

# Claiborne Farm, LLC

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Effective Date: August 29, 2025

Employee & Eligible Beneficiaries,

As an employee of Claiborne Farm and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact Dawn Snedegar.

**For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.**

## IMPORTANT INFORMATION

### **MEDICARE PART D NOTICE (Creditable)**

**Medical Plan:** Anthem Buy-Up, Core, and Base Plans

### **About Your Prescription Drug Coverage and Medicare**

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. Claiborne Farm has determined the prescription drug coverage offered by this 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 to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

Visit <http://www.cms.hhs.gov/CreditableCoverage/> which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

**Note:** In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

### **When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?**

You should also know if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 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 in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

### **For more information about your options under Medicare prescription drug coverage...**

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

**For more information about Medicare prescription drug coverage:** Visit [www.Medicare.gov](http://www.Medicare.gov) or 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 800-MEDICARE (800-633-4227). TTY users should call (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](http://www.socialsecurity.gov) or call (800) 772-1213 (TTY 1-800-325-0778).

**Remember** to 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).

## **NOTIFICATIONS**

### **HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE OF PRIVACY PRACTICES 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 Notice of Privacy Practices ("Notice") describes the legal obligations of *Claiborne Farm's GROUP HEALTH PLAN* (the "Health Plan") and your legal rights regarding certain health information, called protected health information, held by the Health Plan under the Health Insurance Portability and

Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and the corresponding regulations (collectively referred to as "HIPAA"). The Health Plan is sponsored by *Claiborne Farm* (Employer Name).

### **Contact Person**

If you have any questions about this Notice or about the Health Plan's privacy practices, or wish to exercise any of your privacy rights, please contact *Dawn Snedegar*.

### **How the Health Plan Uses and Discloses Protected Health Information**

Under HIPAA, the Health Plan may use or disclose protected health information under certain circumstances without your permission, provided that the legal requirements applicable to the use or disclosure are followed. The following categories describe the different ways that the Health Plan may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways the Health Plan is permitted to use and disclose information will fall within one of the categories. Most of the time, the Health Plan will use, disclose, and request only the minimum information necessary for these purposes.

**For Treatment.** The Health Plan may use or disclose protected health information to facilitate medical treatment or services by health providers. The Health Plan may disclose health information about you to health care providers, including doctors, nurses, technicians, or hospital personnel who need the information to take care of you. For example, the Health Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription conflicts with your current prescriptions.

**For Payment.** The Health Plan may use or disclose protected health information to make payments to health care providers who are taking care of you. The Health Plan may also use and disclose protected health information to determine your eligibility for Health Plan benefits, to evaluate the Health Plan's benefit responsibility, and to coordinate Health Plan coverage with other coverage you may have. For example, the Health Plan may share information with health care providers to determine whether the Health Plan will cover a particular treatment. The Health Plan may also share your protected health information with another organization to assist with financial recoveries from responsible third parties.

**For Health Care Operations.** The Health Plan may use and disclose protected health information to run the Health Plan. For example, the Health Plan may use protected health information in connection with quality assessment and improvement activities; care coordination and case management; underwriting, premium rating, and other activities relating to Health 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 Health Plan administrative activities. However, the Health Plan will not use genetic information for underwriting purposes.

**To Business Associates.** The Health Plan may contract with third parties, known as "Business Associates," to perform various functions or provide various services on behalf of the Health Plan. To perform these functions or to provide these services, Business Associates may receive, create, maintain,

transmit, use, and disclose protected health information, but only after they agree in writing to safeguard protected health information and respect your HIPAA rights. For example, the Health Plan may disclose protected health information to a third-party administrator to process claims for Health Plan benefits. As Required by Law. The Health Plan will disclose protected health information when required to do so by federal, state, or local law.

**To Prevent a Serious Threat to Health or Safety.** The Health Plan may use and disclose protected health information 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.

**To the Employer.** The Health Plan may disclose protected health information to certain employees of the Employer who are involved with Health Plan administration. These employees are permitted to use or disclose protected health information only to perform plan administration functions or as otherwise permitted or required by HIPAA, unless you have authorized further disclosures. Protected health information cannot be used for employment purposes without your specific authorization.

**Workers' Compensation.** The Health Plan may disclose protected health information 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.** The Health Plan may disclose protected health information for public health activities, including, for example, to prevent or control disease, injury, or disability; or to report child abuse or neglect.

**Health Oversight.** The Health Plan may disclose protected health information to a health oversight agency for activities authorized by law, including, 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.** The Health Plan may disclose protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process.

**Law Enforcement.** The Health Plan may disclose protected health information if asked to do so by a law-enforcement official in certain limited circumstances.

**Family Members.** The Health Plan may disclose protected health information to a family member or close personal friend who is involved in your care or payment for your care or for notification purposes. Generally, you will have an opportunity to object to these disclosures. With only limited exceptions, all mail regarding the Health Plan will be sent to the employee unless we have agreed otherwise. This includes mail relating to participation of the employee's spouse and other family members in the Health Plan, such as availability of Health Plan benefits and information on the processing of any Health Plan benefits (including explanations of benefits (EOBs)).

Coroners, Medical Examiners, and Funeral Directors. The Health Plan may disclose protected health information to a coroner, medical examiner, or funeral director, as necessary for them to carry out their duties.

National Security and Intelligence Activities. The Health Plan may disclose protected health information to authorized federal officials for national security activities authorized by law.

Military. The Health Plan may disclose protected health information as required by military and veterans authorities if you are or were a member of the uniformed services.

Research. In very limited situations, the Health Plan may disclose protected health information to researchers; however, usually we will need to get your authorization.

Compliance With HIPAA. The Health Plan is required to disclose protected health information to the United States Department of Health and Human Services when requested to determine compliance with HIPAA.

Authorizations. Other uses or disclosures of protected health information not described above will be made only with your written authorization. For example, the Health Plan generally needs your authorization to disclose psychiatric notes about you; to use or disclose protected health information for marketing; or to sell protected health information. You may revoke your authorizations at any time, so long as the revocation is in writing. However, the revocation will not be effective for any uses or disclosures made in reliance upon the authorization.

## **Your Rights**

You have the rights described below with respect to protected health information about you, subject to certain conditions and exceptions. You can get more information by connecting with the Contact Person identified on the first page of the Notice.

**Right to Have Personal Representative Act on Your Behalf.** You have the right to designate one or more persons to act on your behalf as your personal representative. A personal representative is someone who, under applicable law, is authorized to make decisions related to your health care. The Health Plan may require the personal representative to provide documentation of their authority to make health care decisions on your behalf. For example, the Health Plan may ask to see a health care power of attorney.

**Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your Health Plan benefits. The Health Plan will work with you to provide the requested information in the form and format you requested; a mutually agreeable alternative form and format; or another form and format permitted by law. You must submit your request to inspect or copy protected health information in writing to the Contact Person. If you request a copy of the information, then the Health Plan may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Health Plan may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, then your review rights will be explained to you.

**Right to Amend.** If you believe that protected health information the Health Plan has about you is incorrect or incomplete, then you may ask to amend the information. You have the right to request an

amendment for as long as the information is kept by or for the Health Plan. To request an amendment, your request must be made in writing and submitted to *Dawn Snedegar*. In addition, you must provide a reason that supports your request. If the Health Plan denies your request, you will receive an explanation, and you will have the right to file a statement of disagreement. The Health Plan may include a rebuttal statement, and any future disclosures of the disputed information will include your statement and the Health Plan's rebuttal.

**Right to an Accounting of Disclosures.** You have the right to request a list (i.e., an "accounting") of certain times the Health Plan has shared protected health information about you with others. You must submit your request in writing to *Dawn Snedegar* stating the time period you want the accounting to cover, which may not be longer than six years before the date of the request. The first accounting you request within a 12-month period will be provided free of charge. For additional accountings within the same 12-month period, the Health Plan may charge you for the costs of providing the accounting. The Health Plan 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 how the Health Plan uses and discloses protected health information about you for treatment, payment, or health care operations. You also have the right to request a limit on protected health information that the Health Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Health Plan generally is not required to agree to your request. However, if the Health Plan agrees to the request, the Health Plan will honor the restriction until you revoke it or the Health Plan notifies you. To request restrictions, you must make your request in writing to *Dawn Snedegar*. You must identify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that the Health Plan communicate with you in a certain way or at a certain location, such as only sending communications by U.S. mail or only leaving voicemail messages. To request confidential communications, you must make your request in writing to *Dawn Snedegar*. The Health Plan will not ask you the reason for your request. Your request must specify how or where you wish to communicate, and the Health Plan will accommodate all reasonable requests.

## **The Health Plan's Responsibilities**

HIPAA requires the Health Plan to:

- maintain the privacy of protected health information;
- provide you with a copy of this Notice;
- follow the terms of the Notice that is currently in effect; and
- notify affected individuals following a breach of unsecured protected health information.

The Health Plan reserves the right to change the terms of this Notice and to make new provisions effective for all protected health information that the Health Plan maintains, including protected health information created or received prior to any revision. If significant changes are made to this Notice, then the Health Plan will furnish you with a copy of the revised Notice.

## **Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with the Health Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Health Plan, contact *Dawn Snedegar*. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint.

### **SPECIAL ENROLLMENT NOTICE**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

### **USERRA**

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

### **Reemployment Rights**

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

### **Right to Be Free From Discrimination and Retaliation**

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment

because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

### **Health Insurance Protection**

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

### **Enforcement**

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at <http://www.dol.gov/vets>**. An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra/>. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

### **GINA**

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

### **Michelle's Law**

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

### **QMCSO (Qualified Medical Child Support Order)**

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

### **WHCRA**

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and

- Treatment of physical complications of the mastectomy, including lymphedemas.

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). 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, call your plan administrator at the number listed above.

## **NMHPA**

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit [http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpfa\\_factsheet.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpfa_factsheet.html).

## **RESCISSIONS**

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

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

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

as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

## **PREVENTIVE CARE**

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

**Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.**

## **WOMEN'S PREVENTIVE HEALTH SERVICES**

All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network through ABC

CARRIER:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

**Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.**

## **HEALTH AND WELLNESS PROGRAM**

Claiborne Farm and Anthem provides a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions

(e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which could include a blood test for blood related conditions such as diabetes. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. Please speak with Dawn Snedegar for specific details regarding incentives, participation requirements or to request reasonable accommodations or alternative standards.

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

## **PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION**

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) authorized health coaches, nurses or providers 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 Dawn Snedegar.

### **FMLA**

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor [FMLA page](#).

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

### **MHPA/MHPAEA**

Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

### **COBRA NOTICE**

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For 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 coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., \$2,550 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health

Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- 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 Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

**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), employees must notify the Plan Administrator within 60 days after the qualifying event occurs.**

### **How is COBRA Coverage Provided?**

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **Are there other coverage options besides COBRA Continuation Coverage?**

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

### **Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

### **If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. 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](http://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](http://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.

### **Extension of Certain Timeframes due to the COVID-19 Emergency**

On February 26, 2021, the US Department of Labor announced that, due to the ongoing national emergency caused by the COVID-19 outbreak, certain timeframes required under ERISA and the IRS that were previously extended pursuant to the “Extension of Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak” and Notice 2020-01, were further extended. These dates were further clarified by IRS Guidance 2021-58 in October 2021. Specifically, applicable deadlines that fall within the Outbreak Period are extended until the earlier of: (i) the one-year anniversary of the otherwise applicable deadline, or (ii) sixty (60) days after the announced end of the COVID-19 National Emergency. This applies to deadlines applicable to individuals participating in the plan, as well as deadlines applicable to the plan and plan administrators. The deadline extension period is determined on an individual-by-individual or case-by-case basis.

The actual date the compliance timeframe resumes will depend on the date the National Emergency is declared to be over by the Federal Government.

The timeframes for the following plan conditions are extended by this Final Rule:

- HIPAA Special Enrollment Periods (“COBRA Qualifying Events”)
- COBRA Election periods
- The date for making COBRA premium payments
- The date for qualified beneficiaries to notify the COBRA administrator of a qualifying event or a determination of disability
- The date for filing a benefits claim
- The date for filing an appeal of an adverse benefit determination
- The date for requesting an external review of an adverse benefit determination
- The date for filing a corrected request for external review, in the event the initial request was incomplete.

## YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

#### **Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most 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 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 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 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.
- 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,** contact 1-800-985-3059 the federal phone number for information and complaints.

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