ARcare Group Health Plan

Annual Employee Health Plan Notices

2025 Plan Year

IMPORTANT

Provided for information only to Current Employees and New Employees who may become covered under the ARcare Group Health Plan. Not applicable to employees who waive such coverage, or otherwise are not eligible for the ARcare Group Health Plan (e.g., PRN/PT).

No response is necessary.

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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: Benefits Department.

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. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with written notice of the disability determination on a date this is both within 60 days after the date of the determination and before the end of the original 18-month maximum 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. The Plan Administrator must be notified in writing of the second Qualifying Event within 60 days of the second Qualifying Event.

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.

* https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

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.

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

ARcare Group Health Plan
Attn: Dave Ferguson, SVP Group Benefits
117 South 2nd Street, P.O. Box 497
Augusta, AR 72206 (Ph: 870-347-2534)

ARcare

Group Health Plan

Women's Health and Cancer Rights Act of 1998 Annual Notice

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 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 the Plan. Therefore the following deductibles will apply:

	2025 HDHP Option
In-Network	Per Person: $1,650 Per Family: $3,300
Out-of-Network	Per Person: $3,650 Per Family: $7,300

Additionally, these benefits will be covered at the rate of 80% (In-Network) and 60% (Out-of-Network) until the maximum out-of-pocket is reached (HDHP Option $3,650 Per Person/$7,300 Per Family for In-Network, and Unlimited for Out-of-Network). For more information, contact the Benefits Team at (870) 347-2534.

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov

KENTUCKY – Medicaid	NEBRASKA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

OKLAHOMA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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

ARcare

GROUP HEALTH PLAN

INITIAL NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

Our records show that you are eligible to participate in the ARcare Group Health Plan (the "Health Plan"). Federal law requires that we notify you of your right to enroll in the Health Plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this Health Plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. In addition, you may be afforded special enrollment rights if you or your eligible dependent loses coverage under a State Children's Health Insurance Program ("CHIP") or a State Medicaid plan or if you or your eligible dependent becomes eligible for assistance under CHIP or Medicaid with respect to participation in this Health Plan.

Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent (including your spouse) because you and/or your dependents are enrolled in coverage under another group health plan or health insurance, you may have a right to enroll in this Health Plan if the other coverage is terminated as a result of a loss of eligibility (or if the employer stops contributing toward your or your dependents' other coverage). A loss of eligibility may occur as a result of a legal separation, divorce, death, termination of employment or reduction in the number of hours of employment. However, a request for enrollment must be made within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, a request for enrollment must be made within 30 days after the marriage, within 90 days after the birth, within 60 days after the adoption (or placement for adoption), respectively.

Medicaid or CHIP. If you decline enrollment for yourself or for an eligible dependent because of health insurance coverage under a state Medicaid or CHIP plan, there may be a right to enroll in this Health Plan if your or your dependent's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility for such coverage. In addition, there may be a right to enroll in this Health Plan if you or your eligible dependent becomes eligible for assistance under a state Medicaid or CHIP plan with respect to participation in this Health Plan. However, a request for enrollment must be made within 60 days after your or your dependents' coverage terminates or within 60 days after you or your dependent become eligible for such assistance, whichever is applicable.

To request special enrollment or to obtain more information about the Health Plan's special enrollment provisions, contact the Benefits Team at 117 South 2nd; P.O. Box 497, Augusta, AR 72206, (870) 347-2534.

ARcare GROUP HEALTH PLAN
HIPAA PRIVACY NOTICE

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

This HIPAA Privacy Notice ("Notice") describes the obligations of the ARcare Group Health Plan (the "Plan") regarding the privacy of your Protected Health Information held by the Plan pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). This Notice describes how your Protected Health Information may be used or disclosed as permitted under HIPAA or as required by law and to inform you of your privacy rights with respect to your Protected Health Information.

If you have any questions about this notice, please contact the Privacy Officer c/o Benefits Team at ARcare, 117 South 2nd; P.O. Box 497, Augusta, AR 72206, (870) 347-2534.

PROTECTED HEALTH INFORMATION

The HIPAA Privacy Rule protects only certain medical information known as "protected health information ("PHI")." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received from a health care provider, a health care clearinghouse, a health plan, or the Employer on behalf of a group health plan that relates to:

(1) your past, present, or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present, or future payment for the provision of health care to you.

Genetic information is considered PHI for purposes of these rules and federal law specifically prohibits the use or disclosure of your genetic information for underwriting purposes.

REQUIREMENTS UNDER HIPAA

We are required by law to:

- Make sure your PHI is kept private;
- Provide you with certain rights with respect to your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we may use and disclose your PHI without your authorization. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we may disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

- **For Payment.** We may use or disclose your PHI to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share PHI with a utilization review or pre-certification service provider. Likewise, we may share PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

- **To Business Associates**. We may contract with individuals or entities known as Business Associates to perform various functions on behalf of the Plan or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use and/or disclose your PHI, but only after the Business Associates agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

- **For Health Care Operations.** We may use and disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use PHI in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

- **Treatment Alternatives or Health Related Benefits and Services**. We may use and disclose your PHI to send you information about treatment alternatives or other health related benefits and services that might be of interest to you.

- **As Required By Law.** We will disclose PHI about you when required to do so by federal, state or local law. For example, we may disclose PHI when required by national security laws or public health disclosure laws.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose PHI about you in a proceeding regarding the licensure of a physician.

- **To Plan Sponsors.** For the purpose of administering the Plan, disclosure of PHI to certain employees of ARcare may be necessary. However, those employees will only use or disclose that information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS:

- **Disclosure to Health Plan Sponsor.** PHI may be disclosed to another health plan maintained by ARcare for purposes

of facilitating claims payments under that plan.

- **Military and Veterans.** If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** PHI may be released for workers' compensation or similar programs but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** As required by law, PHI may be disclosed for public health actions. These actions generally include the following:
  - to prevent or control disease, injury, or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

- **Health Oversight Activities.** PHI may be disclosed to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

- **Law Enforcement.** PHI may be released if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement; about a death that is believed to be the result of criminal conduct; about criminal conduct at ARcare, and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** PHI may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI about Participants of the Plan to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** PHI may be released about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** PHI may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **Organ and Tissue Donation.** If you are an organ donor, we may release your PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Research.** PHI may be disclosed to researchers when (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board (i) has reviewed the research proposal, and (ii) establishes protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES:

We are required to make the following disclosures of your PHI.

- **Governmental Audits.** Disclosure of PHI is required to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with HIPAA Privacy Rule.

- **Disclosures to Covered Persons.** If you make a request to the Plan, we are required to disclose the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI where the disclosure was for reasons other than for payment, treatment or health care operations, and where the PHI was not disclosed pursuant to your individual authorization.

OTHER DISCLOSURES:

- **Personal Representatives**. We may disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide a written authorization and any supporting documents (i.e., power of attorney) specifically authorizing the disclosure of such PHI to such personal representative. Under the HIPAA Privacy Rule, we do not have to disclose information to a personal representative if we have a reasonable belief that (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

- **Spouses and Other Family Members.** In most cases, Plan communications will be mailed directly to the employee, including mail relating to an employee's spouse or children who may be covered under the Plan. The Plan communications sent to the employee may include information relating to the receipt or denial of Plan benefits by the employee's spouse or children. However, if we receive (and agree to) a Request for Restriction or Confidential Communications, we will send the Plan communications as provided in the Request for Restriction or Confidential Communications. For more information regarding a Request for Restriction or Confidential Communications see the section titled "YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU" below.

DISCLOSURES REQUIRING AUTHORIZATION:

We may use or disclose your PHI in the following circumstances only upon receiving a valid authorization from you:

- **Psychotherapy Notes**. Except as otherwise permitted by law any PHI which includes psychotherapy notes may be used or disclosed only if you provide a valid authorization permitting such use or disclosure.

- **Marketing**. We may use or disclose your PHI for marketing purposes (including subsidized treatment communications) only if you provide a valid written authorization permitting such use or disclosure. However, a valid authorization is not required if the marketing activities are in the form of (1) face-to-face communications or (2) a promotional gift of nominal value.

- **Sales**. Your valid authorization is required for any use or disclosure of your PHI which would constitute a sale of PHI within the meaning of 45 CFR 164.501.

Other uses and disclosures of PHI not covered by this notice or as required by law will be made only with your written authorization. If you provide us with authorization to use or disclose PHI, you may revoke that authorization, at any time as long as the revocation is in writing. Upon receiving the written revocation, we will no longer use or disclose such PHI for the reasons covered pursuant to the written authorization. However, we are unable to take back any disclosures already made with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding your PHI maintained by the Plan:

- **Right to Inspect and Copy.** You have the right to inspect and copy PHI that may be used by ARcare to make decisions about your group health coverage. Usually, this includes medical and billing records. If the Plan maintains an electronic record of your PHI, you have the right to request the receipt of that information in the electronic form and format that you request, if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on the form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to ARcare, 117 South 2nd; P.O. Box 497, Augusta, AR 72206; Attention: Privacy Officer c/o Benefits Team.

  If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You may also ask for the PHI to be sent to a third party. Your request must be in writing and signed and clearly identify the third party who will receive the information. Generally, we will respond to your request within 30 days after we receive it; if we need more time, we will notify you within the original 30-day period.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI you may request that the denial be reviewed by submitting a written request to ARcare, 117 South 2nd; P.O. Box 497, Augusta, AR 72206; Attention: Privacy Officer c/o Benefits Team. Another individual chosen by ARcare will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

  To request an amendment, your request must be made in writing and submitted to ARcare, 117 South 2nd; P.O. Box 497, Augusta, AR 72206, Attention: Privacy Officer c/o Benefits Team. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the request may be denied if it is to amend information that:

- Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Plan;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

We will respond to the request for an amendment within 60 days after receiving the request unless we notify you, in writing, that a 30 day extension is necessary to complete the response. If the request is denied, you have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed information will include such statement.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures the Plan has made of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permitted disclosures about you. However, to the extent that we use or maintain an Electronic Health Record of your PHI, you may request an accounting of disclosures made to carry out treatment, payment or health care operations but only with regard to disclosures made within three years prior to the date on which the accounting is requested.

  To request this list or accounting of disclosures, you must submit your request in writing to ARcare, 117 South 2nd; P.O. Box 497, Augusta, AR 72206, Attention: Privacy Officer c/o Benefits Team. Your request must state the time period you want the accounting to cover, which may not be longer than six (6) years before the date of your request. The request should indicate in what form to provide the list (for example, on paper, electronically). Generally we will respond to your request within 60 days. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on your PHI that the Plan uses or discloses for treatment, payment or health care operations. You also have the right to request a limit on your PHI disclosed to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you received.

  We are not required to agree to your request. However, we will comply with a request for restriction if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment) and (2) the PHI pertains to a health care item or service for which the health care provider was paid in by you or another person. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing to ARcare, 117 South 2nd; P.O. Box 497, Augusta, AR 72206, Attention: Privacy Officer c/o Benefits Team. In your request, you must state (1) what information to limit; (2) whether to limit the use, disclosure or both; and (3) to whom the limits should apply, for example, disclosures to your spouse. You will be provided a written response detailing whether ARcare agrees to or rejects the proposed restriction.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, the request must be in writing to ARcare, 117 South 2nd; P.O. Box 497, Augusta, AR 72206, Attention: Privacy Officer c/o Benefits Team. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to be Notified of a Breach**. You have a right to be notified in the event that we or any of our Business Associates discover a breach of your unsecured protected health information.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  To obtain a paper copy of this notice, please contact ARcare – Benefits Team.

CHANGES TO THIS NOTICE:

This notice may be changed at any time and may include new provisions regarding your PHI maintained by the Plan, as allowed or required by law. If any material change is made to this notice, you will be provided with a copy of the revised notice via intranet posting or by mail to your last known address on file.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with ARcare or with the Office of Civil Rights of the United States Department of Health and Human Services. To file a complaint with ARcare, contact the Privacy Officer at ARcare, 117 South 2nd; P.O. Box 497, Augusta, AR 72206, Attention: Privacy Officer c/o Benefits Team. All complaints must be submitted in writing.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office of Civil Rights or with us.

Notice of Marketplace Coverage Options

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2024 for coverage starting January 1, 2025.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.02% of your household income for the 2025 year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the ARcare Benefits Team at 117 South 2nd; P.O. Box 497, Augusta, AR 72206.

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 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name ARcare Infinity Care Solutions	4. Employer Identification Number (EIN) 58-1666179 30-0726057
5. Employer address, 7. City, 8. State, 9. Zip Code 117 South 2nd; P.O. Box 497, Augusta, AR 72206	6. Employer phone number (870) 347-2534
10. Who can we contact about employee health coverage at this job? Dave Ferguson, SVP Group Benefits	
11. Phone number (if different from above) (870) 347-2534	12. Email address david.ferguson@arcare.net

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are: Employees that work 30 hours a week or more.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are: Biological children, stepchildren, adopted children, or children whom you have legal custody. Disabled children age 26 or older who meet certain criteria may continue on your health coverage.
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Important Notice from ARcare
About
Your Prescription Drug Coverage and Medicare
For the
ARcare Group Health Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ARcare 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. ARcare has determined that the prescription drug coverage offered by the ARcare Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through 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 ARcare prescription drug coverage will not be affected. In other words, you may keep your ARcare prescription drug coverage if you elect Part D coverage and the ARcare Group Health Plan will coordinate with the Part D coverage.

A summary of the ARcare prescription drug coverage is as follows:

2025 Prescription Drug - Retail	2025 Prescription Drug - Mail Order
In-Network Pharmacy - Retail 20% coinsurance after deductible Deductible: $1,650 per person $3,300 per family Out-of-Pocket Maximum $3,650 per person $7,300 per family	**In-Network Pharmacy - Retail** 20% coinsurance after deductible Deductible: $1,650 per person $3,300 per family Out-of-Pocket Maximum $3,650 per person $7,300 per family

If you do decide to join a Medicare drug plan and drop your current ARcare coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment (refer to the Summary Plan Description for rules regarding special enrollment rights). Also, keep in mind that ARcare prescription drug coverage is not available separately from the health coverage offered under the ARcare Group Health Plan. Therefore, you cannot drop your ARcare prescription drug coverage without also dropping your ARcare health coverage.

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 a ARcare 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 ARcare 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:	October, 2024
Name of Sender:	ARcare
Contact Office:	Dave Ferguson, SVP Group Benefits
Address:	117 South 2nd; P.O. Box 497, Augusta, AR 72206
Phone Number:	(870) 347-2534

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. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact a BlueAdvantage customer representative by calling the number on your ID card or the federal phone number for information and complaints is: 800-985-3059.

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