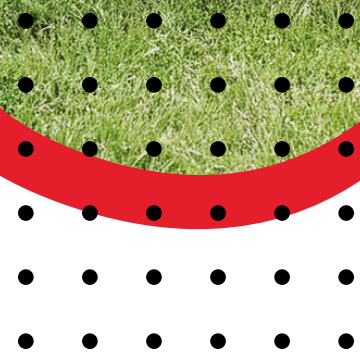




2026

ATLANTIC *Coca-Cola*
BOTTLING COMPANY

Required Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.^{1 2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances,

including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit healthcare.gov/medicaid-chip/getting-medicaid-chip for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description on **Atlantic Bottling SharePoint** or **Atlantic Bottling Microsite** or contact the Atlantic Bottling Company's Benefits Service Center at 515-776-4645. 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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based 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% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of birth, adoption or placement for adoption, you can enroll yourself and your dependents in Atlantic Bottling Company medical coverage as long as you request enrollment by contacting the Atlantic Bottling Company Benefits Center no more than 60 days after the birth, adoption or placement for adoption. Adding a new dependent as a result of marriage must be requested no more than 30 days after the date of marriage. Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

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.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact: Atlantic Bottling Company Benefits Center at 515-776-4645.

NOTICE OF PRIVACY PRACTICES

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Atlantic Bottling Company requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

We are Legally Required to Safeguard Your Protected Health Information

We are required by law to:

- Maintain the privacy of your health information, also known as “protected health information” or “PHI;”
- Provide you with this Notice, comply with this Notice, and if required by law, notify you if we use or disclose any of your PHI in violation of this notice or the privacy laws applicable to the Plans.

Future Changes to Our Practices and This Notice

We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting Atlantic Bottling Company Benefits Service Center at 515-776-4645.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without obtaining your written authorization. This section describes the ways we can use and disclose your protected health information.

Uses and Disclosures for Treatment, Payment and Health Care Operations.

We may use or disclose your PHI for purposes of your treatment. For example, we may **disclose your PHI to physicians, nurses, and other health care professionals who are involved in your care.** We may also use and disclose your PHI to tell you about treatment alternatives or health-related benefits or services that may interest you. In addition, we may provide you with disease management services and we may use and disclose your PHI as necessary for the nurses, pharmacists and other professionals to provide you with these services.

We may also use or disclose your PHI to **provide payment for the treatment you receive** under a Plan. For example, we may use and disclose your PHI to obtain our premiums, to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may also use and disclose your PHI to determine your eligibility or coverage for health benefits, to evaluate medical necessity or the appropriateness of care or charges. In addition, we may use and disclose your PHI as necessary to pre-certify and preauthorize services to you and to review the services provided to you.

We may also use and disclose your PHI to obtain payment under a contract for reinsurance, including stop-loss insurance. We may further use and disclose your PHI to adjudicate your claims. Also, we may disclose your PHI to **other health care providers or entities** who need your PHI in order to obtain or provide payment for your treatment.

In addition, we may use or disclose your PHI **for our health care operations.** For example, we may use your PHI to evaluate the quality of the health care you received from providers in participating networks or preferred providers. We may use or disclose your PHI to conduct audits, for purposes of underwriting and ratemaking, as well as for purposes of risk management. In addition, we may use or disclose your PHI in order to manage our data and information systems. We may use or disclose your PHI to provide you with customer service activities or to develop programs. We may also provide your PHI to our claims administrators, attorneys, accountants and other consultants who assist us in performing our functions and to make sure we are complying with the laws that affect us. In addition, we may disclose your PHI to **other health care providers or entities for certain of their health care operations activities**, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your PHI to these entities if they have or have had a relationship with you and your PHI pertains to that relationship. However, we are prohibited from using genetic information for certain underwriting purposes, such as determining eligibility to enroll in the Plans or determining the amount of premiums to be charged to an individual.

Important Notice from Atlantic Bottling 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 Atlantic Bottling 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. Atlantic Bottling Company has determined that the prescription drug coverage offered by both Wellmark and MedOne 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 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. If you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Atlantic Bottling 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.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **-NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Atlantic Bottling Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.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: January 1, 2026
Name of Entity/Sender: Atlantic Bottling Company
Contact--Position/Office: Haley Fewson
Address: 4 E 2nd Street, Atlantic, IA 50022
Phone Number: 515-412-3131

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. - If you would like more information on WHCRA benefits, -contact your plan administrator Haley Fewson at 515-412-3131 or hfewson@atlanticbottling.com.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the [Frequently Asked Questions \(FAQs\)](#) About the Newborns' and Mothers' Health Protection Act.

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 Balanced Billing For:

Emergency services

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

In certain states, you may also have related state protections:

Visit The Commonwealth Fund website for updated state balance-billing protections at

<https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>.

Applicable state balance billing laws or requirements for noted states are as follows:

ARIZONA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals at in-network facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a dispute resolution process for claims over \$1000, which must be initiated by the enrollee
- Protections do not apply to:
 - ground ambulance services
 - services at out-of-network facilities
 - enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

CALIFORNIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard

- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

COLORADO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals, facilities, and ground ambulance service providers and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care providers
- State provides a payment standard
- Protections do not apply:
 - to enrollees who consent to out-of-network non-emergency services
 - to enrollees of self-funded plans

CONNECTICUT PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
 - ground ambulance services
 - out-of-network facility charges for emergency services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

DELAWARE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for emergency services provided
 - by out-of-network professionals
 - at out-of-network facilities
 - by certain out-of-network ground ambulance service providers
- State prohibits providers from balance billing enrollees for non-emergency services provided at in-network facilities unless they obtain consent from the enrollee
- Above protections apply to:
 - HMO and PPO enrollees
 - For services provided by all or most classes of health care professionals
- State provides a payment standard for emergency services
- State provides the option of arbitration
- Protections do not apply to:
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

FLORIDA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals

- For PPOs, state payment standard applies to (1) emergency services and (2) non-emergency services provided by out-of-network professionals at in-network facilities
- For HMOs, state payment standard only applies to emergency services but the state also has a claim dispute resolution program in place
- Protections do not apply to:
 - ground ambulance services for PPO enrollees
 - PPO enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

GEORGIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard for professionals but not facilities
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

ILLINOIS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by certain specific classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - services received at out-of-network facilities
 - enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

INDIANA PROTECTIONS AVAILABLE

- For HMOs, with respect to emergency services provided by out-of-network professionals and facilities, state (1) requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing; and (2) prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- For HMOs and PPOs, with respect to non-emergency services provided by out-of-network professionals at in-network facilities, state prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing. This prohibition applies to all providers in the state, and therefore might also protect enrollees of self-funded plans.
- Above protections apply to services provided by all or most classes of health care professionals.
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services

IOWA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For emergency services provided by out-of-network professionals and facilities
 - Provided by all or most classes of health care professionals
- Protections do not apply to:

- enrollees of self-funded plans
- non-emergency services

MAINE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For (1) emergency services by out-of-network professionals, facilities and ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of out-of-network health care professionals
- State provides a payment standard
- Protections do not apply to enrollees who consent to out-of-network non-emergency services

MASSACHUSETTS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of out-of-network health care professionals
- Protections do not apply to:
 - ground ambulance services
 - services at out-of-network facilities
 - enrollees who consent to out-of-network services
 - enrollees of self-funded plans

MARYLAND PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To (1) emergency services provided by out-of-network professionals, facilities, and ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all types of out-of-network health care professionals for HMO enrollees
 - Provided by on-call or hospital-based physicians who agree to accept assignment of benefits for PPO enrollees
- State provides a payment standard
- Protections do not apply to enrollees in self-funded plans

MICHIGAN PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of out-of-network health care professionals
- State provides a payment standard
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

MINNESOTA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For non-emergency services provided by out-of-network professionals at in-network facilities

- Provided by all or most classes of out-of-network health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
 - emergency services
 - enrollees of self-funded plans

MISSISSIPPI PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - enrollees of self-funded plans

MISSOURI PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies to:
 - To HMO, PPO, and EPO enrollees
 - For emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - services provided at out-of-network facilities
 - non-emergency services
 - enrollees of self-funded plans

NEBRASKA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network professionals and facilities from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For emergency services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - non-emergency services
 - enrollees of self-funded plans
- State provides a payment standard

NEVADA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply
 - To HMO and PPO enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For emergency services by out-of-network professionals and facilities
 - Provided by all or most classes of health care providers
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - non-emergency services

NEW HAMPSHIRE PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies:
 - To any network-based major medical health insurance product, including HMO, PPO, EPO and POS products
 - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by certain specific classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - services at out-of-network facilities
 - enrollees of self-funded plans

NEW JERSEY PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO, PPO, EPO and POS enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For (1) emergency services provided by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services

NEW MEXICO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to out-of-network non-emergency services
 - enrollees of self-funded plans

NEW YORK PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO, PPO and EPO enrollees.
 - For (1) emergency services provided by out-of-network facilities, professionals, and ground ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to
 - enrollees who consent to non-emergency out-of-network services†
 - enrollees of self-funded plans

NORTH CAROLINA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees

- For emergency services by out-of-network professionals
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - emergency services by out-of-network facilities
 - non-emergency services
 - enrollees of self-funded plans

OHIO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals, facilities, and ground ambulance service providers and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by those classes of health care professionals as defined by regulation
- State provides a payment standard
- State provides a dispute resolution process
- Protections do not apply to:
 - enrollees of self-funded plans
 - enrollees who consent to out-of-network non-emergency services

OREGON PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
 - ground ambulance services
 - services at out-of-network facilities
 - enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

PENNSYLVANIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For emergency services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - out-of-network facility emergency service charges, for PPO enrollees only
 - non-emergency services
 - enrollees of self-funded plans

RHODE ISLAND PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO enrollees
 - For (1) emergency services, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - PPO enrollees
 - ground ambulance services
 - enrollees of self-funded plans

TEXAS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO, PPO, and EPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to out-of-network non-emergency services
 - enrollees of self-funded plans

VERMONT PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For emergency services including ground ambulance services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - out-of-network facility charges for emergency services
 - non-emergency services
 - enrollees of self-funded plans

VIRGINIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency surgical or ancillary services provided by all or most classes of out-of-network professionals at in-network facilities
- State provides a dispute resolution process
- Protections do not apply to ground ambulance services

WASHINGTON STATE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For (1) emergency services provided by all or most classes of health care professionals and out-of-network facilities and (2) non-emergency surgical or ancillary services provided by all or most classes of out-of-network professionals at in-network facilities
- State provides a dispute resolution process
- Protections do not apply to ground ambulance services

WEST VIRGINIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO enrollees
 - For emergency services including ground ambulance services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - out-of-network facility charges for emergency services
 - non-emergency services
 - enrollees of self-funded plans

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, visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act> for more information about your rights under federal law.

Visit <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections> for more information about your rights under your state laws.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myalhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myalhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida	flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html	877-357-3268

Medicaid		
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fce-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPPPROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HHSHIPPPprogram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcnp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	cohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)

South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/ mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

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
dol.gov/agencies/ebsa
866-444-EBSA (3272)

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

Wellness Program Notices

Atlantic Bottling Company's 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 physical exam performed by your doctor. You are not required to complete the physical exam.

However, employees who choose to participate in the wellness program will receive an incentive of a reduction in their medical premium for completing their annual physical. Although you are not required to complete the physical exam, only employees who do so will receive a reduction in their medical premium.

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 Haley Fewson at 515-412-3131/hfewson@atlanticbottling.com.

The information from your physical exam will be used to provide you with information to help you understand your current health and potential risks. 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 Atlantic Bottling Company may use aggregate information it collects to design a program based on identified health risks in the workplace, Atlantic Bottling Company will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in

connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is your doctor, in order to provide you with 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 in employment because of the medical information you provide as part of participating 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 Haley Fewson at 515-412-3131/hfewson@atlanticbottling.com.

Accommodations

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact -Haley Fewson at 515-412 3131/hfewson@atlanticbottling.com and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Patient Protection Notice

Wellmark generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Wellmark designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Wellmark at www.wellmark.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Wellmark BCBS or from any other person (including a primary care provider) 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 Wellmark at www.wellmark.com.



ATLANTIC *Coca-Cola*
BOTTLING COMPANY