2023-2024

NTECC

Benefit Enrollment Guide

Important Contacts

Resource	Phone Number	Website/E-mail
Medical and Prescription	1-800-521-2227	www.bcbstx.com
Dental	1-800-521-2227	www.bcbstx.com
Vision	1-800-521-2227	www.bcbstx.com
Life Insurance	1-800-225-5695	www.newyorklife.com
Disability Coverage	1-800-225-5695	www.newyorklife.com
Flexible Spending Accounts	Customer Service 877-661-4727 Email: healthbenefits@alerus.com	www.alerusrb.com
Employee Assistance Program	1-800-344-9752	www.GuidanceResources.com

Table of Contents

This guide highlights the main features of many of the benefit plans sponsored by North Texas Emergency Communications Center (NTECC). Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. NTECC reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Eligibility Guidelines

Employees

All full-time employees working 30 or more hours per week are eligible for NTECC benefits. Employees that become eligible for applicable benefits coverage must enroll within 30 days from the date of hire. Dependents eligible for benefits include your legal spouse and your dependent child(ren). Dependent child(ren) include:

- Natural children
- Legally adopted children or children placed for adoption for whom legal adoption proceedings have been started
- Stepchildren
- Children for whom benefits must be provided through a qualified Medical Child-Support Order
- Any other child for whom you have obtained legal guardianship.

Regardless of marital status, children are eligible for medical, dental, life and vision coverage from birth up to age 26. If a child becomes mentally or physically disabled while covered under the benefit plans, the child's coverage may be continued as long as the child remains disabled and depends on you for support.

Making Enrollment Changes During the Year

In most cases, your pretax benefit elections are irrevocable and remain the same for the entire year (May 1– April 30). During each annual enrollment period, you will have the opportunity to review your benefit elections and make changes for the coming year. During annual enrollment, you may make changes to your coverage such as adding or dropping coverage for yourself and any dependents or changing to other plan options (if eligible and available). Certain coverages allow limited changes to elections during the year. These benefits include the medical, HealthCare FSA, dental, and vision. Under these benefits you may make changes to your elections only during the year if you have a status change. Status Changes include:

- Marriage, divorce, or legal separation
- Gain or loss of an eligible dependent for reason such as birth, adoption, placement for adoption, court order, disability, or death;
- An event that causes a dependent to satisfy or cease to satisfy the eligibility requirements of the Plan, such as reaching the dependent age limits or any similar circumstance
- Changes in your spouse's employment or benefit coverage that affect benefits eligibility.

The change to your benefit elections must be consistent with the status change. You have 30 days from the date of a status change to make appropriate updates. Otherwise, you must wait until the next annual enrollment period to make a change to your elections unless you experience another status change or HIPAA Special Enrollment event. All changes must be reported through the Paycor benefits portal.

In some cases, your election will become effective on the first day of the month following your request. If your change is the result of birth, adoption or placement for adoption, your election will become effective first of the month following the submitted changes. Contact a member of the Human Resources team if you have questions on making changes during the year.

Pretax Payroll Deductions

The Medical, Dental, Vision and FSA Plans, are offered on a pretax basis through the IRS Section 125. By making your contributions on a pretax basis, the premium is withheld from your pay before federal taxes are calculated. This can reduce the amount of taxes you pay per paycheck.

Medical Plan

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured. It's important to be sure you're covered, either through NTECC's plan or through another option available to you, such as your spouse's employer benefits or a government program like Medicare or Medicaid.

Our new medical plan is with Blue Cross Blue Shield and has an In-Network Deductible of $500 for individual and $1,500 for family with an out-of-pocket maximum of $1,500 for individual and $4,500 for family coverage. NTECC contributes to your benefit premiums.

All the providers in the **Blue Choice PPO network** can change frequently. To find out if your doctor participates in the network, go to www.bcbstx.com and select Find Care, and then select Find a Doctor or Hospital to find an in-network provider near you.

Medical Premiums & Contributions

PPO Premier Plan	Total Monthly Plan Cost	Monthly Rate Paid by NTECC	Monthly Rate Paid by Employee	Per Paycheck Rate Paid by Employee
Employee Only	$717.77	$692.77	$25.00	$11.54
Employee & Spouse	$1,420.84	$1,070.84	$350.00	$161.54
Employee & Children	$1,570.37	$1,420.37	$150.00	$69.23
Employee & Family	$2,273.45	$1,773.45	$500.00	$230.77

Medical Plan Highlights

The table below highlights some plan features and cost sharing amounts. For full plan details, please review the plan documents found on the Paycor Benefits Enrollment portal.

	BCBS – MTBCP002	
	In-Network	Out of Network
Annual Deductible		
Individual	$500	$10,000
Family	$1,500	$20,000
Annual Out-of-Pocket Maximum		
Individual	$1,500	Unlimited
Family	$4,500	Unlimited
Coinsurance/Copays		
Preventive Care	Covered at 100%	50% after ded
Virtual Visits	$0 Copay	Not Covered
Primary Care Physician	$30 Copay	50% after ded
Specialist (Preferred/Non-Preferred)	$60 Copay	50% after ded
Diagnostics, X-Ray, and Lab Services	No charge after office copay	50% after ded
Imaging (CT/PET scans, MRIs)	0% after deductible	50% after ded
Urgent Care	$75 Copay per visit	50% after ded
Emergency Room	$500 Copay per visit	
Inpatient Hospital Care	0% after deductible	50% after ded
Outpatient Surgery	0% after deductible	50% after ded

NTECC Wellness Program

NTECC offers at **NO COST TO YOU,** a wellness program which provides you with access to a variety of wellness opportunities each year through Blue Cross Blue Shield of Texas. NTECC employees can keep track of their wellness rewards by accessing their member profile via **www.bcbstxcom**. Participation in the wellness program is not mandated but encouraged. Employees must be enrolled in the medical program to participate in the below wellness program.

Wellness Program Reward Activities	2023 - 2024 Wellness Year
Register for Blue Access for Members (BAM) – BCBS TX Member Profile	5 points
Biometric Screening with Primary Care Physician	25 points
BMI (<= 27.5)	Achieve 3 out of the 5 risk factors by March 1, 2024
Fasting Glucose (<=100)	
Cholesterol (< 200)	
Triglycerides (< 150 mg/dl)	
Blood Pressure (<=140/90)	
Intervention Programs	
Omada – Diabetes Prevention Solution	40 points
Wondr Health – Metabolic Reversal Program	50 points
Hinge Health – Digital Musculoskeletal Program	40 points
Preventative Screenings	
Complete one of the following: •Annual Physical/Prenatal Exam •Complete any Colon Screening •Complete a Pap Screening •Complete a Mammogram Screening	25 points
Annual Dental Exam	20 points
Annual Vision Exam	20 points
Additional Wellness Activities	
Flu Shot	15 points
Sanvello - Mental wellness (20 weekly check-ins check-ins)	50 points
Contribute article to NTECC newsletter (maximum of 1x per plan year)	10 points
Learn-To-Live (Behavioral Health & Coaching)	25 points
Virtual Visit - MDLive	15 points
Livongo – Hypertension Management Solution	25 points

***By participating in the wellness program, Employees may become eligible for discounted medical rates in the future. Receive 100 points to be entered in a prize drawing. Please complete by March 2024.**

Prescription Drug Coverage

PRESCRIPTION DRUG COVERAGE

If you enroll in the NTECC medical plan, you will automatically receive prescription drug coverage. For the medical plan, prescriptions are provided through BCBS. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

Specialty Prescription Program

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support. If you have a prescription that meets this requirement, BCBS will contact you and provide you with the necessary information to fill your prescription.

Prescription Drug Plan Highlights

	Blue Cross Blue Shield PPO	
	In-Network	Out-of-Network
Retail Prescriptions (up to 30-day supply)		
Tier 1 (Preferred Generic)	$0 Copay / $10 Copay	Retail Copay + 50% coinsurance
Tier 2 (Non-Preferred Generic)	$10 Copay / $20 Copay	Retail Copay + 50% coinsurance
Tier 3 (Preferred Brand)	$50 Copay / $70 Copay	Retail Copay + 50% coinsurance
Tier 4	$100 Copay / $120 Copay	Retail Copay + 50% coinsurance
Tier 5	$150 Copay	Retail Copay + 50% coinsurance
Tier 6	$250 Copay	Retail Copay + 50% coinsurance
Mail Order Prescriptions (90-day supply)		
Tiers 1-4 *Specialty drugs not eligible for mail order	3x Retail Copay	Not Covered

Additional Programs

BCBTX App

The BCBSTX App allows you to access your benefit and claim information when you are on the go. Locate the app in the App Store or text BCBSTXAPP to 33633. You can do the following on the app:

- Find an in-network provider, hospital or facility
- Access claims, coverage, and deductible information
- View and email your member ID card
- Download Explanation of Benefits

24/7 Telemedicine with BCBS

What is telemedicine?

BCBS provides all medical members with a virtual visit option through MDLIVE which is available 24/7/365 specializing in convenient, quality medical care. With board-certified physicians in all 50 states*, those in need can obtain diagnosis, treatment, and prescriptions, when necessary, through the convenience of telephone and digital communications.

Commonly Treated Conditions

- Allergies
- Arthritic Pain
- Cold & Flu
- Tonsillitis
- Laryngitis
- Pharyngitis
- Skin Infections
- Gastroenteritis
- Ear Infection
- Pink Eye
- Insect Bites
- Minor Burns
- Respiratory Infections
- Sinusitis
- Sprains and Strains
- Urinary Tract Infection
- Consulting for International and Domestic Travel

How it Works

1. **Go to www.MDLIVE.com/bcbstx or the MDLIVE app**
   NTECC employees can access a virtual visit by either calling MDLIVE at 888-680-8646 or by logging into your MDLIVE profile. Once you are logged in, you will be able to schedule a virtual visit, at any time, with a U.S. Board Certified Doctors and begin getting the care you need for minor medical symptoms.
2. **Request a Consult**
   Login to your account online or call member services at 888-680-8646 to request a consult anytime 24/7.
3. **Receive Care**
   Receive diagnosis and treatment. Virtual visits provide quality care and peace of mind wherever you are.

Flexible Spending Accounts (FSA)

NTECC allows you to contribute to flexible spending accounts, which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by Alerus.

How the FSAs Work

You can save money on your health care and dependent care costs through the use of tax-advantaged accounts that allow you to use before-tax dollars to pay for eligible expenses. The purpose of these flexible spending accounts (FSA) is to allow you to set money aside on a pre-tax basis to cover expenses that are not otherwise covered under a traditional medical, dental or vision plan. By anticipating your family's health care and dependent care costs for the next year, you can lower your taxable income.

Because of its tax advantages, rules and limitation are clearly defined by the IRS (including eligible expenses.) The IRS requires that you forfeit any amounts not spent by the end of the year (this is commonly referred to as the "use it or lose it" rule).

NTECC offers two types of FSAs:

- Healthcare FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount (subject to IRS maximums) to be taken from your paycheck and deposited into your account throughout the year. Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

Annual Contribution Amount

You can contribute up to $3,050 per year to the Healthcare FSA.

How the Debit Card Works

All NTECC employees electing to participate in the full Healthcare FSA program will receive a Alerus Card. The Alerus Card is a prepaid debit card that allows you to pay for qualified expenses directly from your account. The amount that you elected in your FSA is available immediately at the start of your plan year. When using your Alerus Card, it is important to record and document receipts and other items that validate your Alerus Card transactions. In some cases, you may be required to submit documentation to prove you paid for an eligible medical expense. If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

For a complete list of eligible expenses, visit **www.alerusrb.com** and click on "Resources" and then "Eligible Expenses". If any amounts remain unused in your accounts as of the end of the Plan Year, after all claims have been processed, you will forfeit the remaining amount.

Managing your account can be done online via your Alerus member profile at **www.alerusrb.com**.

Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be:
  - Employed
  - A full-time student at least five months during the plan year, or
  - Mentally or physically disabled and unable to provide care for himself or herself.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care for:

- Your children under age 13 whom you claim as a dependent for tax purposes
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:

- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- After-school care

Annual Contribution Amount

You can contribute up to $5,000 per year to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500.

Important FSA Considerations

- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.
- All types of FSA accounts are subject to the "use it or lose it" policy.

DOWNLOAD THE APP*

- Search **Alerus Retirement and Benefits** in either the App Store or Google Play to download our mobile app.
- The mobile app is available for Apple, iPad, and Android devices.

ALERUS HEALTH BENEFITS

Available on iTunes

GET IT ON Google play

LOGGING IN

- *User ID* is first initial of first name + last name + last four digits of SSN.
- *Password* is last four digits of SSN.
- Once you have established your username and password you will be prompted to create a four digit passcode. At that time you can also enable Touch ID and Facial Recognition.

Dental Plan (PPO)

NTECC's Dental Plan is administered through Blue Cross Blue Shield and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings and orthodontia for children and adults.

Dental PPO Plan (Plan Year May 1, 2023 – April 30, 2024)

The BCBS Dental PPO Plan helps you with the cost of many dental services. BCBS's Dental network is called the **"BlueCare Dental"** network. With this dental plan, you are free to see any dentist you choose. The PPO plan allows participants to choose a dentist from the BlueCare Dental network or one that does not participate in the network at all. Your total out-of-pocket payment will be higher if you visit someone not associated with the network. All in-network dentists have agreed to accept an allowable amount, as determined by BCBS for the services provided. However, if your dentist is out-of-network, your claims will be paid at the maximum allowance, and you will be responsible for the difference between what is paid and what is billed. To look up participating dentists, visit **bcbstx.com/find-care/providers-in-your-network/find-a-dentist.**

Plan Feature	Dental PPO Plan – DTNHR33
Annual Deductible (January 1 – December 31)	$50 Individual / $150 Family
Annual Benefit Maximum	$1,500
Preventive Services (deductible does not apply) (Exams, routine cleanings, fluoride treatments, x-rays, etc.)	100% (no deductible)
Basic Services (Fillings, sealants, periodontics, endodontics, etc.)	80% after deductible
Major Services (Bridges, Dentures, Crowns, etc.)	50% after deductible
Orthodontia (adult and children)	$1,500 Lifetime Maximum

Some services are subject to age and frequency limitations – see plan document for more details.

Dental Premiums and Contributions

Dental PPO Plan	Total Monthly Plan Cost	Monthly Rate Paid by NTECC	Monthly Rate Paid by Employee	Per Paycheck Rate Paid by Employee
Employee Only	$38.98	$29.36	$9.62	$4.44
Employee & Spouse	$77.93	$55.94	$21.99	$10.15
Employee & Child(ren)	$95.55	$74.08	$21.47	$9.91
Employee & Family	$147.50	$123.63	$23.87	$11.02

Vision Plan

NTECC's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Blue Cross Blue Shield

Vision Coverage

If you enroll for vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the BCBS network, you will receive a discount on services. To find a network provider, go to www.bcbstx.com/find-care/providers-in-your-network/vision.

The Vision Plan is designed to cover eye care needs that are visually necessary. You must pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Some services are subject to frequency and other limitations – see plan document for more details.

	In-Network	Out-of-Network
Plan Feature	You Pay	Reimbursement
Exam	$10 Copay	Up to $30
Prescription Glasses		
Single Lenses	$25 Copay	Up to $25
Bifocals – Lined	$25 Copay	Up to $40
Trifocals – Lined	$25Copay	Up to $55
Frames	$130 allowance or 20% off balance over $130	Up to $65
Contacts		
Medically Necessary	Covered in full	Up to $210
Elective – In Lieu of Glasses	$130 allowance	Up to $104
Contact Lens Exam (Fitting and Evaluation)	Up to $40	Not Covered

Benefit Frequency	
Exam	Once every 12 months
Frames	Once every 24 months
Lenses	Once every 12 months
Contacts	Once every 12 months

Vision Premiums and Contributions

VISION	Monthly Rate Paid by Employee	Per Paycheck Rate Paid by Employee
Employee Only	$7.60	$ 3.51
Employee & Spouse	$14.44	$6.66
Employee & Children	$15.20	$7.02
Employee & Family	$22.35	$10.32

Life and AD&D Insurance

NTECC offers life and accidental death and dismemberment (AD&D) insurance coverage to provide financial protection in the event you or your dependents die while you are still working. This coverage is administered through New York Life.

Basic Life Insurance & AD&D Insurance

NTECC provides Basic Life Insurance for all Full Time Employees at *no cost to you*. Basic Life Insurance is equal to 2 times your annual base earnings, up to a maximum benefit of $300,000. The benefit is paid to your beneficiaries in the event of your death.

Beneficiary Designation

You must designate a beneficiary for Basic and Voluntary Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your life and AD&D coverage in the event of your death. You are always the beneficiary of any dependent life and AD&D insurance you elect. You can change your beneficiaries at any time during the year.

If you do not name a beneficiary, or if your beneficiary dies before you, your life and AD&D benefits will be paid to your estate.

Disability Coverage

Short-Term Disability

NTECC pays for STD coverage for all eligible employees. The STD benefit pays a percentage of your total monthly earnings (less other income benefits) if you can't work due to a total disability. Benefits become payable on a weekly basis once you have been disabled for 14 days for sickness or 14 days for injury. Benefits may continue while you are disabled for a maximum of 11 weeks. At that point if you are still disabled you are then eligible to file a Long-Term Disability claim. See additional information on this benefit on the following page.

BENEFITS	New York Life
- Benefit Percentage - Maximum Benefit	60% of Monthly Income $2,000 per week
ELIMINATION PERIOD(Accident)	7 Days
ELIMINATION PERIOD(Sickness)	7 Days
Benefit Duration	13 Weeks
DEFINITION OF DISABILITY	Loss of Duties and Earnings
LIMITATIONS - Pre-Existing Conditions	 3 months / 12 months

Long Term Disability

NTECC pays for LTD coverage for all eligible employees. The LTD benefit pays a percentage of your total monthly earnings (less other income benefits) if you cannot work due to a total disability. Benefits become payable on a monthly basis once you have been disabled for 90 days. Benefits may continue while you are disabled up to Social Security Normal Retirement Age.

BENEFITS	New York Life
- Benefit Percentage - Maximum Benefit - Minimum Benefit	60% of Monthly Income $10,000 per Month $100
OWN OCCUPATION PERIOD	24 Months
ELIMINATION PERIOD	90 Days
DEFINITION OF DISABILITY	Loss of Duties and Earnings
LIMITATIONS - Pre-Existing Conditions - Mental and Nervous / Drug and Alcohol	 3 months / 12 months 24 Months Combined (Lifetime Maximum)

Employee Assistance Program

You and your covered dependents have free access to NTECC's Employee Assistance Program (EAP). This confidential service offers free over-the-phone counseling any time, day, or night, to help you with a variety of personal issues. The EAP also provides up to three (3) free face-to-face counseling sessions for both you and your covered dependents. Counselors can help with concerns about things like:

- Emotional well-being and mental health
- Relationships and parenting
- Addiction and recovery
- Marital and family problems
- Legal and financial issues

To contact the EAP, call 800-344-9752, 24 hours a day, seven days a week, to talk to a professional counselor. You can also get more information online at www.GuidanceResources.com.

First Responder Health - EAP

We know asking for help is hard – the last thing you should have to think about is how your insurance pays. That's why Responder Health has partnered with NTECC to simplify the process. Whether you need inpatient treatment, help with finding the right counselor, or simply just to talk to someone – we have your back, just like you have ours.

When you need to talk, we are here 24/7 just call 206-459-3020. Your peer advocate will work to find the right solution for you.

How to Enroll in Benefits with Paycor

Be sure to have social security numbers available for dependents and beneficiaries prior to logging on

Accessing Your Online Benefits Portal

1. Login to Paycor. Hover over **Me**, and then click **Benefits**.

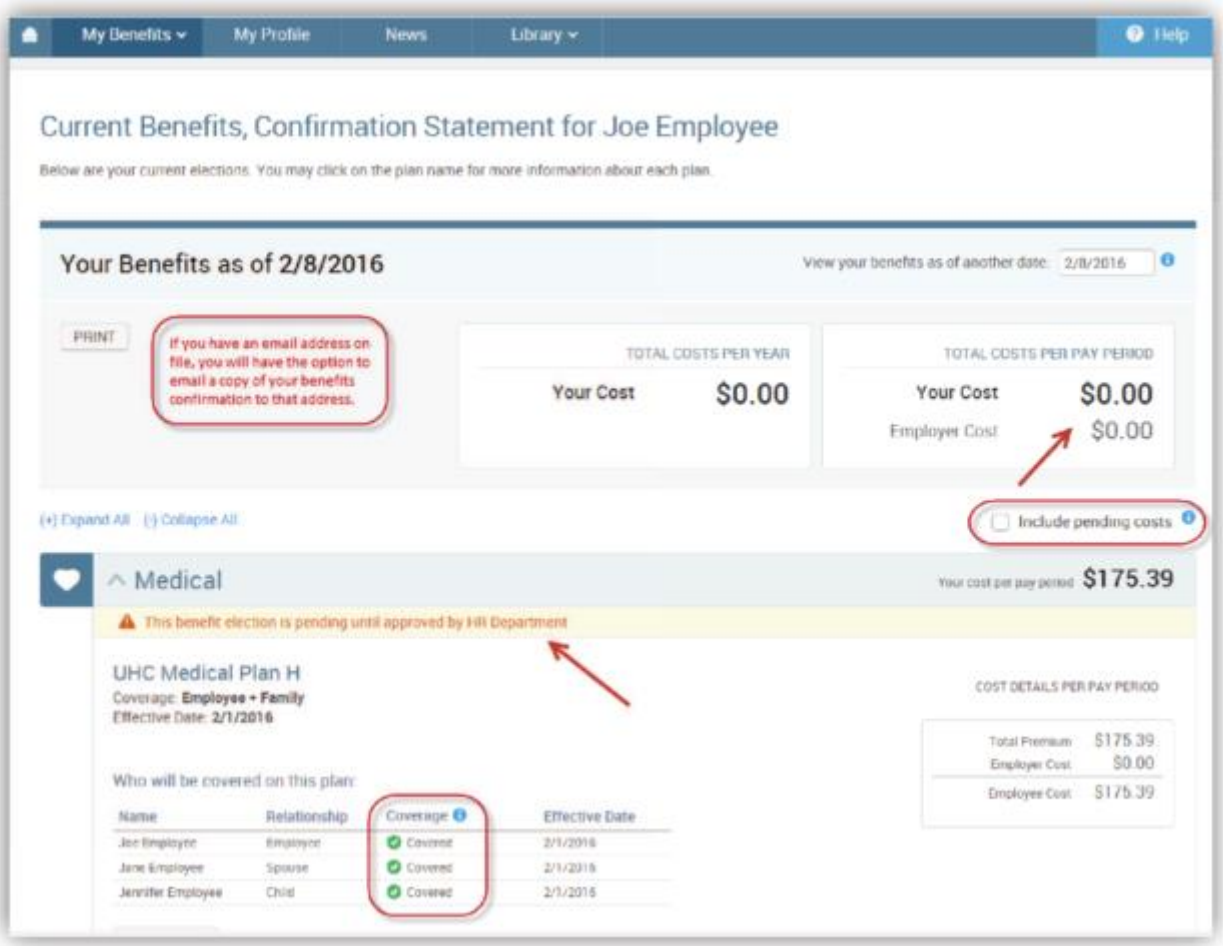
2. You will then be directed to your Benefits Home screen:

3. From this screen, you can:
    - View your benefits
    - Get information on the plans you're enrolled in
    - Find carrier information
    - Process a life event change that allows you to update your benefits, such as:
        - Marriage – add a spouse
        - Birth/Adoption of a child – add a new child
        - Divorce – remove a former spouse
        - Loss of coverage through a spouse's plan – allows you to add benefits

Viewing Current Benefits

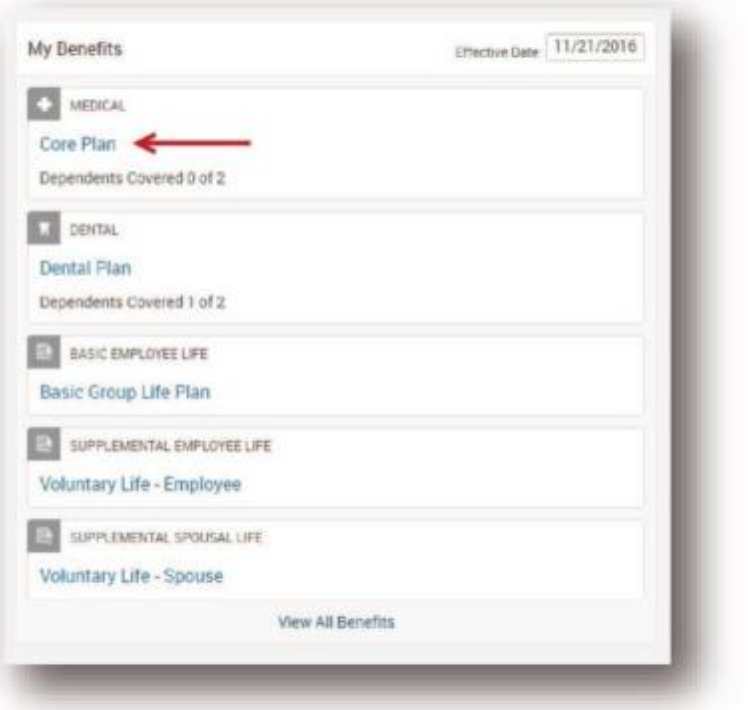
1. You can view your current benefit information by selecting **Current Benefits** when hovering over the **My Benefits** menu:

2. This will take you to a summary confirmation screen that will show all benefits you are enrolled in, pending enrollments, as well as who is covered and the cost. The per pay costs reflected on the page depend on whether or not the "Include pending costs" is selected and if there are benefits in a pended state.

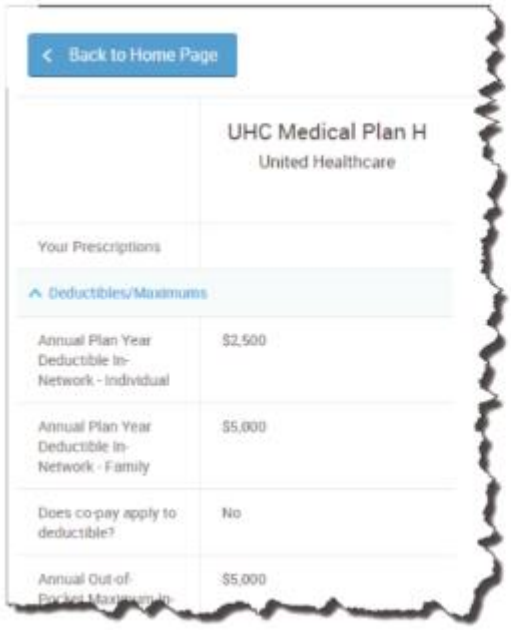


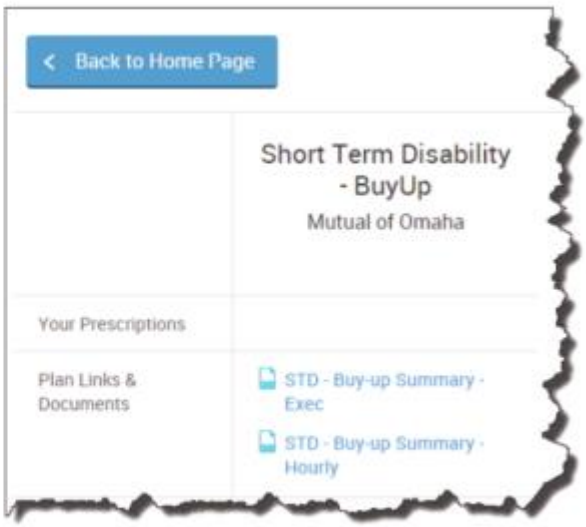
Viewing Plan Information

1. You can view plan detail information and access plan documentation by clicking on the benefit type from the Benefits Quicklook menu on the bottom half of the Home screen.



2. Selecting the plan type, for example "Medical", will take you to a page that will show details of the plan you are enrolled in (if available) as well as any plan documents associated with that plan.

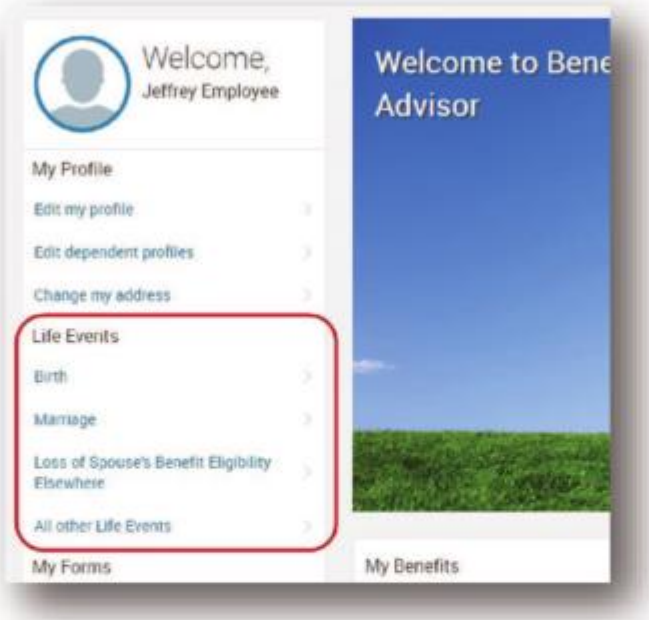

Back to Home Page
UHC Medical Plan H
United Healthcare
Your Prescriptions
Deductibles/Maximums
Annual Plan Year Deductible In-Network - Individual
$2,500
Annual Plan Year Deductible In-Network - Family
$5,000
Does co-pay apply to deductible?
No
$5,000


Back to Home Page
Short Term Disability - BuyUp
Mutual of Omaha
Your Prescriptions
Plan Links & Documents
STD - Buy-up Summary - Exec
STD - Buy-up Summary - Hourly

Processing a Life Event Change

From the Benefits Home screen:

1. Click on the **Life Events** link:



2. The system will walk you through providing the appropriate information based on the life event chosen.
3. After a plan is selected or the plan is waived the plan type icon will turn green. The ***Selection Required** text changes to **Completed**. This lets you know the enrollment for that plan type is complete. The plan pod will display the plan's name, vendor, coverage level, and whether dependents are covered, not covered, or ineligible. Anytime during the enrollment process changes can be made by selecting View Plan Options.

4. Clicking the arrow next to the cost opens a flyout menu with more detailed information, which typically includes the total premium and employer contribution.

5. The system will walk you through the allowable selection/change of your plans based on enrollment rules per the life event type. Note: These changes will not be complete until you get to the end of the enrollment and you click the Save Enrollment button after selecting "I agree, and I'm finished with my enrollment" box.

Required Notices

The following pages contain legal notices for participants in group health plans sponsored by NTECC. These notices are required to be distributed on an annual basis. While no action is required on your part in relation to these notices, these are provided to you for informational purposes and you should take time to familiarize yourself with their content.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by NTECC Health Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on October 1.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. NTECC requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present, or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care

provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Date: May 2023

Name of Entity/Sender: North Texas Emergency Communications Center

Contact/Office: Administrative Services Division

Address: 1649 W. Frankford Road, Suite 150

Phone Number: 469-289-3213

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Since key parts of the health care law took effect in 2014, there is another 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 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 tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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 9.61% 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.

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 at HR@coppelltx.gov.

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.

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.

1. Company Name: NTECC		2. Employer Identification Number (EIN) 47-2521935
3. Employer address 1649 W. Frankford Road, Suite 150		4. Employer phone number 469-289-3213
5. City Carrollton	6. State TX	7. ZIP code 75007
8. Who can we contact about employee health coverage at this job? Administrative Services Department		
9. Phone number (if different from above)	10. E-mail address **ASDHR@ntecc.org**	

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 full time employees working at least 30 hours per week.

With respect to dependents: We do offer coverage. Eligible dependents are: Your legal spouse, a child under the limiting age shown in your schedule of coverage, a child of your child who is your dependent for federal income tax purposes at the time application for coverage of the child is made, and any other child included as an eligible dependent under the plan.

[X] 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.

Medicare Prescription Drug Notice

Important Notice from NTECC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with NTECC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current NTECC coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current NTECC coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through NTECC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare Prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: May 2022

Name of Entity/Sender: North Texas Emergency Communications Center

Contact/Office: Administrative Services Division

Address: 1649 W. Frankford Road, Suite 150

Phone Number: 469-289-3213

COBRA Rights Notice

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to NTECC, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse,

surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. 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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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 Human Resources.

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

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 **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

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.

Plan Contact Information

Date: May 2023

Name of Entity/Sender: North Texas Emergency Communications Center

Contact/Office: Administrative Services Division

Address: 1649 W. Frankford Road, Suite 150

Phone Number: 469-289-3213

Wellness Program and Reasonable Alternatives Notice

NTECC Wellness 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:

- Voluntary health risk assessment which 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 Triglycerides, HDL Cholesterol, Fasting Glucose, Nicotine, Blood Pressure, and a measurement for Waist Circumference.
- The Rally registration as well as value-added programs available through UHC, at no cost to the member.
- Your annual physical and your covered spouse with your Primary Care Physician.

You are not required to complete the health risk assessment, to participate in the blood test or other medical examinations or complete the Rally registration activity. However, employees who choose to participate in the wellness program may receive an incentive of paying a lower medical premium and be eligible for prizes.

The information from your health risk assessment 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 and weight management programs. You also are encouraged to share your results or concerns with your own doctor.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to potentially earn the lower premium, you may be entitled to a reasonable accommodation or an alternative standard. You may inquire about a reasonable accommodation or an alternative standard by contacting the NTECC's Administrative Services Department.

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 NTECC may use aggregate information it collects to design a program based on identified health risks in the workplace. NTECC Wellness Program will never disclose any of your personal information either publicly or to the employer. Also, medical information that personally identifies you that is provided relating to the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is Holmes Murphy, the Wellness Works Clinic, and your physician (if applicable), to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained by the various providers of the Wellness Program mentioned above and not your employer. Your information is stored electronically and will be encrypted. No medical 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.

Reasonable Alternatives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a requirement under NTECC Wellness Program, you might qualify for an opportunity to meet the requirement through a reasonable alternative. Contact the NTECC's Human Resources Department and they can work with you (and if you wish, with your doctor) to find a reasonable alternative that is right for you considering your health status.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at asdhr@ntecc.org.

Other Notices

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in NTECC's medical coverage 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 no more than 31 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you can enroll yourself and your dependents in the NTECC's medical coverage as long as you request enrollment by contacting the benefits manager no more than 31 days after the marriage, birth, adoption or placement for adoption. For more information, contact NTECC's Human Resources Department.

60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide and this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

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 consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays, and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact Human Resources or your medical plan administrator.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information which is maintained by and for the plan for enrollment, payment, claims, and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources.

Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, NTECC provides female plan participants with expanded access to recommended preventive services, including contraceptives, without cost sharing. Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit **https://www.healthcare.gov/preventive-care-women/**.

CHIP NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from NTECC, 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 on the following page, 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, dial **1-877-KIDS NOW**, or visit **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 States listed on the following page, you may be eligible for assistance paying your employer health plan premiums. The list of States is current as of January 31, 2020. Contact your State for further information on eligibility.

To see if any other states have added a premium assistance program since January 31, 2020, 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

State	Website/E-mail	Phone
Alabama (Medicaid)	**http://www.myalhipp.com**	1-855-692-5447
Alaska (Medicaid)	*Premium Payment Program:* **http://myakhipp.com** *Medicaid Eligibility:* **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx** *E-mail:* **CustomerService@MyAKHIPP.com**	1-866-251-4861
Arkansas (Medicaid)	**http://myarhipp.com/**	1-855-692-7447
California (Medicaid)	**http://dhcs.ca.gov/hipp** **hipp@dhcs.ca.gov**	916-445-8322
Colorado (Medicaid and CHIP)	*Medicaid:* **https://www.healthfirstcolorado.com/** *CHIP:* **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus**	1-800-221-3943 1-800-359-1991

State	Website/E-mail	Phone
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268
Georgia (Medicaid)	**https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**	678-564-1162 ext. 2131
Indiana (Medicaid)	*Healthy Indiana Plan for low-income adults 19-64:* **http://www.in.gov/fssa/hip/** *All other Medicaid:* **https://www.in.gov/medicaid**	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* **https://dhs.iowa.gov/ime/members** *CHIP:* **http://dhs.iowa.gov/Hawki** *HIPP:* **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	**https://www.kancare.ks.gov/**	1-800-792-4884
Kentucky (Medicaid and CHIP)	*Medicaid:* **https://chfs.ky.gov** *KI-HIPP:* **https://chfs.ky.gov/agencies/dms/members/Pages/kihipp.apsx** *KI-HIPP E-mail:* **KIHIPP.PROGRAM@ky.gov** *KCHIP:* **https://kidshealth.ky.gov/Pages/index.aspx**	 1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	**www.medicaid.la.gov** **www.ldh.la.gov/lahipp**	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	**https://www.maine.gov/dhhs/ofi/applications-forms**	*Enroll:* 1-800-442-6003 *Private HIP:* 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	**https://www.mass.gov/info-details/masshealth-premium-assistance-pa**	1-800-862-4840
Minnesota (Medicaid)	**https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**	1-800-657-3739
Missouri (Medicaid)	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana (Medicaid)	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**	1-800-694-3084
Nebraska (Medicaid)	**http://www.ACCESSNebraska.ne.gov**	1-855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	**http://dhcfp.nv.gov/**	1-800-992-0900
New Hampshire (Medicaid)	**https://www.dhhs.nh.gov/oii/hipp.htm**	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	*Medicaid:* **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** *CHIP:* **http://www.njfamilycare.org/index.html**	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina (Medicaid)	**https://medicaid.ncdhhs.gov/**	919-855-4100
North Dakota (Medicaid)	**http://www.nd.gov/dhs/services/medicalserv/medicaid/**	1-844-854-4825
Oklahoma (Medicaid and CHIP)	**http://www.insureoklahoma.org**	1-888-365-3742
Oregon (Medicaid)	**http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html**	1-800-699-9075
Pennsylvania (Medicaid)	**https://www.dhs.pa.gov/providers/providers/pages/medical/HIPP-program.aspx**	1-800-692-7462
Rhode Island (Medicaid and CHIP)	**http://www.eohhs.ri.gov/**	1-855-697-4347 or 401-462-0311 (Direct Rite)
Utah (Medicaid and CHIP)	*Medicaid:* **https://medicaid.utah.gov/** *CHIP:* **http://health.utah.gov/chip**	1-877-543-7669
Vermont (Medicaid)	**http://www.greenmountaincare.org/**	1-800-250-8427
Virginia (Medicaid and CHIP)	**https://www.coverva.org/en/famis-select** **https://www.coverva.org/en/hipp**	1-800-432-5924
Washington (Medicaid)	**https://www.hca.wa.gov/**	1-800-562-3022
West Virginia (Medicaid)	**http://mywvhipp.com/**	1-855-699-8447
Wisconsin (Medicaid and CHIP)	**https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**	1-800-362-3002
Wyoming (Medicaid)	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**	1-800-251-1269

NOTES