beginning in 2014, there was a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2026 open enrollment period for health insurance coverage through the Marketplace begins on November 1, 2025 and ends on December 15, 2025 for coverage starting Jan. 1, 2026. After January you can get coverage through the Marketplace for 2026 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.) The NORTH COUNTRY HOSPITAL plans meet this requirement.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa 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, 2023.
Contact your State for further information on eligibility :

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA– Medicaid
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+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/programs/third-party-liability/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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kancare.ks.gov
Phone: 1-800-792-4884

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 877-524-4718

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-342-6207

MAINE – Medicaid (MaineCare)
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll Free Number for HIPP program at 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2024, 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.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Your Right To Privacy HIPAA Basics

In April 2003, the final regulations that place restrictions on how personally identifiable health information may be used and disclosed by certain organizations became effective.
These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protections for all health information.
In summary, the HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed;
- Require that individuals be told how their health information will be used and disclosed;
- Provide individuals with a right to access, amend or copy their medical records;
- Give individuals a right to receive an accounting of disclosures, to request
- special restrictions, and to receive confidential communications; and
- Impose fines where the requirements contained within the regulations are not met.

Restrictions on Use & Disclosure
The rules allow health care providers, health plans, and health care clearinghouses (Covered Entities) to use and disclose your personally identifiable health information for purposes of treatment, payment, or health care operations.

For example, your health care provider may submit your health information to a health insurance company in order to seek payment for the treatment provided to you. Your primary care physician can share your health information with a specialist that he or she recommends you consult. In these cases, your written permission to disclose your health information is not required.
In general, any use or disclosure not considered treatment, payment, or a health care operation requires your written authorization, unless an exception applies. For example, your physician may not share your health information with your employer or a life insurance carrier without your written permission.

However, disclosure of health information is permitted for certain purposes specifically listed in the HIPAA Privacy Rules, such as national security, law enforcement and public health issues. If you authorize release of your health information to a third party, the information released may no longer be protected by HIPAA.

Notice of Privacy Practices
You are entitled to receive an explanation of how your personally identifiable health information will be used and disclosed. For example, a physician or hospital is required to provide you with a Notice of Privacy Practices at your first visit. You will be required to sign an acknowledgement indicating that you received the Notice of Privacy Practices.

If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices immediately after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices in order to understand your rights and know who to contact if you feel your privacy rights have been violated.

Right to Access, Amend, or Copy
You have a right to view and copy your medical records. You may be charged a fee for the cost of reproduction. If you believe that information within your medical records is incorrect or if important information is missing, you have a right to request that your medical records be amended.

Right to an Accounting of Disclosure
You also have a right to a list of uses and disclosures made of your medical records where the use or disclosure was not for purposes of treatment, payment, health care operations, or pursuant to your written authorization.

Right to Request Restrictions
You may request in writing that a health care provider or health plan not use or disclose information for treatment, payment, or other administrative purposes unless specifically authorized by you, when required by law, or in emergency circumstances. Health care providers and health plans must consider your request, but are not legally obligated to agree to those restrictions.

Confidential Communications
You have a right to receive confidential communications containing your health information. Health care providers and health plans are required to accommodate your reasonable request. For example, you may ask that a physician contact you at your place of employment or send communications regarding treatment to an alternate address.

Violations of Privacy Rights
If you believe that your privacy rights have been violated, you may contact the Privacy Officer for the organization that you feel has violated your right to privacy. The name of the Privacy Officer should be included in the Notice of Privacy Practices provided to you by that organization.

If the Privacy Officer does not adequately resolve your concerns, you may contact the Department of Health and Human Services — Office of Civil Rights (OCR). OCR is responsible for enforcing the HIPAA Privacy Rules. Its http://www.hhs.gov/ocr/privacyhowtofile.htm, and a complaint form http://www.hhs.gov/ocr/howtofileprivacy.pdf

Penalties for Noncompliance
The HIPAA Privacy Rules do not provide individuals with a private right to sue, although methodologies for allowing a portion of civil penalties to be paid to affected individuals must be established by February 17, 2012.
Currently, health care providers, health plans, and health care clearinghouses that do not comply with the HIPAA Privacy Rules may be subject to civil money penalties ranging from $100 to $50,000 per violation, with maximum penalties ranging from $25,000 per year to $1.5 million per year. Criminal violations of the HIPAA Privacy Rules may also be referred to the Department of Justice for enforcement.

Criminal penalties for such violations include:

- $50,000 and/or up to one year in prison for knowingly obtaining or disclosing protected health information not permitted by law;
- $100,000 and/or up to five years in prison for obtaining or disclosing protected health information under false pretenses; and
- $250,000 and/or up to ten years in prison for obtaining protected health information with an intent to sell, transfer, or use it for commercial advantage, personal gain, or malicious harm.

State Attorneys General (AG) may also bring suit against Covered Entities to enjoin further violations and obtain damages on behalf of residents of their states, if HHS has not already taken action. The AG may seek damages of up to $100 per violation, with a maximum of $25,000 per year.

HIPAA Privacy Resources

- Office of Civil Rights (HHS) **http://www.hhs.gov/ocr/**
- Health Privacy Project **http://www.healthprivacy.org**

This is for informational purposes only and is not intended to replace the advice of an insurance professional or legal counsel. Please seek professional advice before making decisions about your personal finances or legal rights.

This is intended to provide an objective, reader-friendly summary of the rights afforded to individuals by the HIPAA Privacy Rules. This information may be used to supplement the Notice of Privacy Practices required by HIPAA. In no event should this article be used in place of any legal notice required by HIPAA.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 day after your 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 31 days after the marriage, birth, adoption, or placement for adoption.

If you are declining 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 plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your 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.

Notice of Women's Health and Cancer Rights

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). 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 lymphedema.

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, contact your Health Insurance issuer.

Notice of Newborns' and Mothers' Health Protection Act

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 child-birth 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.

These summaries are for Information Purposes Only

The information in this booklet is only a brief description of the benefits and insurance plans, and is not a Summary Plan Description (SPD) for the plan.

For complete details on any benefit, refer to your member handbook, or the plan's benefit booklet. If there are any inconsistencies between the descriptions in this booklet and the insurance contracts, the insurance contract and plan agreements will contain legal, binding provisions and will prevail.

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