HHM

CERTIFIED PUBLIC ACCOUNTANTS

2026

Employee Benefits Guide

What's Inside

Please note this guide is designed to provide an overview of the coverages available. Your employer reserves the right to amend or change benefit offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations. If any discrepancy exists between this guide and the official documents, the official documents will prevail. If you would like a printed copy of the materials, please contact your employer.

Please contact Human Resources if you have any questions regarding your benefits plan.

Enrollment Changes

Changes to your enrollment may be made annually during open enrollment each year. Mid-year changes may be made for qualifying events such as marriage/divorce, birth/adoption, death, change in job status of yourself or your spouse, and/or change in Medicaid/CHIP eligibility.

However, all changes must be made within 30 days (with the exception of Medicaid/CHIP, which gives you up to 60 days) of your qualifying event. You must notify Human Resources immediately when you experience a qualifying event.

Section 125 Plan Premium Conversion

Section 125 Premium Conversion Plan lets you exclude your Medical, Dental and Vision premiums from your taxable income, meaning your premiums will come out of your income pre-tax. This lowers your taxable income. By default, your premiums will be deducted pre-tax, increasing your take-home pay anywhere from a couple hundred dollars to a thousand or more annually.

Summary of Material Modifications

This document is to serve as a Summary of Material Modifications to the Summary Plan Description (SPD) for the HHM Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

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 Annual Notices section for more details.

Benefit Contacts

Benefit	Carrier	Phone Number	Website/Email
Medical Benefits	BlueCross BlueShield of TN	1-800-565-9140	www.bcbst.com
Health Savings Account (HSA)	Health Equity	1-866-889-8583	www.myhealthequity.com
Telemedicine	TextCare	423-922-8182	N/A
Dental Benefits	BlueCross BlueShield of TN	1-800-565-9140	www.bcbst.com
Vision Benefits	BlueCross BlueShield of TN	1-800-565-9140	www.bcbst.com
Basic and Voluntary Life and AD&D	Lincoln Financial Group	1-800-423-2765	www.lincolnfinancial.com
	Guardian	1-888-482-7342	www.guardianlife.com
Disability Products	Lincoln Financial Group	1-800-423-2765	www.lincolnfinancial.com
Other Voluntary Benefits	Guardian	1-888-482-7342	www.guardianlife.com
Employee Assistance Program (EAP)	Lincoln Financial Group	1-888-628-4824	www.guidanceresources.com
Online Enrollment	Employee Navigator	N/A	https://employeenavigator.com/benefits/Account/Login Company Identifier: HHMCPAS
Benefits Department	Kelry Mann	423-702-7225	kmann@hhmcpas.com

Medical Benefits

HHM's medical benefits are provided through **BlueCross BlueShield of Tennessee**. HHM offers plan options in the BCBST Network S and Network P. In these networks, you have the flexibility to go to any provider that you choose.

If you select an out-of-network physician or facility, you will be subject to higher deductibles and out-of-pocket maximums. But anytime you select an in-network physician or facility, you will see significant discounts and savings.

To find an in-network provider near you, go to www.bcbst.com. Please be sure to consult either the online directory or the BCBST customer service department to confirm that your provider participates in the network.

		Monthly Premiums
Option 1 PPO - Network P	Employee Only	$411.41
	Employee + Spouse	$1,303.97
	Employee + Child(ren)	$1,084.80
	Family	$2,062.63
Option 2 HDHP - Network S	Employee Only*	-$162.49
	Employee + Spouse	$203.77
	Employee + Child(ren)	$90.64
	Family	$477.85
Option 3 HDHP - Network P	Employee Only*	-$121.15
	Employee + Spouse	$290.59
	Employee + Child(ren)	$166.30
	Family	$603.31

***Please note: HHM contributes $162.49 per month to your HSA for Option 2 and $121.15 per month for Option 3 (Individual coverage only)**

Medical Benefits

Medical Benefits*	Option 1 PPO Network P	Option 2 HDHP Network S	Option 3 HDHP Network P
Deductible: Individual / Family	$2,500 / $5,000	$8,500 / $17,000	$8,500 / $17,000
Out-of-Pocket Maximum: Individual / Family	$4,600 / $9,200	$8,500 / $17,000	$8,500 / $17,000
HRA Medical Deductible and Out-of-Pocket Maximum: Individual / Family	N/A	The individual is responsible for the first $3,500 of the total individual deductible ($8,500) and the remaining $5,000 is split 80% HHM-HRA ($4,000) and 20% Individual ($1,000). The Family is responsible for the first $7,000 of the family deductible ($17,000) and the remaining $10,000 is split 80% HHM-HRA ($8,000) and 20% Family ($2,000). The out-of-pocket maximum is $4,500 individual and $9,000 for Family.	
Out-of-Pocket Maximum After HRA: Individual / Family	N/A	$4,500 / $9,000	$4,500 / $9,000
Covered Services Overview			
Preventive Care	100%*		
Office Visit - Primary Care Physicians	$50 Copay	100%	100%
Office Visit - Specialists	$50 Copay	100%	100%
Urgent Care	$50 Copay	100%	100%
Emergency Room	$250	100%	100%
Most Other Services	70% after deductible	100%	100%
Pharmacy - Retail Network			
Preventive	N/A	$10/$35/$60 Copay	$10/$35/$60 Copay
Generic	$10	100%	100%
Preferred	$60	100%	100%
Non-Preferred	$90	100%	100%
Specialty (Self-Administered)	$90	100%	100%

*Review plan documents for out-of-network benefits, prior authorization requirements, limits on the number of visits per year and service restrictions.

Spousal Surcharge

The Medical Plans include a provision that benefit eligible employees may only cover a spouse as a dependent if the spouse does not have access to medical coverage through their employer. If you choose to cover your spouse that has access to other medical coverage through their employer, you will be charged a surcharge of $100 per month. Employees will be required to complete a Spousal Coverage Affidavit each year at open enrollment. The affidavit is located in our enrollment system, Employee Navigator.

Health Reimbursement Arrangement

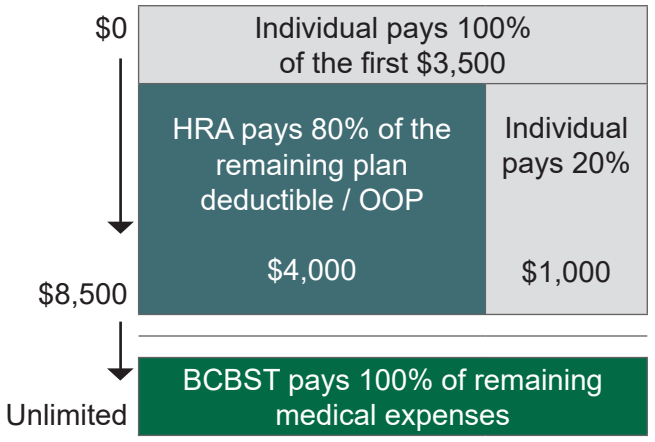
To offset the rising cost of healthcare, HHM provides a Health Reimbursement Arrangement (HRA) to all employees enrolled in the HDHP medical option. The purpose of the HRA is to contribute toward the payment of in-network deductible and out-of-pocket expenses incurred by you, as an employee, or for one of your covered family members.

Please note: copays are an out-of-pocket expense that count toward your out-of-pocket maximum but they are not eligible for HRA reimbursement.

Please follow along with the example for an individual deductible below to better understand how the HRA will help pay for medical expenses.

1. The employee pays the first $3,500 of medical expenses.
2. HHM's HRA pays 80% of the remaining deductible and out-of-pocket expenses ($4,000).
3. The employee pays 20% of the remaining deductible and out-of-pocket expenses ($1,000).
4. BCBST pays 100% of the remaining in-network claims.

INDIVIDUAL HRA EXAMPLE



Individual Deductible: $3,500
Individual OOP Max: $4,500
HRA Liability: $4,000

Blue Resources

BCBSTN Mobile App – You're constantly on the go, so you need a convenient way to keep up with your BlueCross health plan. With our mobile app for iOS and Android, BCBSTN, you can find doctors, look up claims information or access a digital version of your Member ID card. You can also access BCBS Wellness and Rewards Program.

To get started, log in to the application using the same username and password you use on the BlueAccess online member portal. Or just tap **Register Now** to quickly register. Have your Member ID card handy. Just a few taps and you'll be on your way to accessing your details.

BCBS Reward's Program – The BlueCross BlueShield of Tennessee Reward's Program is a member-based incentive initiative designed to promote and encourage healthy lifestyle habits. Members can earn points by completing health and wellness activities, which can be redeemed for a variety of rewards. Subscriber and covered spouse can each earn Visa gift card per quarter, per year.

Reward Activity	Points	How to Earn
Personal Health Assessment	50	1 per year necessary to be eligible and earn points
Annual Wellness Visit	100	1 per year
Physical Activity-Device Steps	Unlimited per day	1 point = per 5,000 steps
Flu Shot	50	1 per year
Chronic Condition/Case Management Engagement (2 consults)	Up to 100	Earn after completing 2nd consult and earn 50 points. 1 per quarter, 100 points max per year
Cancer Screenings (Mammogram, Colorectal, Cervical, or Prostate)	100	Earn for only 1 screening per year
Diabetes Management (A1C, urine test, and kidney function)	Up to 150	50 points each test. 1 test per year
Healthy Maternity Completion	100	1 per year

ID Theft Protection – In addition to protecting your health, BCBST wants to help protect your personal information. BCBST has partnered with Experian to provide identity protection services as part of your medical plan at no cost to you.

Healthy Maternity – This program can provide support throughout your pregnancy and help you have a healthy delivery. Moms-to-be who enroll in the program will get one-on-one support from a maternity nurse. You will also receive postpartum support for up to eight weeks after your baby is born, newborn education, and help with how to get the most from your maternity benefits.

Member Discounts – Blue365 encourages you to live a healthier lifestyle by making healthy choices more affordable. You have access to great deals – like 20% off at Reebok.com, discounted products through Jenny Craig, or discounted gym memberships.

Behavioral Health – If you're living with mental illness, BCBST is here to help. The Behavioral Health team can connect you with: Evaluations, Counseling, Community resources, Treatment programs, and Inpatient or Outpatient services.

Tobacco Cessation – When you commit to quit, your Member Care team can connect you with the resources you need. They include: Health coaching to help you meet your goals, Self-directed courses to guide you and personalized advice. Quit now to live healthier.

Health Savings Account

HealthEquity

If you are enrolled in the High Deductible Health Plan, you are eligible to participate in a Health Savings Account (HSA) through **HealthEquity**.

An HSA is established to pay for future qualified medical, dental and vision expenses that are incurred by you or your IRS-eligible dependents enrolled in the plan, allowing you to set aside money pre-tax.

2026 Annual Maximum Contributions to your HSA

Employee:	**$4,400**
Family:	**$8,750**
Catch-Up Contribution for those 55+:	**$1,000**

Your contributions to the HSA will be payroll deducted and the funds deposited into an HSA when payroll processes. When a qualified expense is incurred, you use your HSA debit card or request reimbursement for the expense. Unused account dollars are yours to keep, even if you retire or leave the company.

Please note: If you can't claim a child as a dependent on your tax returns, then you may not spend HSA dollars on services provided to that child.

Qualified Expenses

HSA funds can be used to pay for qualified medical, dental or vision expenses that aren't reimbursed by insurance or otherwise reimbursed, including:

- Medical services (fees and expenses charged by physicians, surgeons, specialists and other health care providers)
- Dental treatment (including fillings, extractions, braces and x-rays)
- Eye examinations, glasses, contact lenses, surgery
- Prescription medicines
- Psychiatric care

HSA funds may be used for qualified medical expenses for your spouse or dependents, even if they aren't covered by the High Deducible Health Plan.

www.healthequity.com

TextCare

If you need access to medical care, **TextCare** provides board-certified providers via text message - 24/7.

Services include:

- Direct access to on-demand, high-quality care
- Discuss primary and urgent care needs, chronic condition management and routine medication needs
- Get support finding and scheduling a specialist visit
- Appointments are not required, simply text for care
- Accessible via text message and video chat - there's no app to download and no fees or copays to use the service!
- Available to all those eligible for the HHM group health plan

Scan the QR code to save the TextCare contact directly to your phone!

Frequently Asked Questions

Q: How do I contact TextCare?

A: Send a text message to **423-922-8182**. Your care team will respond within 5 minutes. Appointments are not required, and there is no app to download.

Q: What can I use TextCare for?

A: Your care team can help with any health or medical question and should be your first point of contact for any issue. Even if your issue cannot be resolved virtually, the care team provides expert care navigation and will refer you to specialty providers.

Q: Will my TextCare team be able to understand my question or issue via text?

A: Yes! You can chat, upload pictures, or one-click into a video visit with your provider.

Q: What if I need additional care outside of TextCare?

A: Your TextCare provider may refer you to other high-quality, low-cost providers and specialists.

Q: What if I need medication to treat my diagnosis?

A: Your TextCare provider can prescribe medication, and the prescription will be sent to a local pharmacy.

Q: What if my initial visit requires a follow-up?

A: Your care team will reach out via text message to schedule a follow-up appointment.

Q: Should I go to an Urgent Care or the ER?

A: Many urgent care and emergency room visits end up being unnecessary. TextCare is available to you 24/7 and can help triage the situation to avoid a lengthy trip to the ER. However, we encourage you to call 911 or go to the ER if you are experiencing a medical emergency.

Q: Who is eligible for this service? Can my family use TextCare?

A: Yes! TextCare is available to all those eligible for the HHM group health plan.

Q: Will my employer have access to my health information?

A: No! All patient information is strictly confidential. TextCare is managed by One to One Health, a workplace healthcare provider headquartered in Chattanooga, Tennessee. One to One Health complies with all HIPAA and healthcare regulations to maintain your privacy, ensuring your health information is kept confidential.

Wellness Program

Eligibility

Employees are eligible to enroll the first day of the month following thirty (30) calendar days after continuous full time employment (work an average of 30 or more hours per week).

Program Details

This HHM program is designed to promote the health and wellness of HHM employees by partially reimbursing the employee for expenses associated with approved health/physical fitness club memberships. It is meant to reimburse HHM employees for expenses related to the employee's activity only.

HHM will reimburse ½ of employee's monthly dues for health club memberships up to a maximum of $360 per year ($30 per month). This benefit does **not** apply in Chattanooga, TN.

As a condition of participating in the plan Staff Member agrees to:

- Fill out and sign the HHM Health Club Reimbursement Agreement form.
- Provide proof of membership and dues and submit to Human Resources with this document upon signing up for the plan.
- Verify membership fees annually upon request.
- Notify HHM if your health club membership terminates.
- Reimburse HHM by payroll deduction for any months which reimbursement was received while not a member of a health club.

Please see Human Resources for details regarding approved facilities.

Dental Benefits

Your dental benefits at HHM are provided by **BlueCross BlueShield Tennessee**. This dental plan is a PPO (similar to your medical plan), in that you may visit any provider that you choose, however, you will most likely see increased benefit levels if you go to a provider in-network.

To find a provider in the network, visit www.bcbst.com.

Monthly Premiums		Full Premium	ER Monthly Contribution	EE Monthly Contribution
Option 1	Employee Only	$26.52	$26.52	$0.00
	Employee + Spouse	$71.76	$26.52	$45.24
	Employee + Child(ren)	$71.76	$26.52	$45.24
	Family	$71.76	$26.52	$45.24
Option 2	Employee Only	$31.46	$26.52	$4.94
	Employee + Spouse	$97.70	$26.52	$71.18
	Employee + Child(ren)	$97.70	$26.52	$71.18
	Family	$97.70	$26.52	$71.18

Dental Benefits	Option 1	Option 2
Deductible: (Aggregate) Individual / Family	$50 / $150	
Calendar Year Maximum	$1,000	$2,000
Benefits Paid by the Plan		
Preventive - Includes exams, cleanings (2 per year), sealants, x-rays	100%	
Basic - Fillings, periodontic services, minor oral surgery	80%	
Major - Root Canals, periodontic surgery, crowns, dentures, bridges, anesthesia	50%	
Orthodontia Coinsurance / Lifetime Maximum	None	50% to $1,500

Vision Benefits

Your vision plan is provided by **BlueCross BlueShield Tennessee (BCBST)**. When using in-network providers, this PPO plan covers most exams, eyeglass and medically necessary contacts in full. Discounts are available for upgrades on covered frames and lenses as well.

To find an in-network provider or surgery center, call customer service or go to www.bcbst.com.

Monthly Premiums	
Employee Only	$8.00
Employee + Spouse	$15.99
Employee + Child(ren)	$16.80
Employee + Family	$26.39

Should you choose to see an out-of-network provider, BCBST will reimburse you up to a specified amount. Please see the plan document for the out-of-network reimbursement schedule.

Vision Benefits	In-Network	
	Frequency	Details
Vision Exam	Every 12 months	$10 Copay
Prescription Glasses	Every 12 months	$10 Copay
Frames		BCBST will pay $150 retail + 20% off balance over allowance
Lenses		$10 Copay
Contact Lenses (instead of glasses)	Every 12 months	Up to $55 Copay
Elective		BCBST will pay $150 retail + 20% off balance over allowance
Medically Necessary		$10 Copay

Basic and Voluntary Life

Basic Life/AD&D Insurance

At HHM, Basic Life/Accidental Death and Dismemberment (AD&D) Insurance is a provided benefit at no cost to you through **Lincoln Financial Group**.

Basic Life/AD&D	
Coverage Amount	1x annual compensation to a maximum of $15,000
Age Reduction	65

**Benefit will terminate upon retirement.*

Voluntary Life and AD&D Insurance

You have the option to purchase Voluntary Term Life and AD&D through **Guardian**. AD&D Insurance pays an additional percentage of the amount of your life insurance benefit. You may purchase:

Voluntary Life/AD&D			
	Employee	**Spouse**	**Child(ren)**
Coverage Amount	$300,000	50% of employee amount up to $150,000	up to $10,000
Guaranteed Issue Amount	$100,000	$10,000	$10,000

Disability Products

Voluntary Short-Term Disability Insurance

Short-Term Disability (STD) Insurance can help support you and your family should you become temporarily disabled. This coverage is provided by **Lincoln Financial Group** and is paid entirely by you. You may elect benefits up to 60% of your weekly salary ($100 minimum, $2,000 maximum) per week, in $50 increments.

Long-Term Disability Insurance

Long-Term Disability (LTD) Insurance can protect your income in case of a long-term injury or illness. This coverage is provided through **Lincoln Financial Group** and paid entirely by HHM.

Disability Details	Voluntary Short-Term Disability	Long-Term Disability
Income Replacement	60% of weekly earnings	66.67% of monthly earnings
Maximum Benefit	$2,000/week	$5,000/month
Accident Elimination Period	7 days	90 days
Illness Elimination Period	7 days	
Benefit Duration	Up to 13 weeks	Social Security Normal Retirement Age

Other Voluntary Benefits

Guardian

You have the option to enroll in payroll deduction recovery policies through **Guardian**.

- **Cancer Insurance** - Helps with medical expenses like chemotherapy and with non-medical expenses like travel and lodging to help keep life as normal as possible for you and your family.
- **Accident Insurance** - Helps pay for expenses such as ambulances, ICU confinement, rehabilitation and family support when an accident occurs. Cash benefits are paid directly to you (unless you choose otherwise), helping ease the financial stress of your accident.
- **Critical Care & Recovery Insurance** - Helps with the expenses not covered by major medical plans such as ICU confinement, human organ transplants, transportation and lodging, which can help prevent high deductibles and out-of-pocket expenses from derailing your life plans. Cash benefits are paid directly to you (unless otherwise assigned), which can help ease the financial stress of your illness.

Employees interested in payroll deduction for Cancer, Accident, Critical Care & personal recovery policies need to let Human Resources know of their interest. The only time these products can be enrolled in is at Yearly Open Enrollment and within 30 days of employment.

Employee Assistance Program

Lincoln Financial Group's **EmployeeConnect**[SM] employee assistance program offers professional, confidential services to help you and your loved ones improve your quality of life. Confidential help is available 24 hours a day, seven days a week for services including counseling for marital/family, depression, addiction, stress/anger, life transitions or any issue for short term counseling for you or an immediate household family member.

IN-PERSON GUIDANCE	UNLIMITED 24/7 ASSISTANCE	ONLINE RESOURCES
• In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year) • In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings	• Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more • Legal information and referrals for family law, estate planning, consumer and civil law • Financial guidance on household budgeting and short- and long-term planning	• Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNow[SM] mobile app. • You'll find articles and tutorials, videos and interactive tools such as financial calculators, budgeting worksheets and more

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor. For more information about the program, visit GuidanceResources.com, download the GuidanceNow[SM] mobile app or call 1-888-628-4824.

GuidanceResources.com login credentials:
Username: **LFGSupport**
Password: **LFGSupport1**

How to Enroll - Employee Navigator

To enroll in your benefits, log onto https://employeenavigator.com/benefits/Account/Login.

If you already have an account, enter your username and password.

- If you forgot your username or password, you can click - ***Forgot Username?*** Or ***Forgot Password?***

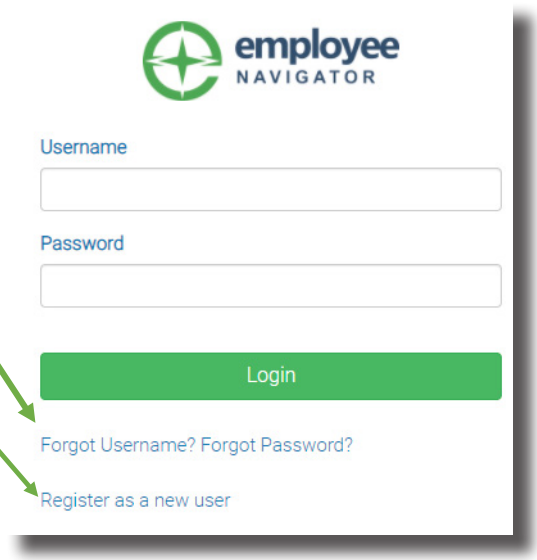
If this is your first time logging in, select ***Register as a new user***. Complete your account by entering the following information:

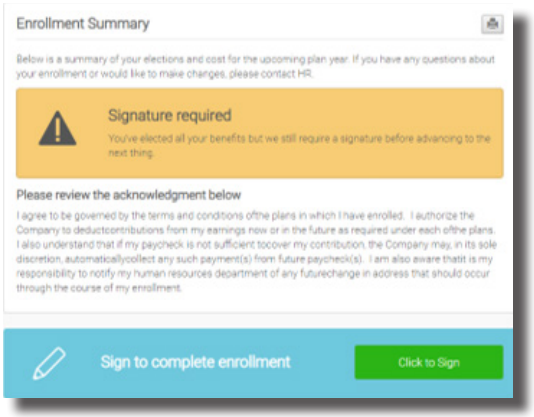
- Company Identifier: HHMCPAS

Next, create your username and password. We recommend using your email address as your username. Your password must be a minimum of 6 characters long and include a number and a symbol. Click ***I agree with terms of use*** and then click ***Next***.

Once you are logged in, complete the system-prompted steps.

In order to submit your benefit elections and beneficiary designations, be sure to select **Click to Sign** on the Enrollment Summary page.





Notes

Annual Notices

SUMMARY OF BENEFIT COVERAGE The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is provided by your Medical carrier. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual open enrollment period, upon plan renewal and upon request at no charge to you.

CONSENT TO RECEIVE ELECTRONIC NOTICES

By participating in Open Enrollment, and providing an email address, I understand and consent that:

1. The following documents and/or notices may be provided to me electronically: **Summary Plan Descriptions; Summaries of Material Modifications; Summary Annual Reports; COBRA Notices; Summary of Benefits and Coverage; Notice of Health Insurance Marketplace Coverage Options; and Other ERISA required or Model Benefit Notices.**
2. I may provide notice of a revised e-mail address or revoke my consent at any time without charge by sending an e-mail or calling the Human Resources/Finance Department.
3. I am entitled to request and obtain a paper copy of any electronically furnished document free of charge by contacting the Human Resources/Finance Department contact.
4. In order to access information provided electronically, I must have a computer with Internet access; an e-mail account that allows me to send and receive e-mails; and Microsoft Word or Adobe Acrobat Reader.

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).

To see if any other states have added a premium assistance program since **July 31, 2025**, 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

Alabama	855-692-5447
Alaska	866-251-4861
Arkansas	855-692-7447
California	916-445-8322
Colorado	800-221-3943
Florida	877-357-3268
Georgia	678-564-1162
Indiana	800-403-0864
Iowa	888-346-9562
Kansas	800-792-4884
Kentucky	855-459-6328
Louisiana	855-618-5488
Maine	800-442-6003
Massachusetts	800-862-4840
Minnesota	800-657-3672
Missouri	573-751-2005
Montana	800-694-3084
Nebraska	855-632-7633
Nevada	800-992-0900
New Hampshire	603-271-5218
New Jersey	800-356-1561
New York	800-541-2831
North Carolina	919-855-4100
North Dakota	844-854-4825
Oklahoma	888-365-3742
Oregon	800-699-9075
Pennsylvania	800-692-7462
Rhode Island	855-697-4347
South Carolina	888-549-0820
South Dakota	888-828-0059
Texas	800-440-0493
Utah	888-222-2542
Vermont	800-250-8427
Virginia	800-432-5924
Washington	800-562-3022
West Virginia	855-699-8447
Wisconsin	800-362-3002
Wyoming	800-251-1269

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

For a listing of State websites, visit: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

For states not listed:
877-543-7669
www.insurekidsnow.gov

OMB Control Number 1210-0137
Expires 1/31/2026

NOTICE OF PATIENT PROTECTIONS

Your medical plan may require the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. Until you make this designation, the medical plan may designate one for you. For information on how to select a PCP, and for a list of the participating providers, contact your carrier.

If you must select a PCP for your child(ren), you may designate a pediatrician as such.

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Introduction. The Consolidated Appropriations Act of 2021 was enacted on December 27, 2020, and contains many provisions to help protect consumers from surprise bills, including the No Surprises Act under title I and Transparency under title II.

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 service. 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 Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

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

HIPAA– PRIVACY ACT LEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN’S HEALTH AND CANCER RIGHTS ACT The Women’s Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract providers.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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

SECTION 111 OF JANUARY 1, 2009 Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including Social Security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine if the Employer plan or Medicare/Medicaid/SCHIP is primary for those employees covered under a government plan and an employer sponsored plan.

THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996 The Newborns’ and Mothers’ Health Protection Act of 1996 provides that 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). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans 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). Please contact us if you would like any additional information on The Newborns’ and Mothers’ Health Protection Act or WHCRA.

MICHELLE’S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC), this law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle’s Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans’ Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38. The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the USERRA. See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country’s uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides employees with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans’ Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans’ Preference.

HIPAA SPECIAL ENROLLMENT

SPECIAL ENROLLMENT NOTICE This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage If you are declining coverage 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 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth, or Adoption If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Medicaid or CHIP If you or your dependents lose eligibility for coverage under Medicaid or the Children’s Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Kelry Mann

1200 Market Street Chattanooga, TN 37402

423-702-7225

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation’s infrastructure, one of which is the “Health Information Technology for Economic and Clinical Health (HITECH) Act.” The HITECH Act supports the concept of meaningful use (MU) of electronic health records (EHR), an effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for

Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

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

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

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to non quantitative treatment limitations (such as medical management standards).

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

WELLNESS PROGRAM Our company's Wellness Program is 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 will be asked to complete a voluntary health risk assessment or "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 other medical examinations.

The above Wellness Program notice is only applicable if your plan administrator or medical plan provides a wellness program.

ADA NOTICE REGARDING WELLNESS PROGRAM

****Only applicable if your plan administrator or medical plan provides a wellness program for which individual medical information is obtained (e.g., through completing a health risk assessment or biometric screening."***

The group may provide 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 personally identifiable information from your HRA and the results from your biometric screening will not be shared with your employer in accordance with HIPAA regulations. It may 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 carrier or wellness vendor 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.

If you are participating in a company sponsored or carrier sponsored wellness program, 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.

HIPAA NOTICE OF PRIVACY PRACTICES

Kelry Mann

1200 Market Street Chattanooga, TN 37402

423-702-7225

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research & comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting plan administrator.
- You can file a complaint with the U.S. Dept. of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation or include it within a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: understanding your rights.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: understanding this notice.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request or in our office.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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.

Plan contact information

Kelry Mann

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423-702-7225

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www.baldwin.com

Important Notice from Our Company About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Our Company has determined that the prescription drug coverage offered by the medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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 employee coverage will not be affected. You can keep this coverage if you elect part D and the Medical Carrier plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not 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 with Our Company 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.

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

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

Date	01/2026
Name of Entity	HHM
Contact	Kelry Mann
Address	1200 Market Street Chattanooga, TN 37402
Phone	423-702-7225

CERTIFIED PUBLIC ACCOUNTANTS