Notice of Special Enrollment Rights for Health plan coverage

As you know, if you have declined enrollment in MyEyeDr.'s health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

MyEyeDr. will also allow a special enrollment opportunity if you or your eligible dependents either:

Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or

Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the MyEyeDr. group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Women’s Health and Cancer Rights Act notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 703-847-8899.

Newborns' and Mothers' Health Protection Act 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 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 703-847-8899.

Wellness program notices

EEOC Notice (for Wellness Plans that include Disability-Related Inquiries or Medical Examinations)

Sample language. The EEOC notice requirement is satisfied by use of the following (or similar) language:

Notice regarding wellness program

MyEyeDr.'s OneTeam Wellbeing Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a 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 will also be asked to complete a biometric screening, which will include a blood test for blood glucose and cholesterol (LDL, HDL, and Triglycerides). 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 will receive an incentive of reduced medical premium contribution for completing a biometric screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the reduced medical premium contribution.

Additional incentives of up to $375 (in the form of CareFirst's BlueRewards Visa Incentive Card that can be used to pay for annual deductible or other out-of-pocket expenses like copays or coinsurance) may be available for employees who participate in certain health-related activities such as completing the RealAge test (2x), selecting a PCP, completing a health screening, and participating in health coaching. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at HR@myeyedr.com or 703-847-889.

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, such as Health Coaching. 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 MyEyeDr. may use aggregate information it collects to design a program based on identified health risks in the workplace, the OneTeam 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 are a registered nurse, a doctor, or a CareFirst health coach 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 Human Resources at HR@myeyedr.com.

No Surprises Act notice

*Special Note: this notice is **required** to be made publicly available, posted on a public website, and included on each applicable EOB. Inclusion in an enrollment or new hire guide is optional, but employers may feel it is an effective way to inform participants of their rights against surprise billing*

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're protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

  - Cover emergency services by out-of-network providers.

  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you’ve been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

HIPAA Special Enrollment Notice

Group health plans that are subject to HIPAA's portability provisions must notify employees of the plan's special enrollment rules. Employees must be notified on or before they become eligible to enroll.

Special enrollment for standalone health plans (e.g., dental/vision) is optional. Some plans offer special enrollment for all benefits, regardless. Modify this notice according to plan's special enrollment rules.

For the HIPAA Special Enrollment notice, click here**.**

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

The Women's Health and Cancer Rights Act requires group health plans and health insurance issuers to provide certain benefits relating to post-mastectomy surgery. A notice about these rights must be provided to a participant upon enrollment in the plan and thereafter on an annual basis. The enrollment notice and the annual notice have different content requirements. However, Mercer recommends providing the enrollment notice annually during open enrollment and in new hire materials (instead of the annual notice).

For the Women's Health and Cancer Rights Act (WHCRA) notice, click here**.**

Newborns' and Mothers' Health Protection Notice

The Newborns' and Mothers' Health Protection Act (NMHPA or Newborns Act) requires group health plans to provide hospital coverage for a newborn and a mother for a period of least 48 hours following a normal vaginal delivery and 96 hours following a cesarean delivery.

A statement of rights must be included in the plan's SPD or other communication materials providing a description of plan benefits to participants.

Although not required, Mercer recommends including this notice in open enrollment and new hire materials along with other health plan notices to ensure that it is distributed to plan participants. The provided notice includes language that group health plans may use in their SPDs to describe the federal requirements relating to hospital lengths of stay in connection with childbirth. Plans subject to state insurance requirements will need to include any applicable state insurance rules in their SPDs as well as the provided notice.

For the Newborns' and Mothers' Health Protection notice, click here**.**