Pushpay

Resi

Benefits Guide

January 1, 2024 – December 31, 2024

MarshMcLennan Agency

Table of Contents

Eligibility

Eligible Employees:
You may enroll in the benefits described in this benefits guide if you are an employee working at least 30 hours per week.

Eligible Dependents:
If you are eligible for medical, dental, and vision benefits, then your dependents are too. In general, eligible dependents include your spouse, domestic partner, and children up to age 26.

The Pushpay benefits plan follows the definition of domestic partnership provided by Washington State law. Domestic partnerships are defined as same-sex couples over the age of 18 and heterosexual couples in which one partner is over the age of 62. Eligible couples must also share a common residence.

When Coverage Begins:
Benefits may begin on the first of the month following or coinciding with your date of hire, and upon completion of enrollment.

Eligible Status Changes:
An eligible status change is a change that may impact your eligibility or dependent's eligibility for benefits.
Examples of some eligible status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs and if you would like to add or drop coverage for yourself or a dependent, you must make the changes to your benefits within 30 days of the event date. Documentation will be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change.

Medical Plans - Cigna

Pushpay offers two (2) medical plans through Cigna and both utilize the Cigna Open Access Plus network. You may locate in-network providers in your area by visiting www.mycigna.com.

- The Copay Plan has set copay amounts for services such as office visits and prescriptions, while the deductible and coinsurance apply for procedures such surgeries, hospital stays, and complex imaging (MRI, CT scan).

- The HDHP requires you to meet your deductible for any non-preventive care before the plan starts to pay. The HDHP is paired with a Health Savings Account (HSA) and a generous contribution from Pushpay to help you pay for out-of-pocket healthcare expenses. You also have the opportunity to contribute to your HSA and lower your taxable income (see page 7 for more details on the HSA).

	Cigna			
	Open Access Plus Network			
	Copay Plan		HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Individual	$750	$1,500	$2,000	$4,000
Family	$1,500	$3,000	$4,000	$8,000
Coinsurance	Plan Pays: 80% | You Pay: 20%	Plan Pays: 50% | You Pay: 50%	Plan Pays: 80% | You Pay: 20%	Plan Pays: 50% | You Pay: 50%
Calendar Year Out-of-Pocket Maximum				
Individual	$2,500	$5,000	$4,000	$8,000
Family	$5,000	$10,000	$8,000	$16,000
Physician Office Visit *(Includes Telehealth Visits with your Provider)*				
Primary Care	$30 copay	50%	80%	50%
Specialty Care	$30 copay	50%	80%	50%
Preventive Care				
Annual Exams & Screenings	100%	Not Covered	100%	Not Covered
Diagnostic Services				
Outpatient X-ray and Lab Tests	80%	50%	80%	50%
Imaging (MRI, CT, PET)	80%	50%	80%	50%
Urgent Care Facility	$30 copay	50%	80%	50%
ER Facility	80%	80%	80%	80%
Inpatient Hospital	80%	50%	80%	50%
Outpatient Facility/Surgical	80%	50%	80%	50%
Mental Health & Substance Use Disorder				
Inpatient	80%	50%	80%	50%
Outpatient	100%	50%	80%	50%
Other Services				
Chiropractic/Acupuncture *Limited to 25 visits PCY*	$30 copay	50%	80%	50%
Outpatient Rehab Therapy *Limited to 45 visits PCY*	$30 copay	50%	80%	50%
Retail Pharmacy (30-Day Supply)				
Tier 1 - Generic Drugs	$10 copay	Not Covered	80%	Not Covered
Tier 2 - Pref Brand Drugs	$35 copay	Not Covered	80%	Not Covered
Tier 3 - Non-Pref Brand Drugs	$70 copay	Not Covered	80%	Not Covered
Mail Order Pharmacy (90-Day Supply; Specialty: 30-Day Supply)				
Tier 1 - Generic Drugs	$25 copay	Not Covered	80%	Not Covered
Tier 2 - Pref Brand Drugs	$88 copay	Not Covered	80%	Not Covered
Tier 3 - Non-Pref Brand Drugs	$175 copay	Not Covered	80%	Not Covered

Cigna Information

myCigna - On myCigna.com and through the myCigna app, you can:

- Find in-network doctors and medical services
- Review coverage
- Manage and track claims
- View, print, or fax your ID card
- See cost estimates for medical procedures and prescription drugs
- Compare quality-of-care information
- Compare prescription costs for 30-and 90-day medications and see if a lower-cost drug alternative is available
- Find retail pharmacies that offers a 90-day supply
- Access a variety of health and wellness tools and resources

- **Cigna One Guide**: Combining digital technology with our personalized customer service, your Cigna One Guide team is here to help you resolve health care issues, save time and money, get the most out of your plan, find the right hospitals, doctors, and other healthcare providers in your plan's network, get cost estimates, understand your bills, and navigate the healthcare system. To access, please call the number on your Cigna ID card or access the Cigna One Guide support tool by downloading the myCigna App.
- **Health Information Line:** Speak with a clinician who can help you understand and make informed decisions about health issues you are experiencing at no extra cost. Just call the number on your Cigna ID card anytime day or night.
- **Active & Fit Direct:** As a Cigna customer, through the Cigna Healthy Rewards® program, you have access to the Active&Fit Direct℠ program, which offers fitness center memberships to 8,000+ fitness centers nationwide for $25 a month (plus a $25 enrollment fee). Please visit https://www.activeandfitdirect.com/contactus if you need assistance or more information about this program.

Primary Care
MDLIVE allows you and your covered family members to get medical care from the comfort and safety of home via video or phone. You can connect 34/7 with an MDLIVE provider on www.mycigna.com
Behavioral Health Tools & Programs
Talkspace allows you to receive care for mental health therapy via text, voice, or video calls. Please visit www.talkspace.com/covered to get started.
iPrevail is a digital therapeutics program designed by experienced health care providers to help you take control of the stresses of everyday life. It is loaded with interactive video lessons and one-on-one coaching to help with depression and anxiety. Please visit www.mycigna.com to access.
happify is a self-directed app with activities, science-based games, and guided meditations. These are designed to help you reduce stress and anxiety, gain confidence, defeat negative thoughts, and boost overall health and performance. Please visit www.happify.com/cigna to access.
Ginger offers confidential mental healthcare through behavioral health coaching via text-based chats, self-guided learning activities and content, and video-based therapy and psychiatry. Learning activities and content, and video-based therapy and psychiatry. Support is available anytime, anywhere, for a variety of mental health challenges you may be struggling with – all from the privacy of your smartphone. Please download the Ginger Emotional Support app to get started. Once you have downloaded the app, make sure you enter your health plan information to verify your eligibility. If you are having trouble, you can email help@ginger.com for help.

Savings and Spending Accounts – Navia Benefit Solutions

The Health Savings Account

Employees participating in the High Deductible Health Plan (HDHP) are eligible for a tax-advantaged Health Savings Account (HSA) provided by Navia Benefit Solutions. The HSA is used with a debit card to pay for eligible health care expenses, or it reimburses you for eligible expenses paid out of pocket and can also be used as a retirement savings vehicle by investing and growing you contributions to assist with medical expenses in retirement. Money in the HSA is yours to use on eligible expenses and will follow you should you leave Pushpay.

Tax Advantages

1. Contributions to the HSA are deducted pre-tax and reduce your taxable income
2. Money spent out of the HSA for eligible health-related expenses is not taxed
3. HSAs earn tax-free interest. Amounts over $2,000 can be invested and accrue tax-free earnings.

Eligibility

HSAs are only available to Employees enrolled in the HDHP plan. You cannot have any other medical coverage, including Medicare. You must be a U.S. Resident, cannot be eligible to be claimed as someone else's tax dependent, and cannot participate in a Health Care Flexible Spending Account.

Contributions and Annual Limits

HSA Contribution From Employer - Monthly	
Employee Only	$62.50
Employee + Spouse	$125.00
Employee + Child(ren)	$125.00
Employee + Family	$125.00

2024 HSA Annual Maximums	
Individual	$4,150
Family	$8,300

The Flexible Spending Accounts

The HCFSA (Health Care Flexible Spending Account) plan with Navia Benefit Solutions are a financial tool for spending pre-tax dollars on eligible health care or dependent care.

How FSAs Work

Choose a contribution amount based on how much you plan to spend during the year on eligible healthcare or dependent care. Equal amounts will be deducted from your pre-tax income each pay period and deposited into your FSA. If you have a HCFSA, these funds will be loaded onto your card January 1. You may use your FSA Debit Card to pay providers for eligible expenses, or pay out of pocket and request reimbursement. FSAs are required to be used for their intended purpose, a Health Care FSA must be used for eligible health care expenses while limited purpose FSAs must only be used for Dental and Vision. A dependent care FSA would only be used for eligible dependent care expenses. You cannot claim a tax deduction for an FSA and you may not use an FSA to reimburse expenses where you have an income tax deduction or credit. You may not participate in an HDHP with an HSA if you are enrolled in an FSA.

2024 FSA Maximums	
Healthcare FSA	$3,200
Limited Purpose FSA	$3,200
Dependent Care FSA	$5,000

Dental Insurance – Delta Dental of Washington

Pushpay offers a dental plan through Delta Dental of Washington. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Please note that services received from a Delta Dental PPO Dentist will be covered at a higher level than services provided by Premier or Non-Participating Dentists. If you need to find a PPO dentist, you may go to www.deltadentalwa.com or call (800) 554-1907.

	Delta Dental of Washington Dental Plan	
	Delta Dental PPO Dentists	**Delta Dental Premier & Non-Participating Dentists (MAC* Reimbursement)**
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Waived for Preventive Care	Yes	Yes
Calendar Year Maximum		
Per Person	$1,500	$1,500
Preventive/Diagnostic	100%	100%
Basic/Restorative	90%	80%
Major	50%	50%
Orthodontia – Adults & Children		
Benefit Percentage	50%	50%
Lifetime Maximum	$1,500	$1,500

***MAC:** Maximum Allowable Charges. Delta Dental's payments will be based on actual charges or Delta's maximum allowable fees for non-participating dentists, whichever is less.

PPO vs. Premier vs. Non-Participating – What's the Difference?

You are encouraged to visit a Delta Dental network dentist because they can provide services at discounted rates and file all claims paperwork for you. Delta Dental will pay their portion and you are only responsible for your stated deductibles, coinsurance and/or amounts in excess of the plan maximums. In most cases, you will experience the greatest out-of-pocket savings if you choose a dentist from the Delta Dental PPO network.

If you choose a non-participating dentist, you will be responsible to have the dentist complete your claim forms and to ensure that the claims are sent to Delta Dental. Claim payments will be based on actual charges or Delta's maximum allowable fees for non-participating dentists, whichever is less. You are then responsible for any balance remaining after Delta pays. Unlike Delta's participating dentists, Delta has no control over non-participating dentist's charges or billing procedures.

Voluntary Pre-Authorization

When you need extensive treatment, like a crown, ask your dentist for a "Pre-determination". You will get a **Confirmation of Treatment and Cost** from Delta Dental of Washington. It details your dentist's treatment plan, what your benefits cover, and how much you may owe your dentist for the treatment.

Vision Insurance - Vision Service Plan (VSP)

Pushpay provides vision insurance through Vision Service Plan (VSP). This plan uses VSP's Signature network. If you visit a provider within the network, your benefits will be greater. Out-of-network benefits are based on a reimbursement schedule and when you visit out-of- network providers, you are responsible for submitting the claim to VSP for reimbursement.

To locate a VSP provider, make sure you go to www.vsp.com or call (800) 877-7195.

	VSP **Vision Plan – In Network Benefits**
Copay	
WellVision Exam	$25 copay for exam and glasses
Vision Materials	
Lenses	Single vision, lined bifocal, lined trifocal and standard progressive lenses:
Frame	$150 allowance, then 20% savings on amounts over allowance $170 allowance for featured frame brands $80 Costco frame allowance $150 Walmart/Sam's Club frame allowance
Elective Contacts (in lieu of frames and lenses)	$150 allowance, plus up to $60 copay for contact lens exam and fitting
Benefit Frequencies	
Exam	Once every 12 months
Frame	Once every 24 months
Lenses	Once every 12 months
Contacts	Once every 12 months

Extra Savings!

- **Glasses and Sunglasses:** Extra $20 to spend on featured frame brands. Go to www.vsp.com for details.
- **Retinal Screening:** No more than a $39 copay on routine retinal screening as an enhancement to a WellVision exam.
- **Laser Vision Correction:** Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Using your VSP Benefit is Easy

- **Create an account at** www.vsp.com. Once your plan is effective, review your benefit information.
- **Find an eye doctor** who's right for you by visiting www.vsp.com or calling (800) 877-7195.
- **At your appointment, tell your provider that you have VSP**. There is no ID card necessary.

That's it! VSP will handle the rest! There are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

Like shopping online? Go to eyeconic.com and use your vision benefits to shop over 70 brands of contacts, eyeglasses, and sunglasses.

Life and Accidental Death & Dismemberment (AD&D) - MetLife

Pushpay provides basic life and AD&D benefits to eligible employees. The life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan; payment will be determined by MetLife's schedule of benefits.

MetLife Basic Life and AD&D	
Classes	**Benefit Amount**
Class 1: Active Full-Time Employees earning $50,000+	1x basic annual earnings up to $500,000*
Class 2: All Other Full Time Employees	Flat $50,000

*The value of employer-paid Life Insurance coverage over $50,000 is imputed as income and will be reflected on your pay statement.

The above benefits will begin to decrease at age 70. See your MetLife benefit summary for more information.

Important Reminder! Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes. You can update your beneficiary at any time during the year.

Voluntary Life and Accidental Death & Dismemberment (AD&D) - MetLife

You can purchase additional life and AD&D coverage through MetLife for yourself and your eligible dependents. If you decided to waive coverage during your initial eligibility period and decide to enroll later, you will be required to submit a health questionnaire (also called evidence of insurability) to MetLife. Participants who have purchased coverage can increase one increment annually, at open enrollment, without submitting a health questionnaire if your coverage is still below the Guarantee Issue amount.

Guarantee Issue amounts do not require you to complete an evidence of insurability form and are only available during your initial eligibility period. To see the cost of coverage, please review the cost of coverage provided by MetLife.

	MetLife Vol. Life and AD&D
Employee	
Benefit Maximum	5x your basic annual earnings not to exceed $500,000
Benefit Increments	$10,000
Guarantee Issue	$100,000
Spouse	
Benefit Maximum	50% of employee's benefit up to a maximum of $100,000
Benefit Increments	$5,000
Guarantee Issue	$25,000
Child(ren)	
Benefit Maximum	$10,000
Benefit Increments	Live birth to 6 months: $1,000 6 months up to age 26*: $1,000 | $2,000 | $4,000 | $5,000 or $10,000
Guarantee Issue	All amounts

*if unmarried and supported by employee

Short-Term Disability Insurance - MetLife

Pushpay offers a short-term disability benefit through MetLife at no cost to you. This benefit covers 60% of your weekly base earnings up to $2,000 per week. The benefit begins after 14 days from the date of a non-work-related injury or illness and could last up to 11 weeks.

Long-Term Disability Insurance - MetLife

Pushpay offers long-term income protection through MetLife at no cost to you. This benefit covers 60% of your monthly base earnings up to a monthly maximum of $9,000 in the event you become unable to work due to an illness or injury. Benefit payments begin after 90 days of disability. This plan does not cover a sickness or accidental injury that arose in the months prior to your enrollment in the plan. Please see the summary plan description for complete plan details.

Employee Assistance Program (EAP) - MetLife

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices, or locating further help.

You can receive up to 5 phone or video consultation at no additional cost with a licensed counselor. Your counselor may refer you to resources in your community for ongoing support.

It's confidential. Your EAP has been set up with MetLife, an outside counseling resource to assure confidentiality. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP will appear in your personnel file.

MetLife is only a phone call away at (888) 319-7819 or at
www.metlifeeap.lifeworks.com with the username: **metlifeeap** and password: **eap**

Voluntary Legal Advice Plan - MetLaw

The following benefits are available to you on a voluntary basis. *For premium information and plan information, please visit the website listed below.*

- MetLaw: this benefit covers you, your spouse and dependents. Telephone and office consultations for an unlimited number of personal legal matters with an attorney of your choice. For more information, you can visit www.members.legalplans.com and register to find out more.

Cost of Coverage

The following tables show the monthly cost of coverage under the different plans that are being offered to you. If you have any questions regarding the cost of your plans, please see your HR or Payroll team.

For information on the cost of coverage for Voluntary Life and AD&D, please refer to the MetLife Benefits Summary included in your ADP Benefits Enrollment.

Copay Plan Tier	Total Monthly Cost	Employer Pays (per month)	You Pay (per month)
Employee Only	$599.07	$549.07	$50.00
Employee + Spouse/DP*	$1,347.99	$997.99	$350.00
Employee + Child(ren)	$1,045.29	$745.29	$300.00
Family	$1,797.24	$1,247.24	$550.00

HDHP Plan Tier	Total Monthly Cost	Employer Pays (per month)	You Pay (per month)
Employee Only	$446.17	$446.17	$0.00
Employee + Spouse/DP*	$936.97	$696.97	$240.00
Employee + Child(ren)	$847.74	$667.74	$180.00
Family	$1,338.53	$988.53	$350.00

Dental Plan Tier	Total Monthly Cost	Employer Pays (per month)	You Pay (per month)
Employee Only	$47.72	$47.72	$0.00
Employee + Spouse/DP*	$103.43	$75.57	$27.86
Employee + Child(ren)	$99.62	$73.66	$25.96
Family	$134.09	$90.91	$43.18

Vision Plan Tier	Total Monthly Cost	Employer Pays (per month)	You Pay (per month)
Employee Only	$8.53	$8.53	$0.00
Employee + 1 Dependent (**Dependent** = Spouse, or DP, or Child)	$12.36	$10.52	$1.84
Employee + 2 or more Dependents (**Dependents** = Spouse/DP + Children **or** Children)	$22.17	$15.60	$6.57

***DP:** For domestic partners that do not qualify as dependents under Section 152 of the Internal Revenue Code, premium associated with domestic partner coverage will be paid by the employee with after-tax dollars and the fair market value of any employer contributions made on behalf of your domestic partner will be imputed as income to the employee. Unless otherwise requested, non-life premiums will automatically be deducted on a pre-tax basis.

Pushpay
Health and Welfare
Benefits Annual Notice Packet

For the 2024 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

Children's Health Insurance Program (CHIP) Notice

Women's Health and Cancer Rights Act (WHCRA) Notice

Newborns' Mothers Health Protection Act (NMHPA) Notice

USERRA Continuation

Genetic Information Nondiscrimination Act (GINA)

HIPAA Special Enrollment Rights Notice

Medicare Part D Creditable Coverage Notice

HIPAA Notice of Privacy Practices

Family Medical Leave Act

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 19 for more details.

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
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	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
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – 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: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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	**NEW YORK – 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2023, 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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (512) 583-3410for more information.

Newborns' And Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA Continuation

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under a group health plan by paying premiums in the manner specified by the Plan Sponsor.

If you do not elect to continue to participate in a group health plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA continuation coverage under a group health plan for up to the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds, subject to the rules that are set out in the applicable Plan features.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Genetic Information Nondiscrimination Act (GINA)

Gina prohibits group health plans from discriminating on the basis of genetic information. Genetic information is:

1. Information about an individual's genetic tests;
2. Genetic tests of an individual's family members; and
3. The manifestation of a disease or disorder of an individual's family members.

The group health plan may collect genetic information after initial enrollment, it may not do so in connection with the annual renewal process. The group health plan may not adjust premiums or increase contributions based on genetic information, nor request or require genetic testing or use genetic information for underwriting purposes.

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Pushpay.health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

Medicare Part D Creditable Coverage Notice

Important Notice from Pushpay
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pushpay 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. **Pushpay has determined that the prescription drug coverage offered by the Cigna 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. 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 while enrolled in Pushpay coverage as an active employee, please note that your Pushpay coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Pushpay coverage as a former employee.

You may also choose to drop your Pushpay coverage. If you do decide to join a Medicare drug plan and drop your current Pushpay coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Pushpay 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 Pushpay 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: 01/01/2024
Name of Entity/Sender: Pushpay
Contact--Position/Office: Pushpay People Team
Address: 18300 Redmond Way, Suite 300
Redmond, WA 98052

HIPAA Notice of Privacy Practices

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.

Pushpay sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Pushpay, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which 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.

Note: If you are covered by one or more fully-insured group health plans offered by Pushpay , you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Pushpay HIPAA Privacy Officer, Pushpay

Pushpay
Attention: HIPAA Privacy Officer
Pushpay People Team
18300 Redmond Way, Suite 300
Redmond, WA 98052

Effective Date This Notice as revised is effective January 1, 2024.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information 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 might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information 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 your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information 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 & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. 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 us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information 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 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. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. 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.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information 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.

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

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information 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
We may disclose your protected health information 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 your protected health information in response to a court or administrative order. We may also disclose your protected health information 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 an order protecting the information requested.

Law Enforcement
We may disclose your protected health information 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 we believe may be the result of criminal conduct;
- about criminal conduct; 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
We may release protected health information 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 medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information 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.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information 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 protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: 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 or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights
You have the following rights with respect to your protected health information:

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 care benefits. To inspect and copy your protected health information, submit your request in writing to the

Privacy Officer at the address provided above under Contact Information. 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. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information 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 the Privacy Officer at the address provided above under Contact Information. 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, we may deny your request if you ask us to amend information that:

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

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an "accounting" of certain disclosures of your protected health information. 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 permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. 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 protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our 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 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, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

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, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. 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. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Family Medical Leave Act

The Family and Medical Leave Act (FMLA) provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. It also requires that their group health benefits be maintained during the leave.
FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

Covered employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- for the birth and care of the newborn child of an employee;
- for placement with the employee of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when the employee is unable to work because of a serious health condition.

Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Whether an employee has worked the minimum 1,250 hours of service is determined according to FLSA principles for determining compensable hours or work.

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition.

Upon return from FMLA leave, an employee will be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. Group health insurance coverage for an employee on FMLA leave is maintained under the same terms and conditions as if the employee had not taken leave.

For additional information regarding your benefits under FMLA, please contact the Pushpay People Team


Pushpay
Resi


MarshMcLennan
Agency