HIPAA Privacy Notice

Attached is a Notice of Privacy Practices that Broadridge is required to distribute for its group health plans to all participants, under the privacy rules issued in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This law created a national standard requiring health plans and others in the health care industry to keep confidential individuals' medical records and other protected health information ("Protected Health Information" or "PHI"), and imposes administrative, contractual, and operational requirements on health plans, and those that administer health plans.

This notice describes how our group health plans protect your PHI and how PHI may be used or disclosed. PHI includes individually identifiable information that relates to your health, including information about treatment and payment for health care services. This notice also describes your rights with respect to PHI and how you can exercise those rights. Please be aware that if you are covered by an insured health or dental plan, you will receive a separate notice from the insurer or HMO. Personal information obtained through the administration of our disability, leave and workers' compensation programs is not specifically covered under this law.

The Broadridge Benefits Department wants to assure you that all personal information, including PHI, remains confidential, in accordance with applicable law, as well as the Broadridge privacy policies.

If you have any questions regarding this notice please contact the Broadridge Benefits Department in writing at the address listed on the last page of the notice.

BROADRIDGE FINANCIAL SOLUTIONS, INC. GROUP HEALTH PLANS
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.

"We" refers to the group health plans offered by Broadridge Financial Solutions, Inc. ("Broadridge"). "We" also refers to the third party administrators which Broadridge has engaged to provide health benefits to you. "You" or "yours" refers to the individuals who participate in these plans, including all the participant's dependents who receive health benefits from the plans. If you are covered by an insured health or dental plan, you will receive a separate notice from the insurer or HMO.

Use and Disclosure of Protected Health Information

We are required by federal law to protect the privacy of individually identifiable health information that we create or receive (referred to in this notice as "Protected Health Information"). Protected Health Information (which includes genetic information), is confidential health information that identifies you or could be used to identify you, and relates to a past, present or future physical or mental health condition, the provision of health care to you, or the payment of your health care expenses. We are also required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information, and to abide by the terms of this notice, as it may be updated from time to time.

This notice only applies to health-related information received by or on behalf of the Broadridge group health plans. If Broadridge obtains your health information in another way – for example, if you are hurt in a work accident or if you provide medical records with your request for leave under the Family and Medical Leave Act – then this notice does not apply, but Broadridge will safeguard that information in accordance with other applicable laws and Broadridge policies. Similarly, health information obtained in connection with a non-group health plan benefit, such as long term disability or life insurance, is not protected under this notice. This notice also does not apply to information that does not identify you and with respect to which there is no reasonable basis to believe that the information can be used to identify you.

Your Protected Health Information will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws. To the extent required under the HIPAA privacy rules, the PHI used and disclosed by the Broadridge group health plans will be limited to the minimum amount of PHI necessary for these purposes.

For treatment purposes, we may disclose your Protected Health Information to assist one or more of your health care providers to provide, coordinate or manage health care and its related services, such as disclosing your health information

to a medical specialist to whom your primary care physician has referred you.

For payment purposes, we may use or disclose your Protected Health Information to determine responsibility for coverage and benefits, such as when we confer with other health plans to resolve a coordination of benefits issue. We also may use your Protected Health Information for other payment-related purposes, such as to assist in making plan eligibility and coverage determinations, for utilization review activities, and to help employees resolve covered expense and claim payment issues.
For health care operations purposes, we may use or disclose your Protected Health Information in a number of ways involving plan administration, including for quality assessment and improvement, vendor review, and underwriting activities. Your information could be used, for example, to assist in the evaluation of one or more vendors who support us, or we may contact you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Plan. However, we are prohibited from using or disclosing your genetic information for underwriting purposes.

In addition, the federal regulations permit us to use or disclose your Protected Health Information without your authorization under various conditions, including:

- as required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law,
- for public health activities,
- disclosures to an appropriate government authority regarding victims of abuse, neglect or domestic violence,
- to a health oversight agency for oversight activities authorized by law,
- to your family members, close friends, or other persons involved in your health care if you are present and you do not object to the disclosure (or if it can be inferred that you do not object), or, if you are not present or are unable to object due to incapacity or emergency, the disclosure is in your best interest. Following your death, the Broadridge group health plans may disclose your PHI to your family members, close friends, or other persons who were involved in your health care unless you doing so would be against your stated preferences. Disclosure will be limited to your PHI that is directly relevant to the person's involvement in your health care.
- the Broadridge group health plans may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be useful to you. The Broadridge group health plans may also use and disclose your PHI to communicate face-to-face with you to encourage you to purchase or use a product or service that is not part of the health benefits provided by the Broadridge group health plans, or to provide a promotional gift of nominal value to you.
- in connection with certain judicial and administrative proceedings,
- to a law enforcement official for law enforcement purposes,
- to a coroner or medical examiner,
- to cadaveric organ, eye or tissue donation programs,
- for research purposes, as long as certain privacy-related standards are satisfied,
- to avert a serious threat to health or safety,
- for specialized government functions (e.g., military and veterans activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations),
- for workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault,
    - for disclosure to a Business Associate,
    - for us to discuss treatment alternatives with you,
    - for us to inform you about health-related benefits and services,
    - for us to share it with another individual involved in your care or payment of your care,
    - for marketing purposes, limited to face-to-face communications with you to encourage you to purchase or use a product or service that is not part of the health benefits provided by the Plans, or to provide a promotional gift of nominal value to you.

We may also disclose your Protected Health Information to the Broadridge Benefits Department without your authorization to administer the Broadridge group health plans. If you are covered under an insured health plan, the insurer may disclose Protected Health Information to Broadridge without your authorization in connection with payment, or health care operations. Broadridge will not disclose your Protected Health Information to any individuals at Broadridge not involved in administering the health plans. Broadridge is not permitted to use your Protected Health Information for any employment-related actions or decisions without your written authorization, or in connection with any other benefit plan maintained by Broadridge.

In addition, Broadridge may use or disclose "summary health information" for purposes of obtaining premium bids or modifying, amending, or terminating the group health plans. Summary health information is information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom Broadridge provides benefits under the Broadridge group health plans and from which the individual identifying information, except for five-digit zip

codes, has been deleted. Broadridge also may use or disclose Broadridge group health plan eligibility and enrollment/disenrollment information – for example, for payroll processing.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization in writing at any time by delivering a written revocation form to Broadridge Benefits Department. If you revoke your authorization, we will no longer use or disclose your Protected Health Information except as described above (or as permitted by any other authorizations that have not been revoked). However, we cannot retrieve any Protected Health Information disclosed to a third party in reliance on your prior authorization. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to the disclosure of Protected Health Information, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the recipient's involvement with your health care.

State law may further limit the permissible ways we use or disclose your Protected Health Information. If an applicable state law imposes stricter restrictions, we will comply with that state law.

Your Rights Regarding Protected Health Information

You have the right to request in writing the following with respect to your Protected Health Information:

Right to Inspect and Copy. You may request access to certain medical records that contain your Protected Health Information in order to inspect and request copies of those records. If you request copies, we may charge you copying, mailing, and labor costs. To the extent that your Protected Health Information is maintained in an electronic health record, you may request that we provide a copy to you or to a person or entity designated by you in an electronic format. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records containing Protected Health Information, you may obtain a request form from the Broadridge Benefits Department. You do not have the right to access your (i) psychotherapy notes, (ii) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, maintained in a Designated Record Set, or (iii) Certain Protected Health Information that is subject to the Clinical Laboratory Improvements Amendments of 1988 ("CLIA"), 42 C.F.R. § 263a, to the extent the provision of access to the individual would be prohibited by law.

You should submit your request on the required form to the Broadridge Benefits Department. In limited circumstances, we may deny your request to inspect and copy your Protected Health Information. Generally, if you are denied access to Protected Health Information, you may request a review of the denial.

Right to Amend. You have the right to request that we amend your Protected Health Information maintained in a designated record set for as long as the information is kept by or for us. We will comply with your request for amendment unless special circumstances apply. We may deny your request for amendment if you do not provide a reason to support your request or if we believe that the information is accurate. In addition, we may deny your request if you ask it to amend information that was created by another health plan or health care provider (but we will inform you of the source of the information, if known). If your physician or other health care provider created the information that you desire to amend, you should contact the health care provider to amend the information. To make a request for amendment of your Protected Health Information, you may obtain a request form from the Broadridge Benefits Department, and send it to the Broadridge Benefits Department.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your Protected Health Information that we have made to others.

To request an accounting of disclosures you may obtain a request form from the Broadridge Benefits Department, and send it to the Broadridge Benefits Department. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested. The accounting will generally be provided free of charge, but if you request an accounting more than once during a twelve (12) month period, we may charge you a reasonable fee for any subsequent accounting statements. You will be notified of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses. The accounting will not include all disclosures of your Protected Health Information. For example, the accounting will not include disclosures (i) to carry out treatment, payment or health care operations activities; (ii) made to you; (iii) made to friends or family members in your presence or because of an emergency; (iv) made pursuant to your written authorization; (v) for national security or intelligence purposes; or (vi) to correctional institutions or law enforcement officials. If you wish to request an accounting, you may obtain a request form from the Broadridge Benefits Department. Most Protected Health Information relating to your health benefits is used or disclosed by third party vendors (business associates) that administer the group health plans offered by Broadridge. For an accounting of disclosures by a group health plan vendor, you may wish to contact the vendor directly. For more information on your right to request an accounting, or for contact information for the group health plan vendors, contact the Broadridge Benefits Department.

Right to Request Restrictions. You have the right to request a restriction on the Protected Health Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that a provider not use or disclose information about a service you receive if (i) the disclosure is being made for payment or health care operations reasons, and (ii) the restricted Protected Health Information pertains solely to a health care item or service provided where full payment was paid out-of-pocket in full (in other words, another plan has not paid for any part of the item or service) by you.

To request restrictions you must you may obtain a request form from the Broadridge Benefits Department, and send it to the Broadridge Benefits Department. You must advise us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limit(s) to apply.

Note: We are not required to agree to your request, except as provided above.

Right to Request Confidential Communications. You have the right to request that we communicate with you about Protected Health Information in a certain way or at a certain location. For example, you can ask that we send the results of your exam to a specified address, to work or to home.

To request confidential communications you may obtain a request form from the Broadridge Benefits Department, and send it to the Broadridge Benefits Department. We will make attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

Personal Representatives. You may exercise your rights through a personal representative, as permitted under our health information privacy policy, and as determined under applicable state law. This individual must complete a Personal Representative Form. We reserve the right to deny access to your personal representative in certain circumstances.

Complaints

If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below under "Contacting Us" or file electronically by visiting https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. You will not be retaliated against for filing a complaint.

Changes to this Notice

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information we maintain. If we make material changes to this notice, you will receive a new notice by electronic mail and/or a copy will be mailed to your home.

Keep us Informed of Address Changes

You should keep us informed of any changes in your address and the addresses of your covered family members. In the event that your Protected Health Information has been breached, we will notify you at your address on record in accordance with our HIPAA breach notice policy and procedure.

Contacting Us

You may ask questions about this privacy notice, make privacy complaints, or exercise any of the rights described in this notice by contacting the Broadridge Benefits Department in writing at the address and telephone numbers below. They will provide you with additional information.

Broadridge Benefits Department
2 Gateway Center
283-299 Market St
Newark, NJ 07102

Effective date of this notice: October 2022

HIPAA Special Enrollment Rights

If you are declining enrollment for medical benefits for yourself or your eligible dependents because you or your eligible dependents currently have other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the medical benefits coverage provided under the Plan if you or your eligible dependents lose eligibility for that other coverage. For this purpose, an associate and his or her dependents lose other health insurance coverage if:

- you or a dependent had other health insurance coverage at the time medical coverage under the Plan was previously offered, and
- you or your eligible dependents previously declined coverage under the Plan's medical benefits, and either
    - your other coverage was COBRA coverage that has been exhausted, or
    - your other coverage was not COBRA coverage and the other coverage was terminated because of a loss of eligibility for that coverage (such as a result of divorce, death, termination of employment or other factors identified in IRS regulations), or employer contributions towards the other coverage were terminated.

In addition, an associate who is eligible, but has not enrolled in the Plan's medical benefits coverage may enroll when he or she gets married or upon the birth, adoption or placement for adoption of a child, even if the new dependent does not enroll for coverage.

- If you are already enrolled in the Plan's medical coverage, your spouse may enroll at the time of marriage or upon the birth, adoption or placement for adoption of a child, even if the child does not enroll for coverage.
- A child who becomes a dependent as a result of marriage, birth, adoption or placement for adoption may be enrolled, but only if you enroll or are already enrolled.

You must request enrollment within 30 days of the loss of coverage or the marriage, birth, adoption, or placement for adoptions of a child or you will need to wait until the next open enrollment period or, if earlier, the occurrence of another qualified life event in order to make any election changes. **(Extended timeframe may apply:** An extended enrollment timeframe may apply if your special enrollment event occurs during the "Outbreak Period" for **COVID-19.** The Outbreak Period is defined as the period from March 1, 2020 until 60 days after the announced end of the national emergency for COVID-19. The Outbreak Period is disregarded for determining the deadline for enrolling under a HIPAA Special Enrollment event. However, under this special Outbreak Period extension the enrollment deadline can only be delayed up to one year from the original deadline. Contact the Benefits Service Center with any questions and for more information, 877-631-0059.)

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), group health plans and group health insurance issuers must offer special enrollment opportunities. Plans and issuers must permit employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

• losing eligibility for coverage under a State Medicaid or CHIP program, or
• becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance. See separate employer CHIP notice for more details.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) expands special enrollment rights under the Plan medical benefits coverage. An eligible associate and/or dependent may be able to enroll during a special enrollment period. A special enrollment period is not available to an associate and his or her dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis. A special enrollment period applies for an associate and/or dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The associate and/or dependent had existing health coverage under Medicaid or Children's

Health Insurance Program (CHIP) at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and coverage under the prior plan ended because the associate and/or dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP).

- The associate previously declined coverage under the Plan, but the associate and/or dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP).

Under this CHIPRA special enrollment opportunity, coverage will begin only if the Plan receives the completed enrollment form and any required premium within 60 days of the date coverage ended or the date of determination of subsidy eligibility. (**Extended timeframe may apply:** An extended enrollment timeframe may apply if your special enrollment event occurs during the "Outbreak Period" for **COVID-19.** The Outbreak Period is defined as the period from March 1, 2020 until 60 days after the announced end of the national emergency for COVID-19. The Outbreak Period is disregarded for determining the deadline for enrolling under a HIPAA Special Enrollment event. However, under this special Outbreak Period extension the enrollment deadline can only be delayed up to one year from the original deadline. Contact the Benefits Service Center with any questions and for more information, 877-631-0059.)

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 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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

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

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:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

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

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:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

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:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

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

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
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: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it

displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Broadridge Benefits Service Center at 877-631-0059.

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.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Broadridge Financial Solutions, Inc.	33-1151291
5. Employer address	6. Employer phone number
2 Gateway Center, Suite 1704	201-714-3000

7. City	8. State	9. ZIP code
Newark	NJ	07102-5003

10. Who can we contact about employee health coverage at this job?	
Brodridge Benefits Service Center	
11. Phone number (if different from above)	12. Email address
1-877-631-0059	Broadridge.Benefits@broadridge.com

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:

☒ Some employees. Eligible employees are:

Regular associates working 20 or more hours per week are eligible as of the first day of work

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Your spouse, unless you're legally separated; Your domestic partner (per requirements); Your and your spouse's/domestic partner's children to the age of 26, Your unmarried, dependent children age 26 or older and currently covered under the Plan that are physically or mentally disabled and are incapable of earning their own living. (Onset of disability must be prior to age 26 or while covered under the Plan.)

☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Important Notice from Broadridge Financial Solutions, Inc. About Your Prescription Drug Coverage and Medicare

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You are receiving this notice because you (and/or your dependent) currently are, or will be, eligible for 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 Broadridge Financial Solutions, Inc. (Broadridge) 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. Broadridge has determined that the prescription drug coverage offered by the Broadridge medical & prescription plans 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 through December 7th.

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

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

As long as you keep the prescription drug coverage you have elected with Broadridge, you probably do not need to enroll in a Medicare prescription drug plan. Doing so will cost you extra money and may not provide you with any additional prescription drug benefits. For example, if you enroll in both a Medicare prescription drug plan and one of Broadridge's medical and prescription plans, your Broadridge plan is the primary plan and there is no reduction in premiums. But if your Broadridge prescription drug coverage ends (for example, if you drop that coverage because of a qualifying life event), you may want to consider enrolling in a Medicare prescription drug plan to avoid or minimize Medicare's late enrollment penalty. Please note that if you don't enroll in one of Broadridge's medical and prescription plans, you will not be able to re-enroll until the earlier of the next Broadridge open enrollment or the date you have a qualifying life event during the year.

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 Broadridge 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 Broadridge 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:	October 4, 2022
Name of Entity/Sender:	Broadridge Financial Solutions, Inc.
Contact--Position/Office:	Karen Howard VP - Benefits
Address:	2 Gateway Center - 283-299 Market Street, Suite 1704 Newark, NJ 07102
Phone Number:	(201) 714-8584

Your Rights and 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.

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.

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.

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 U.S. Department of Health & Human Services at 1-800-985-3059.

Visit Aetna for more information about your rights under federal law.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, Federal law requires the Plan to inform you that you may be entitled to certain benefits. For individuals receiving certain services related to the mastectomy, coverage will be provided under the Plan 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 the Plan. If you would like more information on these benefits, contact Aetna, www.aetna.com
+1 800 663 0911.