CROWN LINEN



EMPLOYEE BENEFITS GUIDE

PLAN YEAR | 2023-2024

FLORIDA

Brown & Brown

WELCOME TO YOUR BENEFITS ENROLLMENT

Crown Linen LLC. offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This Benefits Guide will provide you a description of our company's benefit programs. Should you have any questions while reviewing this Benefits Guide, please contact our Human Resources Department for assistance. Included in this guide are summary explanations of the benefits and costs as well as contact information for each carrier.

This guide is not intended to cover all provisions of all plans, but rather is a quick reference guide to assist in your decision-making. Please see your Summary Plan Description and/or carrier certificates for complete plan details.

BENEFIT PLANS

EFFECTIVE JULY 1, 2023

or after satisfying the New Hire Waiting Period

Information provided in this booklet is intended to serve as a convenient reference guide. If any information contained in this booklet differs from any plan documentation, please revert to plan documentation.

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors.
For general information, please contact Human Resources.

COMPANY	PLAN	CONTACT INFORMATION
Crown Linen	Human Resources	Lenis Figuera | Payroll & Benefits Generalist (786) 483-3490 figuera@crownlinen.net Regina Rodriguez | Corporate HR Manager (407) 992-8479 regina.rodriguez@crownlinen.net
BB	Benefits Consulting Team	Sabrina Magno | Benefits Coordinator 954-331-1351 sabrina.magno@brbown.com Analisa VanDelinder | Sr. Claims Analyst 954-331-1361 analisa.vandelinder@bbrown.com Sergio Castillo | Employee Benefits Consultant 954-804-7834 sergio.castillo@bbrown.com
UnitedHealthcare	Medical	Customer Service 1-866-633-2446 myuhc.com
UnitedHealthcare	Dental	Customer Service 1-866-633-2446 myuhc.com
UnitedHealthcare	Vision	Customer Service 1-866-633-2446 myuhc.com
APL American Public Life	GAP	Customer Service 1-800-256-8606 ampublic.com
UnitedHealthcare	Life & AD&D STD	Customer Service 1-866-633-2446 myuhc.com
Allstate You're in good hands.	Allstate Worksite	Customer Care Center 1-800-521-3535 allstateatwork.com

ENROLLMENT

HOW TO ENROLL

Crown Linen LLC. is pleased to offer a wide variety of benefits to fit your personal and family needs.

Please take the time to review all sections of this enrollment booklet carefully. If after reviewing the enclosed information you have questions on any of the items enclosed, please feel free to contact Human Resources.

CAFETERIA PLAN

Crown Linen LLC. currently offers a Cafeteria Plan, which provides a valuable tax benefit to both the Company and its employees. A cafeteria plan is a benefit plan authorized by Section 125 of the Internal Revenue Code, which allows employees to elect benefits on a pre-tax basis. Changes to your elections may be made at the next Open Enrollment unless you experience a Qualifying Event. A Family Status Change allows employees to add, change or drop coverage during the plan year due to the following reasons listed below (this list is not all inclusive):

CHANGING ELECTIONS AND QUALIFIED FAMILY STATUS CHANGES DURING THE YEAR

What is considered a “Qualified Family Status Change?”

- Marriage
- Divorce
- Legal Separation
- Birth or Adoption of a child
- Change in child’s dependent status
- Death of a spouse, child or other qualified dependent
- Commencement or termination of adoption proceedings
- Change in spouse’s employment status

These events must be reported to Human Resources within 30 days from the effective date of the “Qualifying Event”, or a missed enrollment opportunity (no coverage) will occur.

Not all Family Status Change events will allow the same election change for each benefit offered. Employees will have 30 days from the change in family status to make changes to the current plans. These events must be reported to the Plan Administrator within 30 days from the effective date of the “Qualifying Event”, or a missed enrollment opportunity (no coverage) will occur.

ELIGIBILITY

WHO'S ELIGIBLE

All active, full-time employees who work 30 hours or more per week – part time, per diem, temporary & seasonal employees excluded.

COBRA eligible individuals are eligible to enroll in the medical, dental and/or vision plans as applicable. If terminating during the Plan Year, you will be eligible to continue that participation through COBRA continuation.

When you enroll, you can also cover your eligible dependents.

WHO IS ELIGIBLE?

• Legal spouse*
• Your unmarried natural child(ren), legally adopted children or step children. Age limits vary as follows:

MEDICAL

• Due to Health Care Reform married or unmarried dependents are eligible up to age 26** as long as the dependent is not being offered insurance coverage through their employer. They do not have to live with the parent, be financially dependent on them for support, or live in the same state. They can be married but their spouse or any dependent children are not eligible.
• At age 26 dependents may still be eligible up to age 30 under certain circumstances under Florida statutes, however, there are stipulations that the dependent cannot be married, must reside in the same state as their parents (unless they are still in school), have no dependents of their own, and have no other insurance.

DENTAL

• Eligible dependents are:
o Your legal spouse and
o Your children who are less than age 26
• Dependent child eligibility ends at the end of the calendar year on or after the date the dependent child is no longer eligible.

**You may be required to show proof of marriage if the last name of your spouse differs from yours.*
***You will be required to show birth certificate if children have a different last name, legal documentation for either the adoption of a child or the court order to cover stepchildren.*

WAITING PERIOD

Newly hired employees are eligible for benefits the first of the month following 60 days. (i.e. if your hire date is May 15, 2023, your benefits effective date is July 1, 2023.)

MEDICAL INSURANCE

Crown Linen LLC. is pleased to announce that our medical coverage will be offered through **United Healthcare effective July 1, 2023**. Please see the plan overviews below. Find a Doctor or Hospital, visit **myuhc.com**.

UnitedHealthcare	NHP - HMO OA HSA DB1C-M / RX NHES-HSA	NHP HMO OA DBZO-M / RX NHSY-R
SERVICES	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Calendar Year Deductible (CYD) Individual / Family	$5,500 / $11,000	$5,000 / $10,000
Coinsurance	100%	100%
Provider Services	**PCP** Required**	**Open Access**
Primary Care Office Visit	0% After CYD	$25
Specialist Office Visit	0% After CYD	$50
Adult Wellness (Includes Preventive Lab)	$0	$0
Hospital Services In-Patient Hospital	0% After CYD	$500 + 0% Aft CYD
In-Patient Physician Services	0% After CYD	0% Aft CYD
Out-Patient Hospital	0% After CYD	$300 + 0% Aft CYD
Emergency Room	0% After CYD	0% Aft CYD
Ambulatory Surgery Center	0% After CYD	$300 + 0% Aft CYD
ASC Physician Services	0% After CYD	0% Aft CYD
Lab / X-Ray	0% After CYD	$0 / $0
Major Diagnostic (MRI, CT, NM, PET)	DDP* 0% Aft CYD / NDDP 0% Aft CYD	DDP* 0% Aft CYD / NDDP 0% Aft CYD
Urgent Care	0% After CYD	$50
Annual Out-of-Pocket Maximum Includes Deductible Individual/ Individual in a Family/ Family	Yes $6,550 / $13,100	Yes $6,850 / $13,700
Lifetime Maximum	Unlimited	Unlimited
Prescription Drugs Tier 1/Tier 2/Tier 3	**CVS - After CYD** $10 / $35 / $70	**CVS** $10 / $35 / $70
Preferred Specialty Retail (up to 30 days supply)	$10 / $150 / $500	$10 / $150 / $500
Mail Order (up to 90 day supply)	$25 / $87.50 / $175	$25 / $87.50 / $175

For more detailed information regarding the medical benefits, refer to the summary of benefits.

MEDICAL PER PAY DEDUCTIONS				
Plan	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
HMO OA HSA	$63.47	$137.59	$120.75	$202.29
NHP OA DBZO	$81.08	$174.58	$153.33	$256.17

***DDP Designated Diagnostic Provider.** Designated Diagnostic Providers are laboratory providers and imaging centers that meet certain quality and efficiency requirements.*
***** PCP Selection Required***

MEDICAL INSURANCE

Crown Linen LLC. is pleased to announce that our medical coverage will be offered through **United Healthcare effective July 1, 2023**. Please see the plan overviews below. Find a Doctor or Hospital Choice Plus, visit **uhc.welcometouhc.com**. Find a Doctor or Facility | Choose Search for Health Plan | Choice Plus.
*No one in the family is eligible for benefits until the family deductible is met.

UnitedHealthcare	NHP POS OA BXKL-M / NHSY-R	
SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible (CYD) Individual / Family	$1,000 / $2,000	$2,000 / $4,000
Coinsurance	100%	70% / 30%
Provider Services	**Open Access**	**Open Access**
Primary Care Office Visit	$30	30% After CYD
Specialist Office Visit	$60	30% After CYD
Adult Wellness (Includes Preventive Lab)	$0	30% After CYD
Hospital Services In-Patient Hospital	0% After CYD	30% After CYD
In-Patient Physician Services	0% After CYD	30% After CYD
Out-Patient Hospital	0% After CYD	30% After CYD
Emergency Room	$350	$350
Ambulatory Surgery Center	0% After CYD	30% After CYD
ASC Physician Services	0% After CYD	30% After CYD
Lab / X-Ray	$0 / $0	30% After CYD
Major Diagnostic (MRI, CT, NM, PET)	DDP* 0% Aft CYD / NDDP 0% Aft CYD	30% After CYD
Urgent Care	$100	30% After CYD
Annual Out-of-Pocket Maximum Includes Deductible Individual/ Individual in a Family/ Family	Yes $3,000 / $6,000	Yes $6,000 / $12,000
Lifetime Maximum	Unlimited	Unlimited
Prescription Drugs Tier 1/Tier 2/Tier 3	**CVS** $10 / $35 / $70	30% After CYD
Preferred Specialty Retail (up to 30 days supply)	$10 / $150 / $500	Not Covered
Mail Order (up to 90 day supply)	$25 / $87.50 / $175	Not Covered

For more detailed information regarding the medical benefits, refer to the summary of benefits.

MEDICAL PAYROLL DEDUCTIONS				
Plan	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
NHP POS BXKL	$115.01	$245.83	$216.10	$360.00

***DDP Designated Diagnostic Provider.** Designated Diagnostic Providers are laboratory providers and imaging centers that meet certain quality and efficiency requirements. For more information, see the following pages.*

MEDICAL INSURANCE

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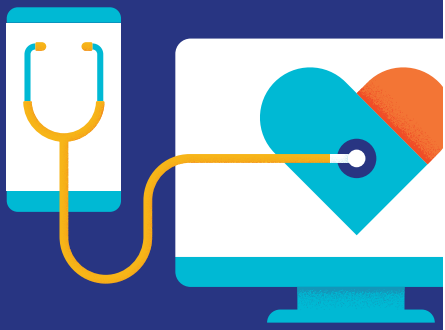
*No one in the family is eligible for benefits until the family deductible is met.

UnitedHealthcare	UHC - CHOICE PLUS BWO6-M / 124Y 2022	
SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible (CYD) Individual / Family	$1,000 / $2,000	$2,000 / $4,000
Coinsurance	100%	70% / 30%
Provider Services	**Open Access**	**Open Access**
Primary Care Office Visit	$30	30% After CYD
Specialist Office Visit	$60	30% After CYD
Adult Wellness (Includes Preventive Lab)	$0	30% After CYD
Hospital Services In-Patient Hospital	0% After CYD	30% After CYD
In-Patient Physician Services	0% After CYD	30% After CYD
Out-Patient Hospital	0% After CYD	30% After CYD
Emergency Room	$350	$350
Ambulatory Surgery Center	0% After CYD	30% After CYD
ASC Physician Services	0% After CYD	30% After CYD
Lab / X-Ray	DDP* $0 / NDDP 50% / $0	30% After CYD
Major Diagnostic (MRI, CT, NM, PET)	DDP* 0% Aft CYD / NDDP 0% Aft CYD	30% After CYD
Urgent Care	$50	30% After CYD
Annual Out-of-Pocket Maximum Includes Deductible Individual/ Individual in a Family/ Family	Yes $3,000 / $6,000	Yes $6,000 / $12,000
Lifetime Maximum	Unlimited	Unlimited
Prescription Drugs Tier 1/Tier 2/Tier 3	**CVS** $10 / $35 / $70	30% After CYD
Preferred Specialty Retail (up to 30 days supply)	$10 / $150 / $500	Not Covered
Mail Order (up to 90 day supply)	$25 / $87.50 / $175	Not Covered

For more detailed information regarding the medical benefits, refer to the summary of benefits.

MEDICAL PAYROLL DEDUCTIONS				
Plan	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
CHOICE PLUS BWO6-M	$134.69	$287.16	$252.51	$420.23

***DDP Designated Diagnostic Provider.** Designated Diagnostic Providers are laboratory providers and imaging centers that meet certain quality and efficiency requirements. For more information, see the following pages.*



Activate your myuhc.com account

Put your health plan at your fingertips

Get the most out of your benefits

Your personalized website, **myuhc.com®**, features tools designed to help you:

- **Find, price and save on care—**you can save with Virtual Visits* and other tools. You can save an average of 36%[1] when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details,** plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills,** get estimates and compare medication pricing**
- **Check your plan balances,** access financial accounts and more

Download the UnitedHealthcare® app

It's perfect for on-the-go access, help finding a nearby doctor and more.

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

**Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

continued

United Healthcare

1- Go to **myuhc.com** > **Register Now**
2- Fill out the required fields and create your username/password
3- Enter your contact information and security questions
4- Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates.

DESIGNATED DIAGNOSTIC PROVIDER (DDP)

Say hello to the Designated Diagnostic Provider benefit

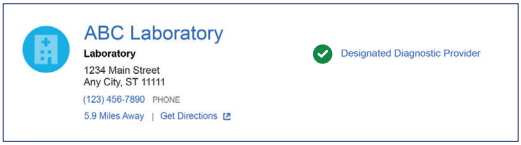
More value for you, more savings for employees

Designated Diagnostic Providers (DDPs) are laboratory and imaging services providers that meet certain quality and efficiency requirements. When your employees choose a DDP for their outpatient lab or imaging services, they'll receive the highest level of benefit from their health plan. This means more value for lab or imaging services—and more value for your employees.

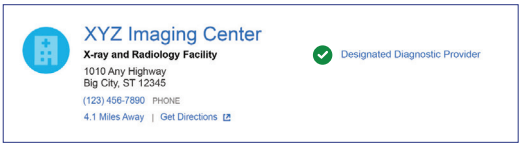
Look for the green check

Participating providers will be designated in the provider search on **myuhc.com®**.

Lab providers



Imaging centers



Preferred lab providers

- Aegis Sciences Corporation
- AmeriPath Inc.
- BioReference Laboratories, Inc.
- Clinical Pathology Laboratories, Inc.
- Invitae Corporation
- Laboratory Corporation of America (LabCorp)
- Mayo Clinic Laboratories*
- Millennium Health, LLC
- Myriad Genetic Laboratories, Inc.
- Natera, Inc.
- Neogenomics Laboratories, Inc.
- Quest Diagnostics, Inc.

Participating DDP providers are subject to change upon annual review process. Available DDPs may expand to include additional facilities.

continued

United Healthcare

GAP INSURANCE

MEDlink® Select Gap Insurance

Group Supplemental Medical Expense Insurance

APL AMERICAN PUBLIC LIFE

WHAT IS GAP INSURANCE?

MEDlink® Gap Insurance from APL is designed to work with your major medical plan to help fill the gaps left by deductibles, coinsurance and co-pays — covering much of your out-of-pocket costs after major medical insurance has paid.

79% increase

The average annual employee **deductible increased 79%** over the last 10 years.*

HOW IT WORKS

1. **CHOOSE** the plan and coverage type that best fits your individual needs or the needs of your family.
2. **USE** your medical insurance as usual! MEDlink® helps cover charges for in-hospital services and outpatient services, including urgent care and diagnostic testing.
3. **FILE** your claim. Use your MEDlink® ID Card at your provider's office, file a claim online or mail in your claim.

KEY FEATURES

- Guarantee Issue with no medical questions or exams when covered under the other medical plan
- ID Card provided
- Convenient payroll deduction
- Cost-effective premiums
- Benefits are assignable, making the claims process simple

EXAMPLE BENEFITS

In-Hospital Benefits

- Treatment while confined in a hospital
- Inpatient treatment of a mental or emotional disorder
- Ambulance service when resulting in hospital confinement

There's no such thing as feeling **too covered, too safe or too protected!**

Outpatient Benefits

- Treatment in an urgent care facility or emergency room
- Physical therapy performed in a physical therapy facility
- Surgery in a hospital outpatient facility or freestanding outpatient surgery center
- Diagnostic testing in a hospital outpatient facility or MRI facility
- Outpatient treatment of a mental or emotional disorder
- Ambulance service
- Physician's Office Treatment
- Cancer Outpatient Treatment
- Independent Lab Facility
- Durable Medical Equipment

This MEDlink® policy provides limited benefits.

This product has limitations and exclusions, all benefits may not be available in all states, does not replace Workers' Compensation Insurance. **This product is inappropriate for people who are eligible for Medicaid coverage.**

**Kaiser Family Foundation: Employer Health Benefits, 2020 Summary of Findings, October 8, 2020, p2*

GAP INSURANCE

MEDlink® Select
Group Supplemental Medical Expense Insurance

APL

Crown Linen LLC

Summary of Benefits		
	Plan 1	**Plan 2**
Funding	Voluntary	Voluntary
Plan Type	In-Hospital and Outpatient Coverage	In-Hospital and Outpatient Coverage
In-Hospital Benefit		
In-Hospital Benefit Maximum	Maximum of $1,000 per covered person per calendar year. Maximum of $3,000 per calendar year for all covered persons combined.	Maximum of $3,000 per covered person per calendar year. Maximum of $9,000 per calendar year for all covered persons combined.
In-Hospital Benefits* • Treatment incurred while confined in a hospital as an inpatient • Inpatient treatment of a mental or emotional disorder - maximum of 30 days of treatment per covered person, per calendar year • Transportation by air or ground ambulance service to a hospital or from one medical facility to another medical facility where a covered person is confined as an inpatient. A licensed ambulance company must provide the ambulance service. All benefits are subject to the in-hospital benefit maximum.		
Outpatient Benefit		
Outpatient Benefit Maximum	$300 per covered person per calendar day for covered outpatient services.	$300 per covered person per calendar day for covered outpatient services.
Outpatient Benefits* • Treatment in a hospital emergency room without subsequently being considered as an inpatient subject to emergency room per occurrence deductible, if applicable to your plan. • Treatment in an urgent care facility • Physical therapy performed in a physical therapy facility • Surgery performed in a hospital outpatient facility or a freestanding outpatient surgery center • Diagnostic testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility • Outpatient treatment of a mental or emotional disorder performed in a hospital outpatient facility - maximum of 30 days of treatment per covered person, per calendar year • Transportation by air or ground ambulance service to a hospital or from one medical facility to another medical facility where a covered person resides less than 18 hours. A licensed ambulance company must provide the ambulance service. All benefits are subject to the outpatient benefit maximum.		
Outpatient Rider(s)		
Office Treatment Rider* Physician covered charges do not include charges for durable medical equipment, cancer treatment, physical therapy or physician's office visit fee. A physician's office does not include a covered outpatient facility.	All benefits are subject to the outpatient benefit maximum	All benefits are subject to the outpatient benefit maximum
Cancer Outpatient Treatment Rider* Must be performed in a cancer treatment facility. A cancer treatment facility also includes a physician's office.	All benefits are subject to the outpatient benefit maximum	All benefits are subject to the outpatient benefit maximum
Independent Lab Facility Rider* Must be performed in an independent lab facility. An independent lab facility is not a physician's office, hospital or MRI facility.	All benefits are subject to the outpatient benefit maximum	All benefits are subject to the outpatient benefit maximum
Durable Medical Equipment Rider* Must be recommended by a physician, covered by the other medical plan and is not disposable or implantable in the body and is not useful to a person in the absence of a sickness or injury.	All benefits are subject to the outpatient benefit maximum	All benefits are subject to the outpatient benefit maximum
Amendment Rider(s)		
Dependent Child Maternity Amendment Rider	Included	Included

*After satisfaction of any applicable in-hospital and/or outpatient deductibles, benefits are payable for out-of-pocket covered charges incurred by a covered person under the other medical plan.

GAP INSURANCE RATES

GAP COVERAGE										
Coverage Type	✓	APL GAP Age: 18 - 54		✓	APL GAP + 55		✓	APL GAP Age: 18 - 54	✓	APL GAP + 55
Employee Only		$13.33			$19.99			$9.09		$13.63
Employee + Spouse		$26.65			$39.98			$18.18		$27.26
Employee + Children		$27.40			$34.07			$18.67		$23.22
Employee + Family		$40.73			$54.05			$27.77		$36.84
	This GAP Plan only applies to health plans F0Q3 or F0PV						This GAP Plan only applies to health plans F0YM or AQPN			

EMERGENCY ROOM | URGENT CARE

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and it may cost hundreds, if not thousands, of dollars. In fact, Harvard University reported that 62% of personal bankruptcies are caused by medical expenses, making medical debt the leading cause of bankruptcy in America.

If you suddenly fall ill or become injured, how can you determine which facility is most appropriate for your condition?

VS

The Emergency Room (ER) is equipped to handle life-threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.

You should go to the nearest Emergency Room if you experience any of the following:

- Compound fractures
- Deep knife or gun shot wound
- Moderate to severe burns
- Poisoning or suspected poisoning
- Seizures or loss of consciousness
- Serious head, neck or back injuries
- Severe abdominal pain
- Severe chest pain or difficulty breathing
- Signs of a heart attack or stroke
- Suicidal or homicidal feelings
- Uncontrollable bleeding

Urgent Care Centers (UCC) are not equipped to handle life-threatening injuries or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.

Some examples of conditions that require a visit to an Urgent Care Center include:

- Control bleeding or cuts that require stitches
- Diagnostic services (X-rays, lab tests)
- Ear infections
- High fever or the flu
- Minor broken bones (e.g., toes, fingers)
- Severe sore throat or cough
- Sprains or strains
- Skin rashes and infections
- Urinary tract infections
- Vomiting, diarrhea or dehydration

Choosing the appropriate place of care will not only ensure prompt and adequate medical attention, but will also help reduce any unnecessary expenses. Although Urgent Care Centers are usually more cost-effective, they are not a substitute for emergency care.

PHARMACY DISCOUNT INFORMATION

Walmart Pharmacy

Visit walmart.com/pharmacy

Your Medical ID Card is not required for the low prices on meds.

$4.00 30 Day Supply / $10.00 90 Day Supply - Generic Only

Since Prescription prices are not regulated, the cost of a prescription may differ by more than $100 between pharmacies. GoodRx is the #1 medical app for iOS and Android. Get prescription drug prices on-the-go, with coupons built unto the app.

- Type your drug name (like Lipitor, Gabapentin, etc.)
- Set your location
- Compare prices, print coupons, save up to 80%

GoodRx

ANDROID APP ON Google play

Download on the App Store

www.goodrx.com

AHF PHARMACY™

Visit ahfpharmacy.org

AHF Pharmacy Services – Specializing in Medications to treat HIV/AIDS

The information contained in this flyer is subject to change without notice.
Please contact the above pharmacies for the most updated information.

DENTAL INSURANCE

Crown Linen LLC. is pleased to announce effective **July 1, 2023** our dental coverage is going to be with **UnitedHealthcare.** To locate a DHMO Provider, visit **myuhc.com** | Dental Providers | Employer Plans | Zip Code | National Select Managed Care. To locate a DPPO Provider, visit **uhc.com/find-a-doctor** | Dental Providers | Employer Plans | Zip Code | National Options PPO.

UnitedHealthcare	DHMO D1068 - S700B	PPO	
BENEFITS	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NET-WORK**
Deductible (Family Max)	n/a	$50 / $150	$50 / $150
Deductible Waived – (Class I)	n/a	Yes	Yes
Benefit Description	Refer to copay schedule	**UnitedHealthcare covers**	
Preventive (Class I)		100%	100%
Basic (Class II)		100%	80%
Major (Class III)		60%	50%
Maximum Annual Benefit	Unlimited	$1,500	
Orthodontic Lifetime Max	$2,835 Child / $2,935 Adult	$1,000 Child Only*	
BENEFITS		**Contracted Rates**	**90th percentile**
Routine Exams - 9430	No Charge	100%	100%
Teeth Cleaning - 1110	No Charge	100%	100%
Full Mouth/Panoramic X-rays - 0330	No Charge	100%	100%
Simple Extractions - 7140	$20	100%	80%
Root Canal (Endodontics) - 3330	$245	100%	80%
Perio. Scaling/Root Planning - 4341	$50 per quad	100%	80%
Full or Partial Dentures - 5110	$325	60%	50%
Crowns - 2740	$245	60%	50%

For more detailed information regarding dental benefits refer to the summary of benefit.

DENTAL BI-WEEKLY DEDUCTIONS				
Plan	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
DHMO	$6.50	$11.38	$14.09	$17.88
DPPO	$17.34	$33.12	$33.42	$51.53

VISION INSURANCE

Crown Linen LLC. is pleased to announce effective **July 1, 2023** our vision coverage will be with **United Healthcare**. To locate a participating Vision provider, log on to: **myuhc.com**.

UnitedHealthcare	IN-NETWORK	OUT-OF-NETWORK
BENEFITS	**TL036 UHC STANDARD NETWORK**	
Vision Exam	$10 Copay	up to $40 Reimbursement
Eye Exam Frequency	Every 12 Months	
Single Vision Lenses (pair)	$25 Copay	up to $40 Reimbursement
Bifocal Lenses (pair)	$25 Copay	up to $60 Reimbursement
Trifocal Lenses (pair)	$25 Copay	up to $80 Reimbursement
Frame Frequency	Every 24 Months	
Selected Frames	$100 allowance + 30% discount over	up to $45 Reimbursement
Contact Lenses Frequency	Every 12 Months	
Lasik / Laser Vision Correction	Discounted	No Discount
Elective Contact Lenses	**(in lieu of eyeglass lenses)**	
In lieu of lenses/frames	$100 allowance	up to $75 Reimbursement

For more detailed information regarding vision benefits refer to the summary of benefits.

VISION BI-WEEKLY DEDUCTIONS				
Plan	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
VISION	$2.36	$4.73	$4.49	$7.05

ALLSTATE WORKSITE INSURANCE

AllState is offering supplemental coverage, which is paid for entirely by employee payroll deductions. The company does not contribute towards the premium for these plans. Through **AllState**, you will have the option of getting more coverage should you or your immediate family become ill. Benefits are paid regardless of other coverage.

DISABILITY INSURANCE
This plan replaces a portion of your income if you become disabled because of a covered accident or a covered sickness.

CANCER INSURANCE
Cancer coverage can help offer peace of mind when a diagnosis of cancer occurs. Cancer Insurance pays cash benefits for cancer and 20 specified diseases to help with the costs associated with treatments and expenses as they happen. Cash benefits can be used for hospital stays, doctor bills, transportation childcare and more. Please refer to the plan documents for complete details for this coverage.

LIFE INSURANCE
Life Insurance helps protect your family from a sudden loss of income in the event of death. Employee Life Insurance will be paid to your beneficiary(ies) if you should pass away.

ACCIDENT INSURANCE
Supplemental accident insurance policy is a medical indemnity plan that provides employees and their families with hospital, physician, accidental death and catastrophic accidental benefits in the event of a covered accident.

Employee only and Family coverage is available.

These are your own policies. If you leave the company or retire, you can take the policy with you and pay the same premium. **AllState** will bill you directly.

NOTICE OF MEDICARE PART D CREDITABLE COVERAGE

FOR MEDICARE-ELIGIBLE EMPLOYEES ENROLLED IN THE UNITED HEALTHCARE PLANS

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 that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

2. **Crown Linen LLC.** has determined that the prescription drug coverage offered by the UHC plans, are on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. **Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from **October 15th through December 7th.** However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

In addition, if you lose or decide to leave employer/union-sponsored coverage, you will be eligible to join a Part D plan at the time using an Employer Group Special Enrollment Period.

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.

If you decide to join a Medicare drug plan, your Crown Linen LLC. coverage will not be affected. If you decide to join a Medicare drug plan and drop your employer sponsored prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop coverage or lose your group coverage and do not 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.

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).

Note: You'll get this notice each year. You may also request a copy.

For more information about your option under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will be mailed a copy from Medicare each year. For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (or see "Medicare & You" Handbook)
- 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).

Date:	July 1, 2023
Name of Entity/Sender:	Crown Linen LLC.
Contact / Position:	Lenis Figuera
Address:	3235 NW 62nd Street, Miami, FL 33147
Phone Number:	305-691-4048

HEALTHCARE REFORM

NOTICE OF HEALTH CARE REFORM CHANGES

As a reminder, the following changes to our **Crown Linen LLC.** Medical Plans are still valid for the 2023 plan year.

• The lifetime benefit limit will be unlimited on essential services. There will be no annual limit on essential benefits.

Essential benefits may include:

- o Ambulatory Patient Services
- o Emergency Services
- o Hospitalization
- o Maternity and Newborn Care
- o Mental Health and Substance Abuse Disorders
- o Prescription Drugs
- o Rehabilitative and Facilitative Services and Devices (including durable medical equipment)
- o Laboratory Services
- o Prevention and Wellness Services
- o Chronic Disease Management
- o Pediatric Services, including oral and vision care

• Certain Preventive services are now covered 100% at no charge when you use **United Healthcare** network providers.

These include:

- o Routine adult physical
- o Routine Well child Exams
- o Routine Gynecological exams (includes pap and related fees)
- o Colorectal Cancer Screening
- o Routine mammograms

• Most Generic Oral Contraceptive Medications & Products for $0 cost-share. (FDA Approved Contraceptive Methods for women). Items available without a prescription are not covered under the Health Care Reform law.

• Pre-existing Condition exclusions do not apply

• Dependents are covered until age 26 – Age 30 if specific criteria are met. Dependents under age 26 may enroll within 30 days of renewal for coverage effective June 1, 2023.

• Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

• Gynecological and obstetric services: Authorization or referral for gynecologic or obstetric care will not be required.

• Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

Form Approved OMB No. 1210-0149 (expires 6-30-2024)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

PART B: Information about Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Crown Linen LLC.	4. Employer Identification Number (EIN) 20-0036473	
5. Employer address: 3235 NW 62nd Street, Miami, FL 33147	6. Employer phone number: 305-691-4048	
7. City: Miami	8. State: FL	9. ZIP code: 33147
10. Who can we contact about employee health coverage at this job? Lenis Figuera		
11. Phone Number (If different from above)	12. Email address: figuera@crownlinen.net	

Here is some basic information about health coverage offered by this employer:
• As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ All Full-time Eligible Employees and COBRA Participants

• With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse/Same-Sex Domestic Partners (Registered). Dependents of employees up to age 26; and dependents who are age 26+ under the guidelines of the State of Florida (FSS 627.6562)

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). **This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket

costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your hours of employment are reduced, or
• Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your spouse dies;
• Your spouse's hours of employment are reduced;
• Your spouse's employment ends for any reason other than his or her gross misconduct;
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
• The parent-employee dies;
• The parent-employee's hours of employment are reduced;
• The parent-employee's employment ends for any reason other than his or her gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
• The end of employment or reduction of hours of employment;
• Death of the employee;
• The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your Plan Administrator.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or

other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of
• The month after your employment ends; or
• The month after group health plan coverage based on current employment ends.

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

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

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

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH, OR ADOPTION

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' and Mothers' Health Protection Act (NMHPA) was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than:

- ✔ 48 hours following a vaginal delivery; and
- ✔ 96 hours following a delivery by cesarean section.

A group health plan may also not require a physician or other health care provider to obtain authorization from the plan for prescribing the minimum hospital stay for the mother or newborn. However, the health plan may impose cost sharing, such as deductibles or coinsurance, on hospital stays related to childbirth.

COVERAGE REQUIREMENTS

The NMHPA sets limits on benefits that are provided for hospital stays after childbirth. However, nothing in the law or regulations requires a mother to give birth in a hospital or stay in the hospital for a specific period of time after giving birth. Also, the NMHPA does not require group health plans to provide any benefits for hospital stays related to childbirth. However, if the plan provides these benefits, it must comply with the NMHPA's minimum requirements.

HOSPITAL LENGTH OF STAY

The final regulations clarify when a hospital stay connected with childbirth begins.

• When a delivery occurs in the hospital, the stay begins at the time of delivery, not at the time of admission or beginning of labor.

• If there are multiple births, the stay begins at the time of the last delivery.
• For deliveries that occur outside of the hospital, the stay begins at the time the mother or newborn is admitted.

The decision of whether a hospital stay is connected with childbirth is a medical decision to be made by the attending provider.

ATTENDING PROVIDER DEFINITION
The regulations provide an exception to the NMHPA's general rule regarding length of hospital stay for situations where the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than 48 or 96 hours, as applicable.

The attending provider is "an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child." The final regulations definitively state that the definition of attending provider does not include a plan, hospital, managed care organization or other issuer.

PROHIBITION ON INCENTIVES
The NMHPA contains a number of prohibitions designed to prevent benefits from being improperly limited. The regulations clarify that a group health plan may not deny a mother or her newborn coverage under the plan to avoid the NMHPA's requirements or provide payments or rebates to a mother to encourage her to accept lesser benefits than those provided for by the NMHPA.

Also, a group health plan may not penalize an attending provider for giving care in accordance with the NMHPA or provide incentives to induce an attending provider to discharge a mother or newborn before the end of the required time period. However, a group health plan may negotiate with an attending provider the compensation for care provided for hospital stays related to childbirth in general.

Authorization and Cost-sharing The final regulations state that a plan may not require a physician or other health care provider to obtain authorization for prescribing a hospital stay in accordance with the NMHPA. In addition, a group health plan may not restrict benefits for a portion of a hospital length of stay provided for by the NMHPA in a way that is less favorable than benefits for a previous portion of the stay.

The regulations do not prohibit imposing cost-sharing, such as deductibles or coinsurance, on hospital stays related to childbirth. However, the cost-sharing must be consistent for the entire stay and cannot be higher for a later portion of the mandated length of stay.

NOTICE REQUIREMENTS
The notice requirements with respect to the NMHPA differ depending on the type of plan or coverage involved. The regulations explain the differences as follows:

• ERISA Plans. ERISA's rules for summary plan descriptions (SPDs) require all group health plans to describe the federal or state law requirements applicable to the plan relating to hospital lengths of stay in connection with childbirth for the mother or newborn. The DOL provided model language regarding the NMHPA in the SPD rules. See below for this model language.

• State and Local Government Plans. Plans that are subject to the NMHPA must provide a notice with specific language describing the federal requirements. The final regulations clarify that the notice can either be included in the plan document that describes benefits or in the type of document the plan generally uses to inform participants and beneficiaries of plan benefit changes. Further, any time a plan distributes one or both of these documents after providing the initial notice, the applicable statement must be included in one or both documents.

• Health Insurance Issuers in the Individual Market. Health insurance issuers in the individual market must also provide notice in the insurance contract containing specific language regarding the federal rules.

STATE INSURANCE MANDATES

The NMHPA and the final regulations do not apply to health insurance coverage (and group health plans that provide benefits only through health insurance coverage) in certain states that have adopted laws similar to the NMHPA. The final regulations clarify that a state law qualifies for this exception if it requires the health insurance coverage to do one of the following:

• Provide for at least a 48-hour hospital length of stay after childbirth (96 hours for a cesarean delivery);
• Provide for maternity and pediatric care in accordance with guidelines for care following childbirth established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics or any other established professional medical association; or
• Require, in connection with coverage for maternity care, that the hospital length of stay decision is made by the attending provider in connection with the mother or with the mother's consent.

ENFORCEMENT

There are no specific penalties for failing to comply with the NMHPA. However, plan participants or the DOL could use ERISA's enforcement scheme to compel compliance with the NMHPA's requirements. For example, a plan participant could bring a lawsuit for benefits due under the NMHPA, and could seek interest and attorneys' fees. In addition, the Internal Revenue Service (IRS) may impose an excise tax of $100 per day on a group health plan that does not comply with the NMHPA, subject to certain limitations and exceptions depending on the nature of the noncompliance.

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).

ENROLLMENT NOTICE - WHCRA

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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; External breast forms that fit into your bra for before or during reconstruction
- 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.

MICHELLE'S LAW

MICHELLE'S LAW—COVERAGE FOR DEPENDENT STUDENTS

Michelle's Law was enacted in 2008 to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law is named after a New Hampshire college student, Michelle Morse, who continued her studies while battling colon cancer in order to maintain health insurance coverage under her parents' plan. Michelle died of colon cancer in November 2005 at the age of 22.

The Affordable Care Act (ACA) further expanded coverage requirements for dependents, effective for plan years beginning on or after Sept. 23, 2010. Under the ACA, group health plans or insurers that provide coverage for dependent children must continue to make coverage available until a child attains age 26, regardless of student status.

COVERAGE REQUIREMENTS

Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for **up to one year** while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under Michelle's Law, a dependent child is entitled to the **same level of benefits** during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

NOTICE REQUIREMENTS

Group health plans are required to provide notice of the requirements of Michelle's Law, in language understandable to the typical plan participant, along with any notice regarding a requirement for certifying student status for plan coverage.

IMPACT OF the ACA

The ACA's adult child coverage mandate diminished the impact of Michelle's Law on many health plans. Under the ACA, if a group health plan or insurer provides dependent coverage for children, the plan or insurer must continue to make the coverage available until the child attains age 26, regardless of student status. Thus, the impact of Michelle's Law on group health plans will generally be limited to health plans that provide coverage to dependent students who are age 26 or over.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you receive emergency care or care from a non-network medical provider at a network hospital or ambulatory surgical center, you are protected from surprise balance billing or billing.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you get care from a doctor or other medical provider, you may have o pay certain out-of-pocket costs, such as copayments, coinsurance, or deductibles. You may have other expenses or have to pay the entire bill if you see a provider or visit a medical facility that is not in your health plan network.

The term "out-of-network" refers to medical providers and facilities that do not have a contract with your health plan. Out-of-network medical providers may be allowed to bill you for the difference between what your health plan agrees to pay and the full amount billed for the service. This is called "balance billing." This amount is likely to be higher than the in-network costs for the same service and may not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. this can happen when you cannot control who participates in your medical care; by For example, when you go to the ER or make an appointment at a network medical facility, but are unexpectedly seen by a non-network medical provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services
If you have a medical emergency and you receive emergency services from an out-of-network provider or medical facility, the most that provider or medical facility can bill you is your health plan's cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you can get after you are in stable condition, except if you consent in writing and waive your protections from being balance billed for these post-stabilization services.

Some services at in-network hospitals and ambulatory surgical centers
When you receive services from a network hospital or ambulatory surgical center, there may be out-of-network medical providers. In these cases, the most these

providers can bill you is the amount of costs shared within your health plan network. This applies to medicine emergency, anesthesia, pathology, radiology, laboratories, neonatology, surgical assistants, hospital medicine and intensive care services. These providers cannot balance bill you and cannot ask you to waive your balance billing protections.

If you receive other services at these network facilities, the providers that non-network cannot balance bill you unless you give your written consent and waiver of your protections.

You are never required to waive your protections against balance billing. You are also not required to receive out-of-network care. You can choose a provider or medical center from your health plan's network.

When balance billing is not allowed, you also have the following protections:

• You are only responsible for paying your share of the costs (for example, copayments, coinsurance, and deductibles that you would pay to a network provider or facility). Your health plan will pay out-of-network providers and facilities directly.

• Generally, your health plan must:

- Cover emergency services without requiring you to obtain prior approval for the services (prior authorization).

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

- Calculate what you owe the provider or facility (cost sharing) based on what you would pay to a network provider or facility and reflect that amount in your explanation of benefits.

- Include any amounts you pay for emergency or out-of-network services toward your deductible or self-pay limit.

If you believe you have been billed incorrectly, you may contact the Department of Health and Human Services at 1-877-696-6775.

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

MEDICAID & 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 January 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
CALIFORNIA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	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
ARKANSAS – Medicaid	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	

FLORIDA – Medicaid	GEORGIA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	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
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
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	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://hs.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
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012	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
LOUISIANA – Medicaid	**MAINE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102	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
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	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

NEW YORK – Medicaid	NORTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)
RHODE ISLAND – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
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)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
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 January 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)

HIPAA NOTICE

Your Information. Your Rights. Our Responsibilities.
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.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

HIPAA NOTICE

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- 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/**.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

HIPAA NOTICE

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you cover age and the price of that coverage. This does not apply to long term care plans.

Example: *We use health information about you to develop better services for you.*

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

HIPAA NOTICE

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Benefit plans are subject to change. Crown Linen LLC. reserves the right at any time, in its sole discretion, to amend, modify, reduce the benefits provided by, or terminate any of its plans. Any amendment, modification, reduction or termination may be made without prior notice to participants, except as required by law. This Benefit Booklet is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this benefit booklet conflicts in any way with the Certificate of Coverage, the COC shall prevail. It is recommended that you review your COC for an exact description of the services, and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information.

Note: While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.