Health Plan Annual Notices and Disclosure Booklet for

AMZ Financial Insurance Services, LLC

In accordance with Federal Law, we are providing you with the following notices and disclosures to help you better understand your rights and obligations as an employee and/or plan participant in our group health plan. Additional notices and disclosures will also be provided to you, either as stand-alone documents or included as part of other benefit materials (as appropriate). Please contact Human Resources with any questions.

Notice of HIPAA Special Enrollment Rights

If you chose to decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment with 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll in this plan if coverage is lost under a Medicaid plan or CHIP, or due to a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP. In these events you must request enrollment within 60 days of the date of a determination of eligibility for premium assistance or the date the Medicaid of CHIP coverage ends.

Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact us at the information listed at the beginning of this document.

Newborns' Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Additional information about the Newborn's and Mothers' Health Protection Act of 1996 (Newborn's Act) can be found at www.dol.gov/ebsa/faqs/faq_consumer_newborns.html.

Women's Health and Cancer Rights Act Notice

If you are going to have (or have had) a mastectomy, you may be entitled to health care 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.

Any benefits payable will be subject to the same deductibles, coinsurance and other provisions applicable to other surgical and medical benefits provided under the plan. Please see your Summary of Benefits and Coverage (SBC) or other plan materials for your medical and surgical deductible and coinsurance information.

To request more information on WHCRA benefits, please contact us at the information above.

Notice of Patient Protections and Selections of Providers

Designation of Primary Care Providers

If the health plan in which you are enrolled (or are enrolling) requires the designation of a primary care provider (or "PCP"), please note that you have the right to designate any primary care provider who participates in the plan's provider network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider as well as a list of the participating primary care providers, contact the plan's insurer/TPA listed on your ID Card and other plan materials.

Direct Access to Obstetrics or Gynecological Specialists

If the health plan in which you are enrolled (or are enrolling) requires referrals to see specialists, you do not need prior authorization to obtain direct access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. Please note, however, that the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals, if applicable.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan's insurer/TPA listed on your ID Card and other plan materials.

Michelle's Law Notice

Health plans which extend coverage to full-time students age 26 or older are required to comply with Michelle's Law, an amendment to ERISA allowing students to take up to 12 months medical leave of absence *without causing a reduction in their health care coverage and/or COBRA premium*.

This means that coverage for dependent children age 26 or older cannot be immediately terminated due to loss of student status caused by a medically necessary leave of absence protected under Michelle's Law. Instead, any such termination of coverage will not occur before the date that is the earlier of:

- 12 months (one year) after the first day of the medically necessary leave of absence, or
- The date on which such coverage would otherwise terminate under the terms of the plan (see ERISA §714(b)).

A medically necessary leave of absence generally means a leave of absence from or other change in enrollment status in a postsecondary educational institution that begins while the child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the plan or coverage. Certification by a treating physician stating that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary may be requested in certain circumstances, however.

Please see plan materials for details pertaining to eligibility for full-time students age 26 or older. Additional information about protections afforded under Michelle's Law can be found at https://www.law.cornell.edu/uscode/text/29/1185c.