Legal Notices

For additional information regarding your benefits please contact the **My Choice** Service Center at 1-844-315-3794.

HIPAA Notice of Privacy Practices

Special Enrollment Notice (Life Event)

CHIP Notice

WHCRA Enrollment Notice

Newborns' Act Disclosure

Medicare Creditable Coverage Notice

Healthcare Marketplace Insurance Notice

Your Rights and Protections Against Surprise Medical Bills (No Surprises Act) Notice

FMLA General Notice

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") describes the privacy practices and legal obligations of the medical, prescription, dental, and vision plans, the employee assistance program ("EAP"), the Flexible Spending Account ("FSA"), and any other health benefit plan that may be sponsored by Safelite from time to time (collectively, the "Health Plan"). These plans are part of the Safelite Health and Welfare Benefits Plan. This Notice does not apply to life insurance, long-term disability, accidental death and dismemberment, or any other non-health plans or benefits.

This Notice describes your rights regarding the medical information about you that the Health Plan maintains. Medical information includes protected health information ("PHI") as defined in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and the corresponding regulations (collectively, "HIPAA "). Medical information, including PHI, is health information about you that is created or obtained by or on behalf of the Health Plan in connection with your eligibility for or receipt of benefits under the Health Plan.

HIPAA requires that the Health Plan maintain the privacy of PHI, give you this Notice, follow the terms of this Notice, and notify affected individuals following a breach of unsecured PHI. Safelite reserves the right to change the terms of this Notice from time to time and to make the new Notice effective for all medical information maintained by the Health Plan or on its behalf. If there is a material change to the privacy practices, a revised Notice will be timely prepared and distributed consistent with the HIPAA Privacy Rule. Except when required by law, a material change to this Notice will not be implemented before the effective date of the new notice in which the material change is reflected.

Third parties, when their services involve the use of medical information, will be required to perform their duties in a manner consistent with this Notice. A third party providing a fully-insured benefit or an EAP may give you a separate notice of privacy practices describing its privacy practices. If so, the third party will follow its own privacy practices to the extent those practices are more restrictive than those described in this notice.

This Notice has been prepared and distributed in accordance with the HIPAA Privacy Rule, as may be amended from time to time. Terms used in the HIPAA Privacy Rule, but not specifically defined in this Notice, will have the same meaning as in the HIPAA Privacy Rule.

How the Health Plan Uses and Discloses Medical Information

The Health Plan has the right to use or disclose medical information under certain circumstances without your permission. The following categories describe the different ways that the Health Plan may use and disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Health Plan is permitted to use and disclose information will fall within one of the categories. Most of the time, the Health Plan will use and disclose only the minimum information necessary for these purposes.

The Health Plan may use or disclose your medical information:

For Treatment. The Health Plan may use or disclose medical information to facilitate medical treatment or services by health providers. The Health Plan may disclose health information about you to health care providers who need the information to take care of you, including doctors, dentists, pharmacists, nurses, technicians, and hospital personnel. For example, the Health Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription conflicts with your current prescriptions. Another example, your health care providers may request medical information from the Health Plan to supplement their own records.

For Payment. The Health Plan may use or disclose your medical information to determine and pay for covered services. Payment activities include determining eligibility; conducting pre-certification, utilization,

and medical necessity reviews; coordinating care; calculating cost sharing amounts; coordination of benefits; reimbursement and subrogation; and responding to questions, complaints, and appeals. For example, the Health Plan may share your medical information (i) with health care providers to determine whether the Health Plan will cover a particular treatment; or (ii) with another organization to assist with financial recoveries from responsible third parties.

For Health Care Operations. The Health Plan may use and disclose medical information for Health Plan operations. For example, the Health Plan may use medical information in connection with quality assessment and improvement activities; care coordination and case management; underwriting, premium rating, and other activities relating to Health Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Health Plan administrative activities. However, the Health Plan will not use, and is prohibited from using, genetic information for underwriting purposes.

To Business Associates. The Health Plan may contract with third parties, known as "Business Associates," to perform various functions or provide various services on behalf of the Health Plan. To perform these functions or to provide these services, Business Associates may receive, create, maintain, transmit, use, and disclose medical information, but only after they agree in writing to safeguard medical information and respect your HIPAA rights. For example, the Health Plan may disclose medical information to a third-party administrator to process claims for Health Plan benefits.

As Required by Law. The Health Plan will disclose medical information when required to do so by federal, state, or local law.

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

To the Employer. The Health Plan may disclose medical information to certain employees of the Employer who are involved with Health Plan administration. These employees are permitted to use or disclose medical information only to perform plan administration functions or as otherwise permitted or required by HIPAA, unless you have authorized further disclosures. Medical information cannot be used for employment purposes without your specific authorization.

For Workers' Compensation. The Health Plan may disclose medical information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

For Public Health Activities. The Health Plan may disclose medical information for public health activities, including, for example, to prevent or control disease, injury, or disability, or to report child abuse or neglect.

For Health Oversight Activities. The Health Plan may disclose medical information to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

For Judicial and Administrative Proceedings. The Health Plan may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process.

For Law Enforcement Purposes. The Health Plan may disclose medical information if asked to do so by a law-enforcement official in certain limited circumstances.

To Others Involved in Your Health Care. The Health Plan may disclose medical information to a family member or close personal friend who is involved in your care or payment for your care or for notification purposes. Generally, you will have an opportunity to object to these disclosures.

To Coroners, Medical Examiners, and Funeral Directors. The Health Plan may disclose medical information to a coroner, medical examiner, or funeral director, as necessary for them to carry out their duties.

For National Security and Intelligence Activities. The Health Plan may disclose medical information to authorized federal officials for national security activities authorized by law.

To the Military. The Health Plan may disclose medical information as required by military and veterans authorities if you are or were a member of the uniformed services.

For Research. The Health Plan may disclose medical information to researchers in very limited situations. Typically, your authorization is required for such disclosures.

To Comply With HIPAA. The Health Plan is required to disclose medical information to the United States Department of Health and Human Services when requested to determine compliance with HIPAA.

Your Authorization

Other uses or disclosures of your medical information not described above will be made only with your written authorization. For example, the Health Plan generally needs your authorization to disclose psychiatric notes about you; to use or disclose medical information for marketing; or to sell medical information. You may revoke your authorizations at any time, so long as the revocation is in writing. However, the revocation will not be effective for any uses or disclosures made in reliance upon the authorization.

Your Rights

You have the rights described below with respect to medical information about you, subject to certain conditions and exceptions. All requests to enforce the rights described below *must be made in writing* to the Contact Person.

Right to Request Restrictions. You have the right to request a restriction or limitation on how the Health Plan uses and discloses medical information about you for treatment, payment, or health care operations. You also have the right to request a limit on medical information that the Health Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Health Plan will consider, but is generally is not required to agree to, your request. If the Health Plan agrees to the request, the Health Plan will honor the restriction until you revoke it or the Health Plan notifies you. The Health Plan has the right to terminate an agreed-upon restriction.

Right to Request Confidential Communications. You have the right to request that when the Health Plan sends communications to you that contain medical information, such as an explanation of benefits, it sends them to you by alternative means or to an alternative location, such as only sending communications by U.S. mail. Your request must provide the alternative means and/or location. The Health Plan will accommodate reasonable requests when you have stated that normal communications would endanger you. The Health Plan may, but is not required to, accommodate other reasonable requests. You may also direct the Health Plan to limit disclosures to family members or others who are involved in your health care or the paying for your care.

Right to Have Personal Representative Act on Your Behalf. You have the right to designate one or more persons to act on your behalf as your personal representative. A personal representative is someone who, under applicable law, is authorized to make decisions related to your health care. The Health Plan may require the personal representative to provide documentation, such as a health care power of attorney, of their authority to make health care decisions on your behalf. The Health Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the Health Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative based on the Health Plan's exercise of professional judgment.

Right to Access Your Medical Information. You have the right to inspect and copy certain medical information that the Health Plan maintains about you. The Health Plan will work with you to provide the requested information in the form and format you requested; a mutually agreeable alternative form and format; or another form and format permitted by law. If you request a copy of the information, then the Health Plan may charge a reasonable fee for the costs of copying, mailing, or other supplies associated

with your request. The Health Plan may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, in whole or in part, the Health Plan will notify you in writing.

Right to Amend / Correct Your Medical Information. You have the right to ask the Health Plan to amend certain medical information about you that is kept by the Health Plan, if you think that the medical information is incorrect or incomplete. Among other reasons, the Health Plan may deny the request if the medical information was not created by the Health Plan, unless the individual provides a reasonable basis to believe that the originator of medical information is no longer available to act on the requested amendment or if the medical information is accurate and complete. If the Health Plan denies your request, you will receive an explanation, and you will have the right to file a written statement of disagreement.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of medical information. Your request must specify the time period for which you are requesting information. The period cannot go back more than six (6) years from the date of your request. The accounting will not include disclosures made to you (or with your written authorization) or in the course of treatment, payment, or health care operations. If you request such an accounting more than once in a twelve (12) month period, the Health Plan may charge a reasonable fee.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice even you previously agreed to receive this Notice electronically.

Complaints

You have the right to file a written complaint if you think this Notice and/or your privacy rights have been violated. You will not be retaliated against or denied any Health Plan benefit or service because you file a complaint. Your complaint should be in writing and include: your name, full address, home and work telephone numbers, and e-mail address; the name, full address, and telephone number of the person or entity that you believe violated your privacy rights; and a description of what happened including how, why, and when you believe this Notice and/or your privacy rights were violated.

Your complaint may be filed with the Health Plan's Contact Person or the Secretary of the U.S. Department of Health and Human Services (with limited exception, this complaint must be filed within 180 days of when you knew or should have known about the alleged violation).

Contact Person

If you have any questions about this Notice or about the Health Plan's privacy practices, or wish to exercise any of your privacy rights, please contact the Contact Person:

HIPAA Privacy Officer
7400 Safelite Way, Columbus, OH 43235
benefits@safelite.com

Effective Date

This Notice is effective January 1, 2024.

Special Enrollment Notice

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 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).

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

To request special enrollment or obtain more information, contact the **My Choice** Service Center at 1-844-315-3794.

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, 2023. 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	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://kidshealth.ky.gov/Pages/index.aspx 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: 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**
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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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, 2023, or for more information on special enrollment rights, contact either:

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

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

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.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Enrollment Notice

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, contact the **My Choice** Service Center at 1-844-315-3794.

Newborns' Act Disclosure

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).

Important Notice from Safelite 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 Safelite 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. Safelite has determined that the prescription drug coverage offered by the Safelite Health and Welfare Benefits Plan 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 prescription drug plan when you first become eligible for Medicare coverage and each year from October 15 through 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-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 and continue your Safelite medical coverage, your current Safelite coverage will not be affected. You can continue your Safelite medical and prescription drug coverage and enroll in a Medicare prescription drug plan.

If you elect to enroll in both the Safelite coverage and a Medicare prescription drug plan, you will continue to be responsible for any required contributions under the Safelite plan plus any Medicare Part A, Part B and/or Part D (prescription drug) premium costs.

You (or a dependent) cannot drop Safelite prescription drug coverage and continue only the Safelite medical coverage, because the Safelite medical and prescription drug benefits are

bundled. Your Safelite medical and prescription drug coverage will coordinate with your Medicare coverage. In that case, Medicare will be the secondary payor for your prescription drug costs.

Alternatively, if you decide to join a Medicare drug plan but drop your Safelite coverage, then Medicare will be your only payor, and the Safelite group health plan will not pay any benefits.

If you do decide to join a Medicare drug plan and drop your current Safelite coverage, be aware that you and your dependents will be able to get this coverage back during the next annual enrollment period, if you experience a qualifying status change or if special enrollment rights apply.

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

If you drop or lose your current coverage with Safelite and do not 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 19 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) for as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the person listed below for further information. **Note:** You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan and if this coverage through Safelite changes. You also can request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will receive 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.
- For personalized help, call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number).
- 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.

Date: 10/15/2023
Name of Entity/Sender: Safelite

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the My Choice Service Center at 1-844-315-3794.

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.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3.	Employer name **Safelite Group Inc.**			4.	Employer Identification Number (EIN) **31-1725961**
5.	Employer address **7400 Safelite Way**			6.	Employer phone number **800-631-6966**
7.	City **Columbus**	8.	State **OH**	9.	Zip code **43235**
10.	Who can we contact about employee health coverage at this job? **People Direct**				
11.	Phone number (if different from above)	12.	Email address **peopledirect@safelite.com**		

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

- As your employer, we offer a health plan to:
  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are: **Associates classified as "Full-Time Regular" or "Full-Time Ten-Two"**

- With respect to dependents:
  ☒ We do offer coverage. Eligible dependents are:
  - **The associates lawful spouse**
  - **The associates or his/her spouse's child(ren) under the age of 26**
    Eligible child(ren) definition includes birth son/daughter, adopted/place for adoption son/daughter, step-son/step-daughter or placed foster child

  ☐ We do offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans: If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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. This Notice provides you with information regarding your rights and protections regarding balance billing. In certain situations, a provider can ask you to waive these protections. **You are NEVER required to waive your protections.**

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.

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.

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.

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, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

ELIGIBILITY REQUIREMENTS

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division