HERITAGE BENEFITS

2026 Employee Benefits

Heritage

HERITAGE BENEFITS

Contacts

GROUP MEDICAL INSURANCE

(844) 235-3270
novahealthcare.com/members
For provider directory, visit novahealthcare.com/findaprovider/medicalproviders and search for the provider network your plan has access to matching the logo found on your ID card.

DENTAL INSURANCE

(888) 600-1600
guardianantytime.com
For dental directory visit, guardianantytime.com and select "Find a Dentist" at the top, then "Find a dentist through your workplace." Under Plan type, select "PPO DentalGuard Preferred."

VISION INSURANCE

(888) 600-1600
guardianantytime.com

FLEX AND HSA PLANS

(800) 688-2611
padmin.com

RETIREMENT PLAN

800-395-1113
myplan.johnhancock.com

BENEFITS OFFICE

(716) 338-0129
benefits@heritage1886.org
heritage1886.org/benefits

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HERITAGE BENEFITS

Kronos Login and Benefit Enrollment

LOGIN TO KRONOS

To login, visit https://secure4.entertimeonline.com/ta/6076112.login. You can also find the Kronos link on our website at heritage1886.org/benefits. Your username is your initials followed by your 5-digit employee number. The temporary password is Iloveheritage#1. Once logged in, you must change your password to something only you will remember.

CURRENT BENEFITS

Take the path My Benefits > Benefit Plans to view the current plans in which you're enrolled and their associated coverages/costs.

QUALIFYING LIFE EVENTS

For qualifying life change events, you have 30 days from the event date to make changes to your benefits. After 30 days, you won't be able to change your coverage until the next open enrollment period. Please provide proof of the life change event to the Benefits Team at benefits@heritage1886.org.

NEW HIRE OR LIFE CHANGE

To enroll in benefits or update benefit information, click on the ≡ icon in the top, left corner of your browser window. From there, click the > symbol taking the path My Benefits > Enrollment. If you qualify to enroll, you'll see the options of "Life Change Event" or "New Employee Enrollment." Click "Start" under the appropriate option. This will take you to the page where you will select or waive each benefit.

ANNUAL OPEN ENROLLMENT

Employees have the ability to make benefit changes for the upcoming year during the "open enrollment" timeframe. To enroll in benefits or update benefit information, click on the ≡ icon in the top, left corner of your browser window. From there, click the > symbol taking the path My Benefits > Enrollment. Click "Start" on Open Enrollment and continue through enrollment process.

DEPENDENTS & BENEFICIARIES

It is important to review and update beneficiary information for any life insurance benefits and dependent information for other coverages as applicable.

You likely have dependents, spouse, or other beneficiaries set up within Kronos. Select "Add Existing" to add existing dependent and/or beneficiary info. If you would like to add a new beneficiary or dependent select "Add New."

HAVING TROUBLE?

If you have any difficulties or if logging on to Kronos proves problematic, we're here to help! Contact the Benefits Office at (716) 338-0129 and someone will walk you through login and enrollment.

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HERITAGE BENEFITS

Group Medical Insurance

MONTHLY PREMIUMS

HYBRID 2000

$394.06 – Single Coverage
$748.24 – Employee + Children
$871.09 – Employee + Spouse
$1,067.99 – Family Coverage

HIGH DEDUCTIBLE 3000/6000

$209.10 – Single Coverage
$397.20 – Employee + Children
$458.40 – Employee + Spouse
$562.80 – Family Coverage

HIGH DEDUCTIBLE 6000/12000

$0 – Single Coverage
$0 – Employee + Children
$0 – Employee + Spouse
$0 – Family Coverage

Benefit	Hybrid 2000	HDHP 3000/6000	HDHP 6000/12000
In- and Out-of-Network Deductible	$2,000/$4,000	$3,000/$6,000	$6,000/$12,000
In-Network Coinsurance	20%	0%	0%
In-Network Out-of-Pocket Maximum	$4,000/$8,000	$3,000/$6,000	$6,000/$12,000
Out-of-Network Coinsurance	40%	40%	20%
Out-of-Network Out-of-Pocket Maximum	$6,000/$12,000	$6,000/$12,000	$8,000/$16,000
Doctor Visits			
Office Visit	$25 copay	After deductible covered in full	After deductible covered in full
Adult Annual Physical	Covered in full	Covered in full	Covered in full
Child Annual Physical/Immunizations	Covered in full	Covered in full	Covered in full
Specialist Office Visit	20% after deductible	After deductible covered in full	After deductible covered in full
Allergy Test and Injections	20% after deductible	After deductible covered in full	After deductible covered in full
Mental Health Care *(outpatient visits)*	20% after deductible	After deductible covered in full	After deductible covered in full
Chemical Dependency *(outpatient visits)*	20% after deductible	After deductible covered in full	After deductible covered in full
Maternity Care			
Office, Hospital, Physician, Newborn	20% after deductible	After deductible covered in full	After deductible covered in full
Urgent/Emergency Care			
Urgent/Convenience Care	$50 copay	After deductible covered in full	After deductible covered in full
Emergency Room Care for Life Threatening Situations	20% after deductible	After deductible covered in full	After deductible covered in full
Emergency Care of Non Life Threatening/Non Urgent	20% after deductible	After deductible covered in full	After deductible covered in full

Benefit	Hybrid 2000	HDHP 3000/6000	HDHP 6000/12000
Hospital Coverage			
Ambulance	20% after deductible	After deductible covered in full	After deductible covered in full
Room & Board *(unlimited days semi-private)*	20% after deductible	After deductible covered in full	After deductible covered in full
Ambulatory Surgery	20% after deductible	After deductible covered in full	After deductible covered in full
Chiropractic Services & Therapy			
Office Visit	20% after deductible	After deductible covered in full	After deductible covered in full
Ancillary Charges	20% after deductible	After deductible covered in full	After deductible covered in full
Other Services			
Free Standing Laboratory	Covered in full	Covered in full	Covered in full
Laboratory	20% after deductible	After deductible covered in full	After deductible covered in full
X-Ray	20% after deductible	After deductible covered in full	After deductible covered in full
Chemo, Dialysis, Radiation	20% after deductible	After deductible covered in full	After deductible covered in full
Home Health Care	20% after deductible	After deductible covered in full	After deductible covered in full
Skilled Nursing Facility *(120 days per admission/360 lifetime)*	20% after deductible	After deductible covered in full	After deductible covered in full
Durable Medical Equipment	20% after deductible	After deductible covered in full	After deductible covered in full
Vision Coverage			
Eye Exam *(every 24 months)*	$25 copay	Not covered	Not covered
Glasses or Contact Lenses *(every 24 months)*	$60 allowance	Not covered	Not covered
Prescription Drug Coverage			
Retail Pharmacy	$15 / $30 / $50 *deductible does not apply*	After deductible covered in full	After deductible covered in full
Non Preferred Speciality Medications	50% coinsurance	After deductible covered in full	After deductible covered in full
Reminder: Heritage offers an In-House Pharmacy Discount Program. Please see In-House Pharmacy flyer for details.			

Deductible *is the amount you pay for health care services before your health insurance begins to pay.*
Coinsurance *is the percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.*
A ***copay*** *is the flat amount of money pay for a healthcare service.*

Note: *To understand prescription costs, talk with your pharmacist, NOVA, or review previous Explanation of Benefits.*

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HERITAGE BENEFITS

Dental Insurance

Heritage offers its employees the opportunity to participate in a voluntary dental plan through Guardian, offering a strong and wide network of participating providers. The plan encourages use of Guardian participating providers. Services may be sought through an out-of-network provider at a reduced benefit. Orthodontia is available with the Buy-Up plan for dependents on Employee + 1 and Family plans.

BASE PLAN MONTHLY PREMIUMS

$24.88 – Single Coverage
$52.00 – Employee + 1
$63.30 – Family Coverage

BUY-UP PLAN MONTHLY PREMIUMS

$33.04 – Single Coverage
$69.08 – Employee + 1
$84.09 – Family Coverage

	Base Plan	Buy-Up Plan
Class/Type I - Preventative		
Initial/Routine Oral Exams X-Rays and Cleaning Flouride Treatment and Sealants	100%	100%
Class/Type II - Basic Services		
Fillings, General Anesthetics, Simple Extractions, Oral Surgery Periodontics and Endodontics	75% Subject to Annual Deductible	100% Subject to Annual Deductible
Class/Type III- Major Services		
Crowns and Restorations Full or Partial Removable Dentures Fixed Bridgework	Not Covered	50% Subject to Annual Deductible
Class/Type IV - Orthodontia		
Children to Age 19	Not Covered	50%
Deductibles	50%	
Single (1x Annual Deductible) Family (3x Annual Per Person Deductible)	Single $50 Family $150	Single $50 Family $150
Maximums		
Calendar Year per Individual Classes subject to Annal Max Lifetime (Orthodontia)	$1,000 II and III None	$2,000 II and III $1,500
Maximum Contract Allowance	Fee Schedule	Fee Schedule
Dependent Age	26	26

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HERITAGE BENEFITS

Vision Insurance

OPTION 1 MONTHLY RATES

$6.44 – Single Coverage
$9.34 – Employee + 1
$16.74 – Employee + Children
$16.74 – Family Coverage

OPTION 2 MONTHLY RATES

$11.89 – Single Coverage
$17.25 – Employee + 1
$30.93 – Employee + Children
$30.93 – Family Coverage

OUT-OF-NETWORK COVERAGE

See Guardian Vision pdf online at www.heritage1886.org/benefits.

Benefit	Description ("Option 2" in BOLD)	Copay
Well Vision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$25
Frame	• $130/**$200** fram allowance • 20% savings on amount over allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Progressive lenses, Scratch coating, Anti-Reflective coating, Photochromatic • Average savings of 20-25% on other lens enhancements • Every 12 months	$55 $95 - $105 $150 - $175 $17 - $70
Contacts *(instead of glasses)*	• $130/**$200** allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Extra Savings	**Description**	
Glasses & Sunglasses	• Choice plans offer 20% off any additional pairs of glasses purchased within 12 months of the exam. Members also receive 20% off the amount exceeding the copay allowands on frams purchased as well as 15% off providers professional services for prescriotion contact lenses. These discounts only apply to services from an in-network provider.	
Retinal Screening	• No more than $39 copay routine screening as an enhancement to a Well Vision Exam.	
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price; discounts only available to contracted facilities.	

HERITAGE BENEFITS

FSA and HSA Plans

FLEXIBLE SPENDING ACCOUNTS (FSA)

Medical FSA and Limited FSA
Heritage offers a Medical Flexible Spending Account (FSA) for employees who do not elect the High Deductible Health Plan (HDHP). An FSA allows employees to set aside, through pre-tax payroll deduction, a pre-determined amount of money to pay for out-of-pocket medical expenses. This plan follows the IRS-allowed items including many dental, vision, and over-the-counter items and includes a debit card. A Limited FSA is available for employees on HDHP plans to cover dental and vision expenses.

- ✓ The maximum election is projected to be $3,400 for 2026. A pre-tax, employee funded spending account, ensuring a low-cost way to enhance employee benefits.
- ✓ $500 of FSA funds can carryover to the next Plan Year.

Dependent Care Account (DCA). A DCA is for expenses for the care of dependents allowing an employee (or an employee and their spouse) to work or to attend school full-time. Eligible expenses for children (under age 13) include pre-school & nursery school program, day care, after school programs, etc.

- ✓ The minimum election is $250 per calendar year.
- ✓ The maximum election is $5,000 per calendar year.
- ✓ No carryover is allowed with Dependent Care FSA per the IRS; it is a use-it-or-lose-it benefit.

HEALTH SAVINGS ACCOUNTS (HSA)

HSAs are available for employees on elect a High Deductible Health Plan and is a great way to put money away at a pre-tax basis for medical expenses now and in the future. HSA funds never expire and you as the account owner are able to designate a beneficiary.

- ✓ Contributions to an HSA accrue over time and can be used as they are available.
- ✓ The maximum contribution for 2026 is $4,400 for an individual and is $8,750 for a family.
- ✓ The cHSA atchup amount for employees over age 55 for 2026 is $1,000.
- ✓ The employer contribution for 2026 will be $250 for an indvidual and $500 for a family.
- ✓ Funds never expire. The owner of the HSA can designate a beneficiary.

HERITAGE BENEFITS

Life Insurance

BASIC LIFE INSURANCE

Heritage Ministries offers all eligible employees a Basic Life and Accidental Death and Dismemberment Insurance policy through Guardian. This policy is at no cost to the employee.

LIFE INSURANCE SUPPLEMENTAL COVERAGE

Heritage Ministries also offers employees the option of purchasing Supplemental Life and Accidental Death and Dismemberment Insurance through Guardian. This may be purchased for the employee, the employee's spouse, or children.

Please reach out to benefits@heritage1886.org for individual information.

HERITAGE BENEFITS

Voluntary Long-Term Disability

Voluntary Long-Term Disability insurance is a new offering through Guardian. This benefit provides off the job coverage for accident and injury. Voluntary Long-Term Disability benefit replaces a portion of your pre-disability earnings, less any offsets from other disability programs or social security payments.

The benefit amount is 60% of your pre-disability monthly earnings; subject to the plan's maximum monthly benefit of $6,000.

When do benefits begin and how long do they continue? Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. The elimination period is 180 days. This benefit has a 24-month own occupation period and a maximum of a 5-year benefit duration. Please note that this plan has a pre-existing condition clause.

Age Brackets	Cost per $100 of Coverage
Under 24	$0.091
25-29	$0.170
30-34	$0.308
35-39	$0.449
40-44	$0.622
45-49	$0.889
50-54	$1.350
55-59	$2.050
60-64	$2.080
65-69	$2.080
70+	$2.080

MONTHLY PREMIUM EXAMPLE

Annual Salary $35,000
Monthly Salary $2,916.67
Age 35
Premium Calculation
($2,916.67 x .449) / 100 = $13.10 *or*
$6.55 per pay period

HERITAGE BENEFITS

Voluntary Short-Term Disability

Voluntary Short-Term Disability insurance is a new offering through Guardian. This benefit provides off the job coverage for accident and injury. The Short-Term Disability benefit replaces a portion of your pre-disability earnings, less any offsets from other disability plans. (e.g., state disability benefits, no-fault auto laws, sick pay, vacation pay, etc.).

The benefit amount is 60% of your pre-disability weekly earnings; subject to the plan's maximum weekly benefit of $1,000.

When do benefits begin and how long do they continue? Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit.

The elimination periods are/is as follows:

- ✓ For Injury – 8 days
- ✓ For Sickness (includes pregnancy) – 8 days

Benefits continue for as long as you are disabled up to a maximum duration of 26 weeks. Please note that this plan has a pre-existing condition clause.

Age Brackets	Rate per $10 of weekly coverage
Under 24	$0.930
25-29	$0.974
30-34	$0.906
35-39	$0.907
40-44	$0.974
45-49	$1.187
50-54	$1.478
55-59	$1.814
60-64	$2.150
65-69	$2.150
70+	$2.150

MONTHLY PREMIUM EXAMPLE

Annual Salary $35,000
Weekly Salary $673.08
Age 35
Benefit design 60% to $1,000
Premium Calculation
($673.08 x .907) / 10 = $61.05 *or*
$30.53 per pay period

HERITAGE BENEFITS

Voluntary Hospital Indemnity Insurance

Voluntary Hospital Indemnity insurance is a new offering through Guardian. This benefit provides a lump sum benefit payment upon hospital admission or confinement. There are two options available, a low plan and a high plan.

Benefits are paid directly to you when you need it most. The benefits are paid even if medical insurance is paying 100% of the cost. Your cost is based on your selected tier of coverage. You can elect coverage based on Employee Only, Employee + Spouse, Employee + Children, or Family.

Below is a chart with the covered conditions. For complete coverage information, reference Guardian 2025 Benefits Summary located at heritage1886.org/benefits.

LOW PLAN MONTHLY RATE

- **$9.66** – Single Coverage
- **$17.78** – Employee + Spouse
- **$14.68** – Employee + Children
- **$22.80** – Family Coverage

HIGH PLAN MONTHLY RATE

- **$18.11** – Single Coverage
- **$33.27** – Employee + Spouse
- **$27.43** – Employee + Children
- **$42.60** – Family Coverage

Benefits	Low Plan	High Plan
Hospital/ICU Admission	$500 per admission, limited to admission(s) per insured	$1,000 oer admission, limited to 1 admission(s) per insured
Hospital/ICU Confinement	$100/$100 per day, limited to day(s) per insured per benefit year	$165/$165 per day, limited to 15 day(s) per insured benefit year
Pre-Existing Conditions Limitation A pre-existing condition includes any condition for which you, in the specified time perioud prior to coverafe in this plan, consulted with a physician, received treatment, or took prescribed drugs	Not Applicable	Not applicable
Child(ren) Age Limits	Children age birth to 26 years	Children age birth to 26 years

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HERITAGE BENEFITS

Voluntary Accident Insurance

Voluntary Accident Insurance is a new offering through Guardian. This benefit provides a lump sum benefit payment upon one of the covered accident conditions. There are two options available, a low plan and a high plan.

Benefits are paid directly to you when you need it most. The benefits are paid even if medical insurance is paying 100% of the cost. Your cost is based on your selected tier of coverage. You can elect coverage based on Employee Only, Employee + Spouse, Employee + Children, or Family. Accidents on and off the job are covered, and coverage portablity is included. For complete coverage information, reference Guardian 2025 Benefits Summary located at heritage1886.org/benefits.

MONTHLY LOW PLAN RATE

- **$6.01** – Single Coverage
- **$9.02** – Employee + Spouse
- **$9.50** – Employee + Children
- **$12.51** – Family Coverage

MONTHLY HIGH PLAN RATE

- **$9.76** – Single Coverage
- **$15.35** – Employee + Spouse
- **$15.70** – Employee + Children
- **$21.29** – Family Coverage

Accidental Death and Dismemberment	Low Plan	High Plan
Benefit Amount(s)	Employee $25,000 Spouse $5,000 Child $5,000	Employee $25,000 Spouse $25,000 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of Speech and Hearing (both ears), Loss of Cognitive Function: 100% of AD&D Hemiplegia and Paraplegia: 50% of AD&D	Quadriplegia, Loss of Speech and Hearing (both ears), Loss of Cognitive Function: 100% of AD&D Hemiplegia and Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D Benefit	200% of AD&D Benefit
Common Disaster	200% of Spouse AD&D Benefit	200% of Spouse AD&D Benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D Benefit Multiple: 100% of AD&D Benefit	Single: 50% of AD&D Benefit Multiple: 100% of AD&D Benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D Benefit	25% of AD&D Benefit
Seatbelts and Airbags	Seatbelts: $10,000 Airbags: $15,000	Seatbelts: $10,000 Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500	$2,500
Children(s) Age Limits	Children age birth to 26	Children age birth to 26

HERITAGE BENEFITS

Voluntary Critical Illness Insurance

Voluntary Critical Illness offered through Guardian provides a lump sum benefit payment upon diagnosis of any qualified critical illnesses listed under covered conditions.

Benefits are paid directly to you when you need it most. The benefits are paid even if medical insurance is paying 100% of the cost. Your cost is based on your age and amount of coverage you select. There will be cost adjustments as you age. You must elect coverage for yourself to cover your spouse and/or children.

Below is a chart of benefits. For complete coverage information, reference Guardian 2025 Benefits Summary located at heritage1886.org/benefits.

Critical Illness - Employee	$15,000 Benefit	$30,000 Benefit
Age	Monthly Rate	Monthly Rate
Under 30	$2.70	$5.40
30-39	$6.00	$12.00
40-49	$12.60	$25.20
50-59	$24.30	$48.60
60-69	$40.20	$80.40
70+	$61.35	$122.70

Critical Illness - Spouse	$7,500 Benefit	$15,000 Benefit
Age	Monthly Rate	Monthly Rate
Under 30	$1.35	$2.70
30-39	$3.00	$6.00
40-49	$6.30	$12.60
50-59	$12.15	$24.30
60-69	$20.10	$40.20
70+	$30.68	$61.35

	Specified Disease	
Benefit Amount(s)	Employee may choose a lump sum benefit of $15,000 to $30,000 in $15,000 increments.	
CONDITION		
Cancer	1st Occurance	2nd Occurance
Invasive Cancer	100%	100%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per Lifetime	Not Covered
Vascular		
Heart Attack	100%	100%
Stroke	100%	100%
Heart Failure	100%	100%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	100%
Kidney Failure	100%	100%
Spouse Benefit	May choose a lump sum benefit of $7,500 to $15,000 in $7,500 increments up to 50% of the employee's lump sum benefit	
Child Benefit (children age birth to 26 years	50% of employee's lump sum benefit	

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HERITAGE BENEFITS

2026 Retirement Plan

Heritage offers a retirement plan through John Hancock to all employees who are at least 19 years of age. Deferrals are effective on the first of the month following 30 days of hire. Employees are eligible for the retirement plan the first of the month following 30 days. Enterance into the plan is done on a quarterly basis.

401K ELECTIVE DEFERRAL

All eligible employees will automatically be enrolled for 3% of their compensation through payroll deductions. Deferrals automatically increase 1% in the first payroll of each new year and thereafter until a maximum of 6% is reached. Employees have the ability to make changes at any point to this auto enroll/auto deferral increase.

ROTH ELECTIVE DEFERRAL

Heritage also offers a Roth IRA which allows you to make after-tax contributions and then get tax-free withdrawals when you retire. Employees have the ability to make changes at any point to their Roth IRA.

To review plan design, please see the Reirement Plan Summary Description at www.heritage1886.org/benefits.

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Brown & Brown 2025 Benefit Guide
Compliance Section on following pages

Hospital/Fixed Indemnity Plan Notice – Effective 1/1/26

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance; it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit Healthcare.gov or call 1-800-318-2596 (TTY:1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissions' website (naic.org) under "Insurance Departments". If you have this policy through your job, or a family member's job, contact the employer.

Your Medicare Part D Notice is located on page 3 of this packet. Some other key notices include CHIPRA, HIPAA Privacy, and Notice of Coverage Options (Marketplace Notice). If you have any questions, please reach out to the contact listed on the next page.

Important Notices

1/1/26

Heritage Ministries Charitable Care Network

Mailing Address 4600 Route 60
Gerry, NY 14740

Contact Name Nicole Mariano

Contact Title Benefits Manager

Contact Email: Benefits@heritage1886.org

Contact Phone: 716-338-0129

Important Notice from Heritage Ministries Charitable Care Network About Your Prescription Drug Coverage and Medicare, Creditable Coverage, Hybrid 2000; HDHP 3000; HDHP 6000

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Heritage Ministries Charitable Care Network 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) **Heritage Ministries Charitable Care Network has determined that the prescription drug coverage offered by the Hybrid 2000; HDHP 3000; HDHP 6000, 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 15 to December 7.

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. The group health plan will determine and pay benefits first, before Medicare, then Medicare will determine its benefit based on any remaining balance.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back during the next annual enrollment period or at the time you experience a status change that allows you to elect coverage, if earlier.

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 this plan 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…

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).

Or contact the person listed below.

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 **Heritage Ministries Charitable Care Network** changes. You also may request a copy of this notice at any time.

Effective Date: 1/1/26

Employer Name: Heritage Ministries Charitable Care Network

Contact Name/Title: Nicole Mariano
Benefits Manager

Address: 4600 Route 60
Gerry, NY 14740

Phone: 716-338-0129

Email: Benefits@heritage1886.org

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)
** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this to the person listed under the "Plan Contact Information, at the end of this notice, along with supporting documentation of the qualified life event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Heritage Ministries Charitable Care Network
ATTN: Nicole Mariano
4600 Route 60
Gerry, NY, 14740
Benefits@heritage1886.org
716-338-0129

Notice of Special Enrollment Rights

This notice is being provided to help you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

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

Marriage, Birth or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact the plan administrator (see cover page for contact information).

Newborns' and 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 of 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Mental Health Parity & Addiction Act

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (see cover page for contact information).

Women's Health and Cancer Rights Act

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). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.
Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator (see cover page for contact information).

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator (see cover page for contact information).

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets
An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Nicole Mariano at 716-338-0129 or Benefits@heritage1886.org.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name **Heritage Ministries Charitable Care Network**		**4. Employer Identification Number (EIN)** **26-1454957**
5. Employer address **4600 Route 60**		**6. Employer phone number** **716-338-0129**
7. City **Gerry**	**8. State** **NY**	**9. Zip Code** **14740**
10. Who can we contact about health coverage at this job? Nicole Mariano		
11. Phone number (if different from above)	**12. Email address** **Benefits@heritage1886.org**	

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

· As your employer, we offer a health plan to:

- ☐ All employees. Eligible employees are:
- ☑ Some employees. Eligible employees are: Full-time, working 30 hours/week or more

· With respect to dependents:

- ☑ We do offer coverage. Eligible dependents are: Your legal spouse and dependent children up to the age of 26
- ☐ 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 this 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.

Your Information. Your Rights. Our Responsibilities.

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.**

Effective Date: 1/1/26

Privacy Officer: Nicole Mariano
Title: Benefits Manager
Email: Benefits@Heritage1886.org
Phone: 716-338-0129

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

· You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
· We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

· You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
· We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

· You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
· We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

· You can ask us not to use or share certain health information for treatment, payment, or our operations.
· We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

· You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
· We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

· You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

· If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
· We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

· You can complain if you feel we have violated your rights by contacting us using the information on page 1.
· You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
· We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

· Share information with your family, close friends, or others involved in payment for your care
· Share information in a disaster relief situation
· *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
· In these cases we *never* share your information unless you give us written permission:
· Marketing purposes
· Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

· We can use your health information and share it with professionals who are treating you.
· *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- *Example: We use health information about you to develop better services for you.*

Pay for your health services
- We can use and disclose your health information as we pay for your health services.
- *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan
- We may disclose your health information to your health plan sponsor for plan administration.
- *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

- How else can we use or share your health information?
- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

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, 2025. 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: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	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	**INDIANA – 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	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
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ 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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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/

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2025, 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)
Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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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.