EMPLOYEE BENEFIT NOTICES

The following pages provide employee benefit plan notices. Please read them carefully as we generally provide these once a year during annual open enrollment. You may see some of these notices in other documents as well, but we consolidate the following notices here for your convenience:

- PROVIDER CHOICE WHEN PLAN REQUIRES A PRIMARY CARE PHYSICIAN
- NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES
- PUBLIC HEALTH INSURANCE MARKETPLACE
- SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA

Throughout these pages you are invited to contact HR for assistance. For any questions or requests you may have about the pages below, including a request for a paper copy of this notice packet, contact HRBenefits@IMAcorp.com.

Before we get into the notices, some basic rules governing our plan are summarized below:

- You may only enroll when first eligible or during our annual open enrollment each Fall.
- **Your election is locked** for the entire plan year, January 1 to December 31.
- You can generally submit an election change in UKG **within 30 days of a qualifying life event** to request a benefit change during the plan year. We may require substantiating documentation of the event, and we may determine the event does not qualify to make the requested change.
- At any time, we may audit dependent status and require current substantiating documentation.
- **Please keep us informed of address or beneficiary changes**.
- When first enrolling in health coverage, a **general notice of rights and responsibilities to continue health coverage under COBRA** is mailed to the home. It explains that when certain life events make an enrolled individual no longer eligible to stay on the plan, coverage might be able to continue for a limited time under COBRA so long as you or your spouse follow our procedures to notify us within 30 days of the qualifying life event.
- Your rights and responsibilities under the Family and Medical Leave Act (FMLA) and our company-specific leave of absence policies are discussed in our employee handbook.

PROVIDER CHOICE WHEN PLAN REQUIRES A PRIMARY CARE PHYSICIAN (Kaiser Plans Only)

Our managed care plan requires each enrolled family member to select an available in-network primary care physician (PCP) or pediatrician within your service area. Until you designate one, our plan will designate one for you. Also, any available in-network obstetric or gynecologic (OB/GYN) health professional may be accessed without PCP referral. However, that OB/GYN will be otherwise subject to normal plan requirements. To find an in-network Kaiser provider, go to kp.org and update the region on the top right corner of the page, then select Doctors & Location to begin your search..

NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES

Your medical plan booklet will explain how to appeal a claim denial through the plan, through a government-authorized third party, and with the help of a consumer assistance office.

EMPLOYEE BENEFIT NOTICES

PUBLIC HEALTH INSURANCE MARKETPLACE

For individuals needing to purchase health insurance on their own, the Affordable Care Act (ACA) created a new public health insurance Marketplace. This website and call center helps individuals shop for private health insurance, helps individuals enroll in Medicaid or the Children's Health Insurance Program (CHIP), and evaluates eligibility for new tax credits. Open enrollment for public Marketplace coverage occurs each fall for coverage starting January 1, but special enrollment periods may be available for certain life events. Learn more or request assistance at www.healthcare.gov.

Please note that insurance companies are not required to participate in the public Marketplace, so you are unlikely to see all plans available in the community when shopping the public Marketplace.

The public Marketplace can help you determine whether you may be eligible for tax credits under section 36B of the Internal Revenue Code for Marketplace coverage. One tax credit can lower your monthly premium, and the other can lower your cost sharing (such as your deductible). Since tax credits are based on your projected household income and typically paid in advance to the insurance company, there is a chance you may have to repay some or all tax credits on your tax return if your income for the year ends up higher than anticipated.

Tax credits are not available to you if eligible for "affordable, minimum value" medical coverage. "Minimum value" means our plan is intended to pay, on average, at least 60% of the costs of medical care received. "Affordable" means our lowest-cost minimum value plan costs you no more than 9.5% (indexed annually) of your household income to be enrolled in single (not family) coverage.

Our plan is intended to be affordable and minimum value. As a result, if you or someone in your family wanted to compare your health insurance options in the public Marketplace to the insurance offered through us, you'll need to remember that:

- You might pay full retail price for public Marketplace insurance (without the new tax credits)
    a) You would no longer be paying for insurance on a pre-tax basis
    b) You would no longer have an employer contribution toward your insurance (note that employer contributions are typically excludable from income for federal income tax)
- You would navigate any questions you have directly with the insurance company you choose (HR will not be able to assist you with your public Marketplace plan)
- Should you desire to come back to our plan in the future, you will either need to:
    a) experience a "qualifying event" recognized by our plan as a mid-year election change, or
    b) wait until our next annual open enrollment

SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA

When you are eligible to participate in our group medical plan, you may have to enroll and agree to pay part of the premium through payroll deduction in order to actually participate.

EMPLOYEE BENEFIT NOTICES

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

SPECIAL ENROLLMENT PROVISION

- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement with you for adoption, you may be able to enroll yourself, your spouse, and your new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.
- **Loss of Eligibility for Other Coverage.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other medical coverage is in effect, you may be able to enroll yourself and your dependents in this plan **if eligibility is lost for the other coverage (or if the employer stops contributing toward it)**. However, **you must request enrollment within 30 days** after the other coverage ends (or after the employer stops contributing toward it).
- **Loss of Eligibility under Medicaid or a State Children's Health Insurance Program (CHIP).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while coverage under Medicaid or CHIP is in effect, you may be able to enroll yourself and your dependents in this plan **if eligibility is lost for the other coverage**. However, **you must request enrollment within 60 days** after the other coverage ends.
- **Eligibility for Medicaid or CHIP State Premium Assistance Subsidy.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through CHIP with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact HRBenefits@imacorp.com.

If You Decline Coverage, You Must Designate the Reason for Declining in UKG

- If you decline enrollment, you must select a reason for declining in UKG. This pop up only happens when the plan as a whole is declined, not when a dependent isn't included.
- You are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or CHIP) is the reason for declining enrollment, and you are asked to identify that coverage.
- If you do not designate a reason for declining coverage, you will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or

placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or CHIP with respect to coverage under this plan, as described above.

- If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or CHIP with respect to coverage under this plan.