ORANGE COUNTY FIREFIGHTERS'

HEALTH & WELFARE BENEFIT TRUST INC.

HEALTH • WELLNESS • FUTURE

EST. 2026

ORANGE COUNTY FIREFIGHTERS'

HEALTH & WELFARE TRUST

COMPLIANCE NOTICES BOOKLET

JANUARY 1, 2027

Disclosures Required for

Medical Plan

Please read through the following pages which contain the notices listed below. **If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Credible Coverage Notice Part D for more details.**

1) **Patient Protection Disclosure –** ensures the employee knows of his/her rights to choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician.
2) **Creditable Coverage Notice Part D** – notifies employee current drug coverage is Creditable or NonCreditable
3) **No Surprises Billing Notice** – protects insured employees from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers
4) **Women's Health Disclosures**
    a. WHCRA Annual and Enrollment Notice -provides protections to patients who choose to have breast reconstruction in connection with a mastectomy
    b. Newborns' and Mothers' Health Protection Act - affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth
5) **HIPAA Notice of Special Enrollment Rights** – allows you to enroll/disenroll in medical plan under certain circumstances
6) **HIPAA Notice of Privacy Practices -** provides individuals a fundamental right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information
7) **Children's Health Insurance Program (CHIP) Notice** - provides notice that individuals who are eligible for employer-sponsored group health coverage but are unable to afford the premium may be eligible to receive premium assistance from a state's Medicaid agency
8) **USERRA -** provides the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations pending patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

Cigna generally allows the designation of a primary care provider if the member wishes to do so. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Cigna customer service on the back of your card or www.mycigna.com

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Cigna customer service on the back of your card or www.mycigna.com

Important Notice from Orange County Firefighters' Health & Welfare Trust Inc. 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 the Orange County Firefighters' Health & Welfare Trust Inc. 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. Orange County Firefighters' Health & Welfare Trust Inc. has determined that the prescription drug coverage offered by Cigna 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.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

If you decide to join a Medicare drug plan, your current Orange County Firefighters' Health & Welfare Trust Inc. coverage may be affected. When you become eligible for Medicare, you can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance
(available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

As an **active employee**, if you do decide to join a Medicare drug plan and drop your current Orange County Firefighters' Health & Welfare Trust Inc. coverage, be aware that you and your dependents will be able to get this coverage back.
As a **retiree**, if you decide to join a Medicare drug plan and drop your current Orange County Firefighters' Health & Welfare Trust Inc. coverage, be aware that you and your dependents will NOT be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with the Orange County Firefighters' Health & Welfare Trust Inc. 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…

Please refer to the contact listed on the next page 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 Orange County Firefighters' Health & Welfare Trust Inc. changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Contact the department 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 the Orange County Firefighters' Health & Welfare Trust Inc. changes. You may request a copy of this notice at any time.

Orange County Firefighters' Health & Welfare Trust Inc.

Union Hall
6969 Venture Circle, Orlando, FL 32807
Phone Number: 407-389-2057

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).

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out of network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and /or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 general, Florida law also provides you protection from balance billing. If you are covered by a PPO or an EPO health insurance policy from Florida, then you can't be balance billed for emergency services (as defined under Florida law) by an out-of-network provider or facility. You are only responsible for paying your copayments, deductibles and coinsurance. If you are covered by an HMO health insurance policy from Florida, then you can't be balanced billed for covered services by an out-of-network provider.

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 can 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 types of 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.

If you are covered by a PPO or an EPO health insurance policy from Florida, Florida law generally protects you from balance billing by an out-of-network provider if you received covered nonemergency services (as defined under Florida law) at an in-network facility and did not have the ability and opportunity to choose a participating provider

Your Rights and Protections Against Surprise Medical Bills (cont'd)

at the facility who was available to treat you. In this instance, you are only responsible for paying your copayments, deductibles and coinsurance.

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

Additionally, Florida law also protects patients with coverage through Preferred Provider Organization ("PPO") or an Exclusive Provider Organization ("EPO") from balance billing for covered services provided at hospitals, urgent care centers or ambulatory care centers for (1) emergency services and (2) non- emergency services provided at an in-network facility by an out-of-network provider if the patient did not have the opportunity to choose an in-network provider. This protection only requires patients to pay their in-network cost sharing amounts.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact:

- The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit https://www.cms.gov/nosurprises for more information about your rights under federal law.
- The Florida Department of Financial Services, Division of Consumer Services at 1-877- MY-FL- CFO.

Good Faith Estimate

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, healthcare providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non- emergency items or services. This includes related costs like medical tests, prescription drugs, equipment and hospital fees.
- Make sure your healthcare provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

Get More Information

For questions or more information about your right to a Good Faith Estimate, visit cms.gov/nosurprises or call 1-800-MEDICARE (1-800-633-4227).

If you think you have been wrongly billed, contact No Surprises Help Desk at 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. The Florida state protections referenced in this notice may not apply if your health plan is self-funded, but the Federal protections contained in this notice would apply.

Women's Health Disclosures

Women's Health and Cancer Rights Act Annual and Enrollment Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? 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. If you would like more information on WHCRA benefits, call your Plan Administrator.

Newborns' & Mothers' Health Protection Act

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

HIPAA Notice of

Special Enrollment Rights

If you are declining 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 towards your or your dependents' other coverage). However, you must request enrollment within“30 days'' after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact:

Paul Riccardi, Chairperson
Union Hall
6969 Venture Circle, Orlando, FL 32807
407-389-2057
Trustee1@ocfirehealthtrust.org

Notice of Privacy Practices

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.

Our Privacy Commitment

In the normal course of doing business, we create, obtain and/or maintain records about you and the services we provide to you. The information we collect is called Protected Health Information ("PHI"). We take our obligation to keep your PHI secure and confidential very seriously. We are required by state and federal law to protect the privacy of your PHI and to provide you with this Notice about how we safeguard and use it, and notify you following a breach of your health information. When we use or give out ("disclose") your PHI, we are bound by the terms of this Notice. This Notice applies to all electronic or paper records we create, obtain and/or maintain that contain your PHI.

Background

This Notice is provided by one or more subsidiaries of The Cigna Group that operate as affiliated covered entities under HIPAA ("we"). The Cigna Group is a health company committed to creating a better future built on the vitality of every individual and every community. Cigna Healthcare provides services to guide our customers through the health care system, empowering them with information and insight they need to make the best choices for improving their vitality. These services include employer-sponsored health plans and solutions, third-party administrator collaboration, or Medicare and individual and family health plans and solutions. Evernorth Health Services creates pharmacy, care and benefits solutions to improve health and increase vitality. We innovate to make the prediction, prevention and treatment of disease more accessible to millions of people.

This Notice of Privacy Practices ("Notice") Describes:

- How we may use and disclose your PHI
- Your rights to access and amend your PHI

We are required by law to:

- Maintain the privacy of your PHI
- Provide you with notice of our legal duties and privacy practices with respect to PHI
- Abide by the terms of the Notice currently in effect for Cigna Affiliated Covered Entities

How We Protect Your Privacy

We understand the importance of protecting your PHI. We maintain technical, physical and administrative safeguards to ensure the privacy of your PHI.

Permitted Uses and Disclosures of Your PHI

How We May Use PHI Without Your Authorization

Treatment – We may use and disclose your PHI to health care professionals or other third parties to provide, coordinate and manage the delivery of health care. For example, to help you obtain services and treatment such as ordering lab tests and using results or your pharmacist we may disclose PHI about you to your doctor in order to coordinate the prescribing and delivery of your drugs. We also may provide you with treatment reminders and information about potential side effects, drug interactions and other treatment-related issues involving your medicine.

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Payment – We may use and disclose PHI about you to receive payment for our services or premiums for your coverage, manage your account, fulfill our responsibilities under your benefit plan and process your claims for drugs you have received. For example, we may give PHI to your health plan (or its designee) so we can confirm your eligibility or coverage, or we may submit claims to your health plan, employer or other third party for payment.

Health Care Operations – We may use and disclose your PHI to carry on our own business planning and administrative operations. We need to do this so we can provide you with high-quality services. For example, we may share your claims information with your doctor if you have a medical need that requires attention; we may use and disclose PHI about you to assess the use or effectiveness of certain drugs, develop and monitor medical protocols, and to provide information regarding helpful health-management services.

Disclosures to Your Employer as Sponsor of Your Health Plan – Where permitted by law, we may disclose your PHI to your employer or to a company acting on your employer's behalf, so that entity can monitor, audit and otherwise administer the employee health plan in which you participate. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your employer's health plan documents for information on whether your employer receives PHI and, if so, the identity of the employees who are authorized to receive your PHI.

Information That May Be of Interest to You – We may use or disclose your PHI to contact you about treatment options or alternatives that may be of interest to you. For example, we may call you to remind you of expired prescriptions or the availability of alternative drugs, or to inform you of other products that may benefit your health.

Individuals Involved in Your Care or Payment for Your Care – We may disclose PHI about you to someone who assists in or pays for your care. Unless you write to us and specifically tell us not to, we may disclose your PHI to someone who has your permission to act on your behalf. We will require this person to provide adequate proof that he or she has your permission.

Parents or Legal Guardians – If you are a minor or under a legal guardianship, we may release your PHI to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.

Business Associates – We arrange to provide some services through contracts with business associates so that they may help us operate more efficiently. We may disclose your PHI to business associates acting on our behalf. Business Associates are required by law and contract to protect the privacy of sensitive information. If any PHI is disclosed, we will protect your information from unauthorized use and disclosure using confidentiality agreements. Our business associates may, in turn, use vendors to assist them in providing services to us. If so, the business associates must enter into a confidentiality agreement with the vendor, which protects your information from unauthorized use and disclosure.

Research – Under certain circumstances, we may use and disclose PHI about you for research purposes. Before we use or disclose PHI about you, we will remove information that personally identifies you, obtain your written authorization or gain approval through a special approval process designed to protect the privacy of your PHI. In some circumstances, we may use your PHI to generate aggregate data (summarized data that does not identify you) to study outcomes, costs and provider profiles, and to suggest benefit designs for your employer or health plan. These studies generate aggregate data that we may sell or disclose to other companies or organizations. Aggregate data does not personally identify you.

Abuse, Neglect or Domestic Violence – We may disclose your PHI to a social service, protective agency or other government authority if we believe you are a victim of abuse, neglect or domestic violence. We will inform you of our disclosure unless informing you would place you at risk of serious harm.

Public Health – We may disclose your PHI for public health activities and purposes, such as regulatory reporting (e.g., reporting adverse events, vaccination efforts to avert the spread of communicable diseases) or for post-marketing surveillance in connection with FDA-mandates or product recalls. We may receive payment from a third party for making disclosures for public health activities and purposes.

Judicial and Administrative Proceedings – We may disclose your PHI in the course of any judicial or administrative proceeding in response to a court order, subpoena or other lawful process, but only after we have been assured that efforts have been made to notify you of the request.

Law Enforcement – We may disclose your PHI, as required by law, in response to a subpoena, warrant, summons or other appropriate process. In some circumstances, we may also disclose PHI to assist law enforcement with identification of relevant individuals, provide information about crime victims, provide information to law enforcement about decedents, and report a crime.

Coroners and Medical Examiners – We may disclose your PHI to a coroner or a medical examiner for the purpose of determining cause of death or other duties authorized by law.

Organ, Eye and Tissue Donation – We may disclose your PHI to organizations involved in organ transplantation to facilitate donation and transplantation.

Workers' Compensation – We may disclose your PHI to comply with workers' compensation laws and other similar programs.

Fundraising – We may use your PHI to send you fundraising communications, but you have the right to opt out of receiving such communications.

Facility Directories – We may use your PHI for purposes of maintaining contact information in a facility directory. Such information may include names, facility location, general information about conditions, and religious affiliation.

Underwriting – We may use or disclose your PHI for the purpose of underwriting and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We are prohibited from using or disclosing PHI that is genetic information for such purposes.

Specialized Government Functions, Military and Veterans – We may disclose your PHI to authorized federal officials to perform intelligence, counterintelligence, medical suitability determinations, Presidential protection activities and other national security activities authorized by law. If you are a member of the U.S. Armed Forces or of a foreign military, we may disclose your PHI as required by military command authorities or law. If you are an inmate in a correctional institution or under the custody of a law enforcement official, we may disclose your PHI to those parties if disclosure is necessary for: the provision of your health care, maintaining the health or safety of yourself or other inmates, or ensuring the safety and security of the correctional institution or its agents.

As Otherwise Required By Law – We will disclose PHI about you when required to do so by law. If federal, state or local law within your jurisdiction offers you additional protections against improper use or disclosure of PHI, we will follow such laws to the extent they apply.

Health Oversight – We may disclose PHI to a health oversight agency performing activities authorized by law, such as investigations and audits. These agencies include governmental agencies that oversee the health care system, government benefit programs, and organizations subject to government regulation and civil rights laws.

Creation of De-Identified Health Information – We may use your PHI to create data that cannot be linked to you by removing certain elements from your PHI, such as your name, address, telephone number and member identification number. We may use this de-identified information to conduct certain business activities; for example, to create summary reports and to analyze and monitor industry trends.

To Avert Serious Threat to Health or Safety – We may disclose your PHI to prevent or lessen an imminent threat to the health or safety of another person or the public. Such disclosure will only be made to someone in a position to prevent or lessen the threat.

Other Uses and Disclosures of PHI

Uses of PHI That Require Your Authorization – Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI require an authorization. These activities and any other uses and disclosures of your PHI not listed in this Notice will be made only with your authorization unless we are permitted by applicable law to make such other use and disclosure, in which case we shall comply with applicable law. You may revoke your authorization, in writing, at any time unless we have taken action in reliance upon it. Written revocation of authorization must be sent to the address listed below.

Additional Protections for Certain Categories of PHI – Certain types of Protected Health Information (PHI) may be subject to enhanced privacy protections under federal and/or state laws. These additional protections may apply to:

- Psychotherapy notes
- PHI related to reproductive health care
- PHI concerning alcohol and drug abuse prevention, treatment, and referral
- PHI involving HIV/AIDS testing, diagnosis, or treatment
- PHI related to venereal and other communicable diseases
- PHI associated with genetic testing

Additional Privacy for Substance Use Disorder (SUD) Treatment – Although we are not a substance use disorder treatment program (a "SUD Program"), we may receive information from a SUD Program about your treatment. We may not disclose this information so that it can be used in a civil, criminal, administrative, or legislative proceeding against you unless (i) we have your written consent, or (ii) a court order accompanied by a subpoena or other legal requirement compelling disclosure issued after we and you were given notice and an opportunity to be heard. In addition, if we use this information to raise funds for our benefit, we must first provide you with a clear and conspicuous opportunity to elect not to receive any fundraising communications.

Redisclosure – I understand that once my PHI is disclosed it may be no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) and may be subject to re-disclosure.

Your Rights With Respect To Your PHI

You have the following rights regarding the PHI we maintain about you.

Right to Inspect and Copy – Subject to some restrictions, you may inspect and copy PHI that may be used to make decisions about you, as well as records of enrollment, payment, claims adjudication, and case or medical management. If we maintain such records electronically, you have the right to request such records in electronic format. You may also have the records sent to a third party, including requesting that we share your PHI with a Health Information Exchange (HIE). If you request copies, we may charge reasonable expenses incurred with copying and mailing the records. Under limited circumstances, we may deny you access to a portion of your records.

Right to Amend – If you believe PHI about you is incorrect or incomplete, you may ask us to amend the information. You must provide a reason supporting your request to amend. We may deny the request in some instances. If we determine that the PHI is inaccurate, we will correct it if permitted by law. If a health care facility or professional created the information that you want to change, you should ask them to amend the information.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures of your PHI. This accounting identifies the disclosures we have made of your PHI other than for treatment, payment or health care operations. The provision of an accounting of disclosures is subject to certain restrictions. For example, the list will exclude the following, among others.

- Disclosures to you as well as disclosures you have authorized
- Disclosures made earlier than six years before the date of your request (in the case of disclosures made from an electronic health record, this period may be limited to three years before the date of your request)
- Certain other disclosures that are excepted by law

If you request an accounting more than once during any 12-month period, we may charge you a reasonable fee for each accounting report after the first one.

Right to Request Restrictions – You have the right to request a restriction or limitation on the PHI we use and disclose about you for treatment, payment or health care operations. You may also request your PHI not be disclosed to family members or friends who may be involved in your care or paying for your care. Your request must be in writing; state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. We will agree to your request to restrict PHI disclosed to a health plan for payment or health care operations (that is, non-treatment) purposes if the information is about a medication for which you paid us, out-of-pocket, in full.

Confidential Communications – You may ask that we communicate with you in an alternate way or at an alternate location to protect the confidentiality of your PHI. Your request must state an alternate method or location you would like us to use to communicate your PHI to you.

Right to Be Notified – You have the right to be notified following a breach of unsecured PHI if your PHI is affected.

Right to a Paper Copy of This Notice – You have the right to request a paper copy of this Notice at any time. For information about how to obtain a copy of this Notice and answers to frequently asked questions, please call Customer Service at the telephone number printed on your customer ID card, or contact us toll-free at: **Cigna Customer Service: 1-800-244-6224** or **Evernorth Customer Service: 1-877-279-6391**

Even if we agreed to provide this Notice electronically, you are still entitled to a paper copy. You may obtain a copy of this Notice from our website at: **www.TheCignaGroup.com** or **www.Evernorth.com**.

Right to File a Complaint – If you believe we violated your privacy rights, you may address a written complaint to our Privacy Office at the contact below. You may also file a complaint with the Secretary of the U.S. Dept. of Health and Human Services. You will not face retaliation for filing a complaint.

Written complaints, revocation of authorization to use or disclose PHI, requests for a copy of your PHI, amendment to your PHI, an accounting of disclosures, restrictions on your PHI or confidential communications may be mailed to:

The Cigna Group Privacy Office
PO Box 188014 Chattanooga, TN 37422
Email Cigna Healthcare: privacyoffice@cigna.com
Email Evernorth: privacy@evernorth.com

Please include your full name, address and customer ID number.

For certain types of requests, you must provide written documentation if applicable. Certain preference edits and forms are available on our website. For help, contact Customer Service at the telephone number printed on your Customer ID card or visit Cigna Healthcare online at: **https://www.Cigna.com/legal/members/member-privacy-forms**.

We Reserve the Right to Revise this Notice – A revised Notice will be effective for PHI we already have about you, as well as any PHI we may receive in the future. We will communicate revisions to this Notice through our websites **www.TheCignaGroup.com/PrivacyPolicy** or **www.Evernorth.com**.

Effective Date – This Notice is effective as of April 14, 2003, and updated as of August 18, 2025.

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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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ 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+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 5/31/2029)

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: https://www.dol.gov/agencies/vets/programs/userra/poster Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — May 2022

ORANGE COUNTY FIREFIGHTERS'

HEALTH & WELFARE BENEFIT TRUST INC.

HEALTH • WELLNESS • FUTURE

EST. 2026