ALLEGIS GROUP

IMPORTANT ANNUAL MEDICAL PLAN NOTICES

For **EXTERNAL EMPLOYEES**

THE HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Key parts of the health care law took effect in 2014, creating 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.

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. For coverage starting in 2024, the Open Enrollment period is November 1, 2023 – December 15, 2023.

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*.

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 the Allegis Benefits Service Center at 1-866-886-9798 or send an e-mail to AskBenefits@allegisgroup.com.

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

**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 Allegis Group	**4. Employer Identification Number (EIN)** 52-1304931	
5. Employer Address 7320 Parkway Drive	**6. Employer Phone Number** 866-886-9798	
7. City Hanover	**8. State** MD	**9. Zip** 21076
10. Who can we contact about employee health coverage at this job? The Allegis Benefits Service Center at 866-886-9798		
11. Phone Number (if different from above)	**12. Email Address** AskBenefits@allegisgroup.com	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

☐ All Employees

☑ Some employees. *Eligible employees are: Set out in your Benefits Guide*

With respect to dependents:

☑ We do offer coverage. *Eligible dependents are: Set out in your Benefits Guide*

☐ 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.*

THE 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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to your enrollment guide and/or Summary of Benefits and Coverage for more information on the deductibles and coinsurance that apply under your plan. If you would like more information on WHCRA benefits, contact the Plan Sponsor.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Under federal law, employer health plans and health insurance issuers offering group health insurance coverage generally may 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours *(or 96 hours)*. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Sponsor.

NOTICE OF PRIVACY PRACTICES

EFFECTIVE SEPTEMBER 23, 2013

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

This Notice of Privacy Practices is being provided on behalf of the self-funded and self-insured medical, dental and vision plans sponsored by Allegis Group, Inc. ("Allegis") (known collectively herein as the "Plan") under provisions of the federal law known as the Health Insurance Portability and Accountability Act of 1996, or HIPAA. This Notice does not apply to any fully-insured health plan or to any other welfare benefit plan provided by Allegis. You should have received separate notices of privacy practices directly from any applicable health insurance issuer or HMO.

YOUR HEALTH INFORMATION

We at Allegis understand that your health information is personal. We are committed to protecting health information about you.

Moreover, HIPAA imposes numerous requirements on group health plans sponsored by employers concerning the use and disclosure of protected health information ("PHI"). PHI is health information that can be clearly linked to a specific individual. It includes, for example, information about the health care received by an individual and the amounts paid for such care. This Notice will tell you about the ways in which the Plan may use and disclose your PHI and how it will act as an "organized health care arrangement." It also describes certain obligations the Plan has regarding the use and disclosure of your PHI and your rights.

It is important to recognize that health information held by Allegis in an employee's personnel records is not covered by this Notice and is not subject to HIPAA, but may be subject to other laws. Also, your personal doctor or health care provider may have different policies

or notices regarding the doctor's use and disclosure of your PHI created in the doctor's office or clinic.

The Plan is required by law to:

- Make sure that PHI is kept private;
- Give you this Notice of the Plan's legal duties and privacy practices with respect to your PHI;
- Follow the terms of this Notice as currently in effect;
- Follow any more stringent state privacy laws that relate to the use and disclosure of health information; and
- To notify affected individuals following a breach of unsecured PHI.

Your PHI will be disclosed to certain employees of Allegis working in the Benefits Department for plan administration purposes. These individuals may use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Allegis cannot and will not use PHI obtained from the Plan for any employment-related actions. Any employee of Allegis who violates the rules for handling PHI established herein will be subject to adverse disciplinary action.

We encourage you to share this Notice with your spouse/domestic partner, dependents, and any others participating in the Plan through your employment with Allegis.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI

The following categories describe different ways that the Plan may use and disclose PHI. For each category of uses or disclosures this Notice will describe the category and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways in which the Plan is permitted to use and disclose PHI will fall within one of the categories.

For Treatment: The Plan may use your PHI for treatment purposes, such as to conduct case management or coordination. The Plan may disclose your PHI to doctors, nurses, pharmacies, or other medical personnel who are involved in treating you. For example, a doctor may prescribe a drug that is contraindicated for use with another drug you are taking because he does not know you are taking the other drug. If the Plan learns that fact, the Plan may inform your pharmacist or doctor.

For Payment: The Plan may use and disclose your PHI for payment purposes, such as:

- To review the treatment and services you receive to determine whether and to what extent they are eligible for payment under the Plan.
- To inform health care providers and suppliers about your eligibility and that of your dependents, if any.
- To inform health care providers and suppliers about required copayment and deductible amounts under the Plan.
- To reimburse you or to make payment to health care providers and suppliers for covered services they provided to you.
- To coordinate benefits when some other plan may be liable for some or all of the costs of your care.
- For purposes of risk adjustment, collection, or reinsurance (including stop-loss and excess of loss insurance).
- To review health care services with respect to medical necessity and appropriateness.
- To communicate with you, your health care providers, and others about the status of claims for your care, as well as to track and receive contributions and premiums under the Plan.

For example, the Plan may need to review, or have a claims administrator or other entity review, information about treatment you received from a doctor to determine whether, or how much, to pay the doctor or to reimburse you for the treatment. The Plan may also review information from a doctor about a treatment you have received or you are going to receive to decide if the Plan will cover the treatment.

For Health Care Operations: The Plan may use and disclose your PHI for its operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use your PHI for activities such as:

- To evaluate the utilization and effectiveness of benefits under the Plan.
- To make underwriting, premium or similar decisions. The Plan is prohibited, however, from using or disclosing, and will not use or disclose, certain genetic information in making these decisions.
- To obtain reinsurance (including stop-loss and excess of loss insurance).

» To submit claims for stop-loss (or excess loss) coverage.

» In the business management and general administration of the Plan, including but not limited to legal services, audit services, fraud and abuse detection programs, and cost management.

» For customer service, internal grievance resolution, or appeals of denials of payment or coverage under the Plan.

To Allegis, the Plan Sponsor: The Plan may disclose your PHI to Allegis for plan administrative purposes. Allegis needs your PHI to administer benefits under the Plan. Allegis agrees not to use or disclose your PHI other than as permitted or required by the documents governing the Plan and by law. Allegis cannot and will not use PHI obtained from the Plan for any employment-related actions. The Plan may also disclose your PHI to Allegis, as the Plan Sponsor, to enable it, among other things, to perform enrollment and disenrollment functions and make decisions about the structure of the Plan.

To, From, and Between Business Associates: The Plan contracts with business associates to provide certain services, such as the review of elements of your care and to administer claims. The Plan may disclose your PHI to its business associates, receive your PHI from its business associates, and its business associates may share PHI between themselves. For example, the Plan may disclose your PHI to the Plan's third party administrators or other service providers. To protect your PHI, however, the Plan requires business associates to sign contracts agreeing to appropriately safeguard your PHI.

Within the Organized Health Care Arrangement: Each of the components of the Plan may share your PHI with each other and with the other members of Allegis's organized health care arrangement, as necessary to carry out treatment, payment and health care operations. For example, the Employee Assistance Plan may share information with the Medical, Visions and Prescription Drug Benefits Programs, as necessary, in order to carry out a coordinated program of treatment for you or your family members.

To Family and Friends: The Plan may disclose your PHI to a family member or friend, provided the information is directly relevant to that person's involvement with your health care or payment for that care. You have a right to request the Plan limit such disclosures as described on pages 6-7.

For Treatment Alternatives and Appointment Reminders: The Plan may use and disclose your PHI to tell you about or recommend possible treatment options or alternatives and to provide appointment reminders.

For Health-Related Benefits and Services: The Plan may use and disclose your PHI to tell you about health-related benefits or services, or about other plans or certain value added services, that may be offered from time to time.

As Required By Law: The Plan will disclose your PHI when required to do so by federal, state or local law.

By Written Authorization: Except as described herein or as permitted by law, the Plan will disclose your PHI only with your prior written permission (called an "authorization" under 4 HIPAA). Most uses of psychotherapy notes, certain uses and disclosures of your health information for marketing purposes, and any sale of your written medical information require your authorization. You may revoke an authorization, in writing, at any time, unless the Plan has taken action relying on the authorization or if you signed the authorization as a condition of obtaining insurance coverage.

SPECIAL SITUATIONS INVOLVING THE USE AND DISCLOSURE OF YOUR PHI

To Avert a Serious Threat to Health or Safety: The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces, the Plan may release your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: The Plan may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: The Plan may disclose your PHI for public health activities (e.g., to prevent or control disease, injury or disability).

Victim of Abuse: The Plan may notify the appropriate government authority, if Plan representative believes you have been the victim of abuse, neglect, or domestic violence.

Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for activities authorized by law. These oversight

activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: The Plan may release PHI if asked or required to do so by a law enforcement official.

Coroners, Medical Examiners and Funeral Directors: The Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release PHI about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: The Plan may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research: The Plan may release your PHI in certain circumstances for research.

Organ and Tissue Donation: The Plan may use and disclose your PHI to facilitate organ and tissue donation and transplant.

To DHHS: The Plan may release your PHI in response to investigations by the Department of Health and Human Services.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI the Plan maintains about you. Except as otherwise provided below, to exercise these rights, you must submit your request in writing to the Plan's HIPAA Privacy Officer at the address below:

Allegis Group, Inc. Group Health Plan(s) c/o Benefits Department
7320 Parkway Drive
Hanover, MD 21076
Attention: HIPAA Privacy Officer – Allegis Health Plan

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and copy your PHI maintained in the Plan's "designated record set." The Plan's designated record set consists of enrollment, payment, case management records and claims processing, as well as other records used by the Plan to make health care decisions about individuals. The designated record set does not include psychotherapy notes and information compiled in anticipation of a criminal, civil, or administrative action or proceeding.

The Plan will generally act on your written request within 30 days of receipt. Where appropriate, the Plan may provide you with a summary of your PHI rather than access to, and copies of, it. To the extent the Plan uses or maintains this information in an electronic health record, you may request that the Plan provide you with a copy of such information in an electronic format. The Plan will provide access in the electronic form and format requested if it is readily reproducible in the requested format.

If you request a copy of the information, the Plan may charge a reasonable fee for the costs of copying and, in some circumstances, summarizing the information and mailing it to you. If the Plan and its business associates do not maintain the PHI, but know where it is maintained, you will be informed where to direct your requests.

The Plan may deny your request to inspect and copy your PHI. In certain very limited circumstances, the Plan's denial will be unreviewable. Ordinarily, however, you may request within a reasonable period of time that the denial be reviewed. Except for unusual circumstances, 90 days will be deemed a reasonable period of time in which to review a request.

Right to Amend: If you feel that the PHI the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You must provide a reason that supports your request. You have the right to request an amendment for as long as the information is kept by or for the Plan.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask the Plan to amend information that:

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

The Plan must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. The Plan may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If the Plan denies your request, it will keep your request on file. The Plan will distribute your request (or a summary) with all future disclosures of the information to which it relates, but only if you ask the Plan to do so. Further, you may submit a written statement disagreeing with the denial and the Plan will keep it on file and distribute it (or a summary) with all future disclosures of the information to which it relates.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the Plan's disclosure of your PHI, with certain exceptions. These exceptions include:

- To you or to persons involved in your health care or payment for that care.
- Pursuant to your written authorization.
- For the purpose of carrying out treatment, payment or health care operations.
- That are incidental to another permissible use or disclosure.
- For disaster relief, national security or intelligence purposes.
- To correctional institutions or law enforcement officers who have you in custody at the time of the disclosure.
- As part of a limited data set.
- To a health oversight agency or law enforcement official if they so request.

Your request must state a time period which may not be longer than six years. The first list you request within a 12 month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The Plan must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. The Plan may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. The Plan will impose a fee for each subsequent request within the 12-month period.

Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI the Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend.

The Plan is required to grant your request to restrict or limit the PHI the Plan uses or discloses about you for payment and/or health care operations if such PHI relates only to a health care item or service for which you paid the health care provider in full, out-of-pocket. In all other circumstances, the Plan is not required to agree with your request.

If the Plan is required to grant your request, or elects to do so, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for PHI created or received after you are notified that the restriction has been removed. The Plan may also disclose your PHI if you need emergency treatment, even if the Plan has provided for a restriction.

Any request for a restriction must indicate what information you want to limit, whether you want to limit the Plan's use, disclosure, or both, and to whom you want the limits to apply.

Right to Confidential Communications: You have the right to file a request to receive communications from the Plan on a confidential basis by using an alternative means for receipt of information or by receiving the information at an alternative location, but only if you believe and state that the disclosure of all or part of your information could endanger you. All reasonable requests will be granted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask the Plan to give you a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO THIS NOTICE

The Plan is required to, and will abide, by the provisions of this Notice as currently in effect, but reserves the right to change this Notice effective for PHI the Plan already has about you as well as any information the Plan receives in the future. The Plan will provide you with a revised Notice as soon as practicable following any material revisions to the Notice. The Plan will post a copy of the Notice on the Plan website. The Notice contains its effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the privacy officer. All complaints must be submitted in writing. You will not be retaliated against for exercising any right or process described in this Notice, including the filing of a complaint or testifying, assisting, or participating in an investigation, compliance review, or hearing.

QUESTIONS

If you have any questions regarding this Notice, please feel from to contact the Plan's Privacy Officer, Rob Greer at 410-540-7792, or write to Mr. Greer at Allegis Group, Inc. Group Health Plan(s), c/o Benefits Department, 7320 Parkway Drive, Hanover, MD 21076 or at rgreer@allegisgroup.com.

MEDICARE PART D

PLEASE NOTE: This Notice only applies to you if you are eligible for Medicare. If your covered spouse/domestic partner or dependent is covered by Medicare please share this notice with them.

Important Notice from Allegis Group Inc. for Basic Medical Plan and High Deductible Comprehensive Medical Plan Participants 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 Allegis 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. Allegis has determined that the prescription drug coverage offered with this plan(s) 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 ARE MY CHOICES?

If you decide to join a Medicare prescription drug plan, your current prescription drug coverage with Allegis will not be affected.

Before choosing whether to enroll in a Medicare prescription drug plan, 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. You could choose to:

#1 - Keep your medical and prescription drug coverage through Allegis Group, and not enroll in a Medicare prescription drug plan yet. This choice is available to you because the prescription drug coverage that is offered to you as part of the overall package of medical benefits provided by Allegis Group is "creditable" - meaning that, on average, it is at least as good as the standard Medicare prescription drug coverage.

#2 - Keep your medical and prescription drug coverage through Allegis Group, but also enroll in a Medicare prescription drug plan now. Under this choice, you will be paying premiums for both the Medicare prescription drug plan you select and for medical and prescription drug coverage through Allegis Group. You will continue to receive medical and prescription drug benefits through Allegis. The benefits (if any) that you receive from the Medicare prescription drug plan you select will depend on the cost and type of prescription drugs that you use, the coverage of the plan that you choose, and the prescription drug coverage provided under Allegis's plan. If you enroll in a Medicare prescription drug plan, you must notify the Allegis Benefits Service Center so that your Allegis benefits can be coordinated with the benefits you receive through the Medicare prescription drug plan.

#3 - Enroll in a Medicare prescription drug plan now and drop your medical and prescription drug coverage through Allegis Group. Under this choice, you will have prescription drug coverage only through the Medicare prescription drug plan that you have selected. However, you will also be dropping ALL of your medical coverage through Allegis—not just the prescription drug coverage—and you may not be able to re-enroll or otherwise 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 Allegis 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 Maxim changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

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

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

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

Date: February 2020
Name of Entity/Sender: Allegis Group, Inc.,
Contact--Position/Office: Benefits Service Center
Address: 7320 Parkway Drive, Hanover, MD 21076
Phone Number: 1-866-886-9798

PREMIUM ASSISTANCE UNDER 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 July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Eligibility: health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: 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

FLORIDA – Medicaid
Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
A 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
Healthy Indiana Plan for low-income adults 19-64
Website: www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – 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)

MAINE – Medicaid
Enrollment Website: www.mymainconnections.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
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for HIPP: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: 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
Website: health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: 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 and CHIP
Website: www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.dmas.virgina.gov/learn/premium-assitance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – 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)

WISCONSIN – Medicaid and CHIP
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 July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

YOUR RIGHTS & PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. In certain circumstances, state laws governing surprise bills may also apply (or may apply instead of these rules). For more information contact the claims administrator listed on the cover of this legal notice package.

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

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

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

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

In certain circumstances, state laws governing surprise bills may also apply (or may apply instead of these rules). For more information contact the claims administrator listed on the cover of this legal notice package.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the claims administrator listed on the cover of this legal notice package.