ABS Automated Benefit Services

2022 Annual Notice

AUTOMATED BENEFITS SERVICES, INC. (ABS) PRIVACY STATEMENT

Company policy requires us to treat information from all clients and members with the professionalism they expect. Maintaining this confidentiality is not only vital to our business success; it's also essential given today's regulatory environment.

Federal rules have set new restrictions on how we use the information we gather on our members. Title V of the Gramm Leach-Bliley (GLB) Financial Services Modernization Act of 1999 is designated to protect the confidentiality of our members' nonpublic personal information.

Customer privacy is important to ABS and our affiliated companies. Our customers have chosen to do business with us; and we recognize our obligation to keep the information we learn about them secure and confidential. The following is an outline of the principles of our commitment:

We intend to collect nonpublic personal information only to deliver superior products and services. This includes information we need to evaluate applications, administer accounts, and service claims.

We will require that only those employees with appropriate authority have access to this data. They will use and disclose this information for business purposes only.

We will not share personally identifiable medical information about our customers with affiliated or non affiliated companies, unless the information is needed to underwrite or administer a customer policy, claim or account, or as required by law.

Whenever we employ non-affiliated companies or individuals to perform functions for us, we will give them access only to the customer information needed to perform those functions and will not allow them to use it for any other purpose. We will require these non-affiliated companies to abide by our privacy standards and retain the data only long enough to perform the stated services except as required by law.

We will maintain the same privacy standards for current and former customers; and we will fully comply with all federal and state law and regulatory requirements that protect consumer privacy.

SPECIAL ENROLLMENT RIGHTS THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

The new special enrollment events occur when an employee or dependent child:

- Loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (acronym "CHIP", for children whose families do not qualify for Medicaid); or
- Becomes eligible for premium assistance from Medicaid or CHIP allowing him or her to enroll in a group health plan.

The special enrollment period is 60 days measured from the date of coverage loss or eligibility for premium assistance, whichever applies.

For additional details, please see attached documents.

REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

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 lymphedemas.

The benefits are subject to all the plan's provisions including annual deductibles, copays, copayments, coinsurance, maximum benefit and Preferred Provider provision not in conflict with the law.

This law became effective for the plan year beginning on or after October 21, 1998.

STATEMENT OF RIGHTS UNDER NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans offering group health coverage generally may not restrict benefits for any hospital length of stay in connection with the childbirth for mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the plan may pay for a shorter stay if the attending provider (e.g. your physician), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hours(or 96- hours) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.