HIMSS

Benefits for Life

2025 Benefits Guide

Table of Contents

Benefits for Life

Our HIMSS team is made up of diverse individuals with families and lives beyond the workplace. That's why our **Benefits for Life** Total Rewards include programs for your emotional, physical, and professional wellbeing. We've made it easier than ever to find the right benefits when you explore our new benefits enrollment website at **HIMSSTotalRewards.com**.

From our newest colleagues to our most seasoned teammates, we hope you'll use information from the website to help customize your benefits to fit your life. Ask questions, get answers, and maximize your benefits for this stage of your life. Share the enrollment site with your family so they can get their questions answered too. Your benefits aren't just for you at work—these are **Benefits for Life**.

HIMSS is committed to providing a competitive Total Rewards package designed to meet your evolving needs. We encourage you to take the time to review your options and select the benefits that will best support your emotional, physical and professional wellbeing no matter where you are on your journey.

This benefits guide provides a summary of your options. Use it in tandem with the enrollment site at **HIMSSTotalRewards.com** to make the best choices. Please review each selection carefully and challenge yourself to make sure you choose the right benefits for you and your family. After all, these are your **Benefits for Life**.

Once you enroll, no changes are allowed unless you have a Qualified Life Event (such as a birth, death, divorce, marriage, etc.).

If you have questions about your benefits choices or how to enroll, please contact your colleagues in Human Resources to get the answers you need. We're here to help.

Welcome

As a HIMSS employee, your benefits are an important component of your Total Rewards package. In accordance with our Total Rewards philosophy, we review our benefits plans on an ongoing basis to ensure we provide options that meet a variety of needs and are market competitive. It's just as important that you review our benefit options to ensure you are choosing the benefits that support your and your family's mental, physical and professional wellbeing needs for the next year.

This guide provides a summary of your benefits options. Please review it carefully and challenge yourself to make sure you are choosing the right benefits for you and your family. Then make your elections before the deadline. **For dental benefits, you must enroll in a dental plan to have dental coverage in 2025.** All elections you make during Open Enrollment period will be effective on January 1, 2025 and remain in effect through December 31, 2025. **If you do not enroll in dental, you will not have dental insurance in 2025.** No changes will be allowed at any other time unless you have a Qualified Life Event (such as a birth, death, divorce, marriage, etc.).

If you have any questions about your benefits choices or about how to enroll, please reach out to Human Resources to get the answers you need. Then you'll be sure to have the benefits you need for the year ahead.

Eligibility

If you are a regular full-time employee who works at least 30 hours per week, you are eligible for benefits. Most of your benefits are effective on the first day of the month following your date of hire. You may also enroll your eligible dependents for coverage. This includes the following:

- Your legal spouse or domestic partner
- Children under the age of 26, regardless of student, dependency or marital status

When Coverage Ends

Coverage in the medical, dental and vision plans ends at 11:59 p.m. on the last day of the month in which your employment ends. All other plan coverages end at 11:59 p.m. on your last day of employment except as otherwise indicated in this summary.

Qualified Life Events

Generally, you may only change your benefit elections during the Open Enrollment period. However, since life happens, you also may change your benefit elections during the year if you experience a Qualified Life Event such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss or gain of other coverage by the employee or dependent
- Eligibility for Medicare or Medicaid

Scan this QR code with your smartphone to visit HIMSSTotalRewards.com to enroll and for more info about your benefits.

You may also text "**himssrewards**" to **855.930.4899** to opt in to important information and reminders about your benefits.

Changing Benefits After Enrollment

You have 30 days from the Qualified Life Event to make changes to your coverage. Depending on the type of event, you may need to provide proof of the event, such as a marriage license. If you do not make the changes within 30 days of the qualified event, you will have to wait until the next Open Enrollment period to make changes (unless you experience another Qualified Life Event).

Benefit Costs

HIMSS pays the full cost of some of your benefits. For others, HIMSS and you share the cost, or you pay the full cost. Pretax means the cost comes out of your pay before taxes are deducted. After-tax means the cost comes out of your pay after taxes are deducted. The chart below shows who pays for each benefit and the related tax treatment.

Benefit	Who Pays	Tax Treatment
Medical, Prescription	HIMSS/You	Pretax
Dental	HIMSS/You for Employee tier You for all other tiers	Pretax
Vision	You	Pretax
Health Savings Account	HIMSS/You	Pretax
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	HIMSS	N/A
Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance	You	After-tax
Disability Coverage	HIMSS	N/A
Flexible Spending Accounts	You	Pretax
Commuter Benefit	You	Pretax
401(k) Retirement Savings Plan	HIMSS/You	Pretax or After-tax
Employee Assistance Plan	HIMSS	N/A
wayForward Behavioral Health Platform	HIMSS	N/A
Voluntary Critical Illness Coverage	You	After-tax
Voluntary Accident Coverage	You	After-tax

Note About Domestic Partner Coverage

If you enroll your domestic partner in the medical, dental and/or vision plans, the portion you pay for their coverage will be deducted from your after-tax earnings, as the IRS does not permit pretax dollars to be used for this purpose. In addition, the portion of your partner's costs paid by the company must be treated as taxable income to you. You will see this value reflected as imputed income on each paycheck and applicable taxes withheld.

Benefit Contributions

Medical	Per Paycheck
BCBS HIGH DEDUCTIBLE PPO + HSA	
Employee Only	$42.59
Employee + Spouse or Domestic Partner	$155.36
Employee + Child(ren)	$142.65
Employee + Family	$227.03
BCBS PPO PLAN	
Employee Only	$97.43
Employee + Spouse or Domestic Partner	$284.30
Employee + Child(ren)	$261.06
Employee + Family	$415.46
HMO PLAN	
Employee Only	$41.40
Employee + Spouse or Domestic Partner	$151.03
Employee + Child(ren)	$138.69
Employee + Family	$220.71

Dental	Per Paycheck
HIGH PPO	
Employee Only	$10.45
Employee + Spouse or Domestic Partner	$36.37
Employee + Child(ren)	$46.29
Employee + Family	$72.08
LOW PPO	
Employee Only	$5.75
Employee + Spouse or Domestic Partner	$28.74
Employee + Child(ren)	$36.77
Employee + Family	$57.25

Vision	Per Paycheck
Employee Only	$3.06
Employee + Spouse or Domestic Partner	$5.81
Employee + Child(ren)	$6.11
Employee + Family	$8.98

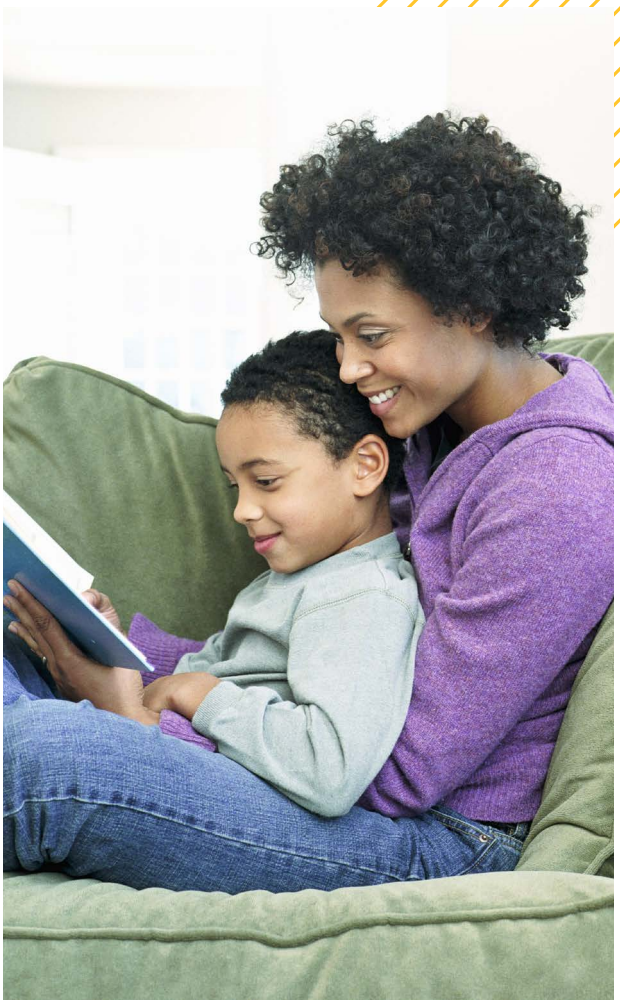
Optional Dependent Life Insurance	Per Paycheck
$2,000 Increments to a maximum of $10,000	$0.138 per $2,000

Optional Life and Accidental Death and Dismemberment (AD&D)

Cost of this benefit varies based on age, benefit election, and salary. Personalized per paycheck costs will be displayed on the group benefits enrollment website.

Accident and Critical Illness Insurance

Cost of this benefit varies based on benefit election and salary. Personalized per paycheck costs will be displayed on the benefits enrollment website.



Save When You Use In-Network Providers

In-network providers offer the highest level of benefits and lower out-of-pocket costs. Network providers charge you reduced fees but providers outside the plan's network set their own rates, which means you may have to pay the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

Medical Plans

Our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens. We partner with Blue Cross Blue Shield of Illinois (BCBSIL) and each medical plan offers:

- Comprehensive healthcare benefits
- In-network preventive care covered at 100%
- Prescription drug coverage

Choose the Plan That's Right for You

The key difference between the plans is the amount of money you'll pay each pay period and when you need care.

- **Preferred Provider Organization (PPO):** This plan offers flexibility with a large network and no requirement to select a primary care provider or request referrals for specialist visits.
- **High Deductible PPO + HSA:** If you enroll in the High Deductible PPO, you can also enroll in a Health Savings Account (HSA). You can use the pretax funds in your HSA to pay for eligible healthcare expenses such as those costs incurred as you meet plan deductible, or you can choose to save funds for the future. To assist with your savings, HIMSS will contribute a fixed amount to your HSA account each calendar year you are enrolled.
- **Health Management Organizations (HMO):** HMOs are highly managed networks of doctors and hospitals that manage all medical care. In this plan, you must select a primary care provider, who will act as your primary point of contact and will refer you to other healthcare professionals or specialists when necessary. Only services provided or referred by your PCP and emergency services are covered under the plan. Only Illinois residents are eligible to enroll in the HMO Plan.

Blue Cross Blue Shield
PPO and HSA Plans: **800.828.3116**
HMO Plan: **800.892.2803**
www.bcbsil.com

Scan this QR code with your smartphone to download the Blue Cross Blue Shield IL app to stay connected to your medical plan on the go!

Medical Plan Comparison

Plan Provision	BCBS High Deductible PPO + HSA		BCBS PPO		BCBS Blue Advantage HMO (for Illinois residents only)
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network only
COMPANY CONTRIBUTION TO HSA					
Individual	$500		N/A	N/A	N/A
Family	$1,000		N/A	N/A	N/A
ANNUAL DEDUCTIBLE					
Individual	$3,300	$6,000	$1,500	$3,000	N/A
Family	$6,000	$12,000	$3,000	$6,000	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)					
Individual	$4,500	$9,000	$4,500	$6,000	$1,500
Family	$9,000	$18,000	$9,000	$12,000	$3,000
	You Pay		You Pay		You Pay
Preventive Care	$0	40%	$0	40%	$0
Primary Care Provider Office Visit	20%*	40%*	$25	40%*	$30
Specialist Office Visit	20%*	40%*	$50	40%*	$30
Urgent Care	20%*	40%*	$100	40%*	$30
Emergency Room	20%*	$300	$350	$350	$300
X-Ray and Lab	20%*	40%*	20%*	40%*	$0*
Inpatient Hospital Services	20%*	40%*	20%*	40%*	$0*
Outpatient Hospital Services	20%*	40%*	$25 for office visit 20%* for other outpatient services	40%*	$0*
Retail Rx (Up to 34-Day Supply)					
Generic	20%*	20%*	$10	$10	$10
Brand Preferred			$40	$40	$40
Brand Non-Preferred			$60	$60	$60
Mail Order Rx (Up to 90-Day Supply)					
Generic	20%*	Not Available	$20	Not Available	$20
Brand Preferred			$80		$80
Brand Non-Preferred			$120		$120

* After deductible

Note: This is a summary only of your coverage. Please refer to your summary plan descriptions for the full scope of coverage. In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

BlueCross BlueShield Programs

We are excited to share the following programs offered under the BCSBIL plans effective January 1, 2025. You must be enrolled in the BCBSIL medical plan to be eligible for these programs. These programs are available at no cost to you!

Wondr Health

Wondr is an online mindful eating behavior modification program proven to deliver sustainable weight loss and reverse obesity, pre-diabetes, and metabolic syndrome. The program provides weekly master classes and mindful eating tools. Wondr is free and available to all colleagues and their dependents (18+) enrolled in our medical plan unless underweight or pregnant. Visit wondrhealth.com/BCBSIL to sign up.

Teladoc (Formerly Livongo) Hypertension and Diabetes Management

Livongo is now part of Teladoc Health. The Hypertension and Diabetes Management programs are robust programs with the goal of helping you manage your chronic conditions. The diabetes program provides a blood glucose meter, test strips, and lancets right to members' doors with real-time personalized coaching at no cost to you. Similarly, the hypertension program provides a blood pressure cuff with real-time personalized coaching at no cost to you. Members who are eligible for the program will receive outreach from Teladoc (Livongo) directly.

Hinge Health

Hinge Health is a musculoskeletal program that takes established, proven non-surgical care guidelines and turns them into a digital, 12-week, coach-led physical therapy program delivered remotely using mobile and wearable technology. Members who are eligible for the program will receive outreach from Hinge Health directly.

Supplemental Medical Plans

Voluntary Accident Insurance

Just as it sounds, accident insurance can help you pay for costs you may incur after an accidental injury. This type of injury includes things such as a car accident, a fall while skiing, or even a fall down the stairs at home. This benefit is paid regardless of any other insurance coverage you might have (including your medical coverage).

Emergency Room Visits

Hospital Stays

Fractures and Dislocations

Medical Exams—
including major diagnostic exams

Physical Therapy

Transportation & Lodging—
if you are away from home when the accident happens

Voluntary Critical Illness Insurance

Critical illnesses can have a huge impact on your life. A critical illness can keep you from working and can make it difficult to do simple, everyday things. Critical Illness insurance pays a fixed one-time benefit amount if you are diagnosed with a covered disease or illness. You can use this money for any purpose you like. These illnesses can include, but are not limited to, the following:

Heart Attack

Multiple Sclerosis

Stroke

Alzheimer's Disease

Parkinson's Disease

Major Organ Failure

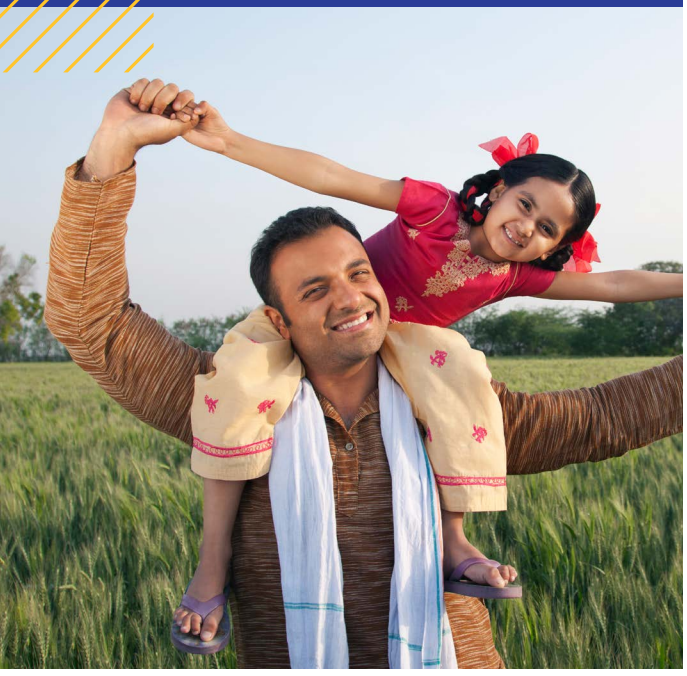
This coverage also includes a wellness benefit that pays $50 per covered person per year for proof of a qualified preventive health screening.

Cigna
800.754.3207
www.cigna.com/customer-forms

Is Always Yours—No Matter What!

One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the company or retire, your HSA goes with you!

1. You can use your HSA funds to cover qualified medical expenses, plus dental and vision expenses too—or retire—tax-free.
2. Unused funds grow and can earn interest over time—tax-free.
3. You can save your HSA funds to use for your healthcare when you leave the Company or retire—tax-free.
4. Balances of more than $1,000 can invest in mutual funds to grow the account tax-free, as long as the earnings are used for qualified medical expenses.



Health Savings Account (HSA)

An HSA is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars—now or in the future. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP medical plan.

How A Health Savings Account (HSA) Works

Eligibility

You must be enrolled in the BCBS HSA High Deductible PPO.

Your Contributions

The company contributes $500 to your HSA for individual coverage and $1,000 for family coverage (amounts are prorated for new hires). You can also contribute on a pretax basis and can change how much you contribute from each paycheck up to the IRS maximum of $4,300 for individual coverage and $8,550 for family coverage (your contribution and the company's contribution should not exceed the maximum). You can make an additional catch-up contribution if you are age 55.

Eligible Expenses

Eligible expenses include medical, dental, vision, prescription, and over-the-counter drug expenses incurred by you and your eligible family members. If you want to enroll in a Healthcare FSA, you are eligible to enroll in a Limited Purpose FSA, which covers dental and vision expenses only.

Wondering if your expense is eligible? Check this **handy list** from WEX.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future healthcare expenses.

Remaining Funds

Money left in your HSA at the end of the year will roll over to the next year—you'll never lose your HSA dollars. If you leave the company or retire, you can take your HSA with you, and continue to pay and save for future eligible healthcare expenses.

Dental Plan

Your dental health is an important part of your overall wellness. Starting in January, dental coverage will be offered through Blue Cross Blue Shield of Illinois. We will continue to offer two dental plan options so you can select the coverage level that's right for you. Both plans offer the same network of providers.

Please consider the dental services you and your family may require to help select the plan that will best meet your needs.

The dental plans cover preventive care (including regular checkups—two cleanings per calendar year) as well as fillings, bridges, crowns, and other dental services.

- **PPO Network:** Lowest cost to you with the largest discount applied to services
- **Out-of-Network:** Highest cost to you with no discounts to services; you pay the coinsurance plus any amounts over the difference in cost between the usual and customary charge and your out-of-network provider's rate

	BlueCare Dental High PPO		BlueCare Dental Low PPO	
	PPO Network	Out-of-Network	PPO Network	Out-of-Network
ANNUAL DEDUCTIBLE				
Individual	$50		$75	
Family	$150		$225	
ANNUAL MAXIMUM				
Per Individual	$1,500		$1,000	
ORTHODONTIA LIFETIME MAXIMUM				
Per Individual	$1,500		$1,500	
DIAGNOSTIC AND PREVENTIVE				
Cleanings, Fluoride Treatments, Sealants, and X-rays—includes two cleanings per calendar year	100%		100%	90%
BASIC SERVICES				
Fillings, Periodontics, Scaling and Root Planning, and Oral Surgery	90%	80%	80%	60%
MAJOR SERVICES				
Crowns, Bridges, Full, and Partial Dentures	60%	50%	50%	40%
Orthodontia (Child Only Up to Age 19)	50%		50%	

Vision Plan

You may elect vision care coverage through EyeMed, which provides quality vision care nationwide. Although vision care services and supplies are covered in-network and out-of-network, your benefits are generally greater when you use in-network providers.

	Participating Provider You Pay	Non-Participating Provider Reimbursement
COST		
Exam	$10	Up to $35
Contact Lens Evaluation & Fitting	$0	Up to $40
COVERED SERVICES—LENSES AND FRAMES		
Single Lenses	$10 copay	Up to $25
Bifocals	$10 copay	Up to $40
Trifocals	$10 copay	Up to $60
Frames	80% of balance over $120 allowance	Up to $48
COVERED SERVICES—CONTACTS IN LIEU OF FRAMES/LENSES		
Contacts—Medically Necessary	$0	Up to $200
Contacts—Elective	85% of balance over $135 allowance	Up to $95
BENEFIT FREQUENCY		
Exams	Once every calendar year	Once every calendar year
Lenses	Once every calendar year	Once every calendar year
Contacts in lieu of frames/lenses	Once every calendar year	Once every calendar year
Frames	Once every other calendar year	Once every other calendar year

Lasik Discounts Available

Save 15% discount off of retail price or 5% off a promotional price through U.S. Laser Network. To locate a provider, call **877.5LASER6**.

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSAs) allow you to pay for eligible expenses using tax-free dollars. There are four types of FSAs—the Healthcare FSA, the Limited Purpose FSA, Dependent Care FSA and Commuter Benefits Program.

Healthcare	Limited Purpose	Dependent Care
Contribute up to $3,300 per year, pretax.	Contribute up to $3,300 per year, pretax.	Contribute up to $5,000 per year, pretax, or $2,500 if married and filing separate tax returns.
Eligible expenses include most medical, dental and vision expenses that are not covered by your health plan. If you have an HSA, you are not eligible for the Healthcare FSA.	Available to those with an HSA. Eligible expenses include most dental and vision care expenses.	Use for eligible dependent care expenses for children to age 13 including day care and after-school programs, as well as elder care programs.
Your elections are effective from January 1 through December 31. You may carry over $660 in unused funds to the following plan year. Any money remaining in your FSA over $660 as of March 31, 2025 will be forfeited per IRS regulations.	Your elections are effective from January 1 through December 31. You may carry over $660 in unused funds to the following plan year. Any money remaining in your FSA over $660 as of March 31, 2025 will be forfeited per IRS regulations.	Your elections are effective from January 1 through December 31. Any money remaining in your FSA as of March 31, 2025 will be forfeited per IRS regulations (there is no carry over).

Commuter Benefits Program

Use pretax dollars to pay for your parking or public transportation expenses while commuting to work. This program is voluntary and you may participate on a month-to-month basis. Any unused funds in any month are rolled over to the next month's contribution.

Account	Use For	Contributions
Transportation or Public Transit	Monthly passes, tokens, fare cards/vouchers (transit and vanpool expenses) for you.	$325 monthly maximum
Parking	Fees associated with parking at or near your place of employment, or parking at or near public transportation to get to work (e.g., parking at a bus or subway station)	$325 monthly maximum

It's Easy to Use These Accounts

1. First, you contribute to the account(s) with pretax dollars deducted from your paycheck. That means no taxes will be withheld from any of those dollars.
2. Then, you pay for certain eligible expenses out of your pocket as usual. You may use your debit card or submit a claim to be reimbursed for those expenses from the dollars in your account.

Life and Accidental Death and Dismemberment (AD&D) Insurance

It's important to prepare for the unexpected and give thought to what expenses and income needs your dependents would have if something happened to you. To help ensure you have financial protection, HIMSS offers several different types of Life and AD&D insurance.

Basic Life Insurance

HIMSS provides basic Life and AD&D insurance in the amount of one times your annual salary ($50,000 minimum/$350,000 maximum) at no cost. Coverage is automatic.

Voluntary Life Insurance

You can also purchase additional Life and AD&D insurance for yourself and your eligible dependents. You may be required to provide proof of good health—also referred to as Evidence of Insurability (EOI).

Coverage For	Coverage Available
Employee	Increments of $10,000 up to 5 times your salary to a maximum of $500,000.
Spouse	Increments of $5,000 up to $250,000—not to exceed 100% of employee voluntary coverage.
Child(ren)	Increments of $2,000 to a maximum of $10,000.

Voluntary Life Insurance Rates

Age	Biweekly Rate Per $1,000	
	Employee	Spouse
< 30	$0.041	$0.043
30–34	$0.049	$0.051
35–39	$0.054	$0.056
40–44	$0.058	$0.060
45–49	$0.084	$0.086
50–54	$0.122	$0.124
55–59	$0.215	$0.218
60–64	$0.326	$0.328
65–69	$0.621	$0.623
70–74	$0.996	$0.998
75+	$5.931	$5.931

Biweekly Child Rate Per $2,000
$0.083

Imputed Income

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds $50,000 and is subject to federal income, Social Security, and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

Thinking about enrolling in voluntary life insurance?

During the enrollment process, ADP will do the math for you! The handy online calculator will help you find the right coverage at the right price based on your age and your dependents' age(s)—before you commit to any amount.

Disability Insurance

If you have a serious injury or illness that keeps you from working, how will you pay your bills? Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or non-work-related injury.

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. The company provides eligible employees with disability income benefits at no cost as shown below. Coverage is automatic.

Coverage	Benefit
Short-Term Disability	• 70% of your weekly earnings to a $2,000 maximum for 13 weeks. • Benefit begins after 7 days of disability.
Long-Term Disability	• 60% of your monthly earnings to a $10,000 maximum. • Benefit begins after 90 days of disability.

401(k) Retirement Savings Plan

One of the best ways to ensure a secure retirement is to start saving as early as possible.

Whether you're new to the organization or an existing employee, you can build a sizeable financial cushion if you take part in HIMSS 401(k) retirement plan. Once you're eligible, you can contribute, make changes year-round through the Empower Participant portal (**https://participant.empower-retirement.com/participant/#/login**), and stay up to date on the go with the Empower app.

The HIMSS 401(k) retirement Plan offers both pre-tax and Roth contributions up to the IRS contribution limits.

Effective January 1, 2025, employees who are at least 21 years of age are eligible to participate in the Plan following completion of 90-days of employment with the organization.

Increase Your Retirement Savings With A 401(k)

- Eligible participants are allowed to make elective deferrals into the Plan subject to the Plan rules and IRS limits.
- HIMSS will match 100% on the first 1% of employee contributions, and 50% on the next 5% of employee contributions. Match contributions will have a two-year cliff vest (contributions prior to January 1, 2023 are immediately vested under the old Plan rules).
- New hires will automatically be enrolled in the Plan at 6% (the amount needed to receive the full employer matching contribution) unless they opt out of the Plan or make a different contribution election that is more or less than the auto-enrollment contribution of 6%. Employees can elect a 0% contribution.
- HIMSS also has the discretion to make a non-elective contribution into your 401(k) account on an annual basis. Eligibility to receive any non-elective contributions begins after 90-days of employment, employees must have worked 1,000 hours in the plan year and must be employed on December 31 in the same plan year that a contribution is made. The non-elective contribution has a 3-year graded vesting schedule.
- Age 50 or older? Make an additional "catch-up" contribution up to the IRS catch-up contribution limit to save even more.

Scan this QR code with your smartphone to stay on top of your retirement savings with Empower's handy app.

Paid Time Off

HIMSS recognizes the need for flexibility in your time away from work. To promote a healthy work-life balance, HIMSS provides eligible employees with Paid Time Off in the following ways: Discretionary Time Off, Paid Holidays, Vacation, and Volunteer Time Off.

Discretionary Time Off

Regular, full-time employees and regular, part-time employees who are scheduled to work 30 hours or more per week are eligible for paid discretionary leave. Upon the successful completion of the introductory period, a regular, full-time employee will begin to accrue five hours of discretionary leave at the end of each full month of service, up to a maximum of eight (7.5 hours per day) discretionary days per calendar year. Discretionary leave will not accrue while an employee is on a short- or long-term disability leave or a workers' compensation leave. Discretionary leave may be carried over into the next fiscal year up to a maximum of 15 days. All discretionary leave for eligible part-time employees will be pro-rated based on a reduced work schedule.

Discretionary leave may be used for the following purposes:

- Employee illness and healthcare appointments
- Dependent illness and healthcare appointments
- Dependent care emergencies
- Urgent personal business that can only be scheduled during business hours
- Bereavement leave not covered under other policy

Paid Holidays

Eligible HIMSS employees will be paid for 11 holidays each year:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Eve Day
- Christmas Day
- Two floating holidays

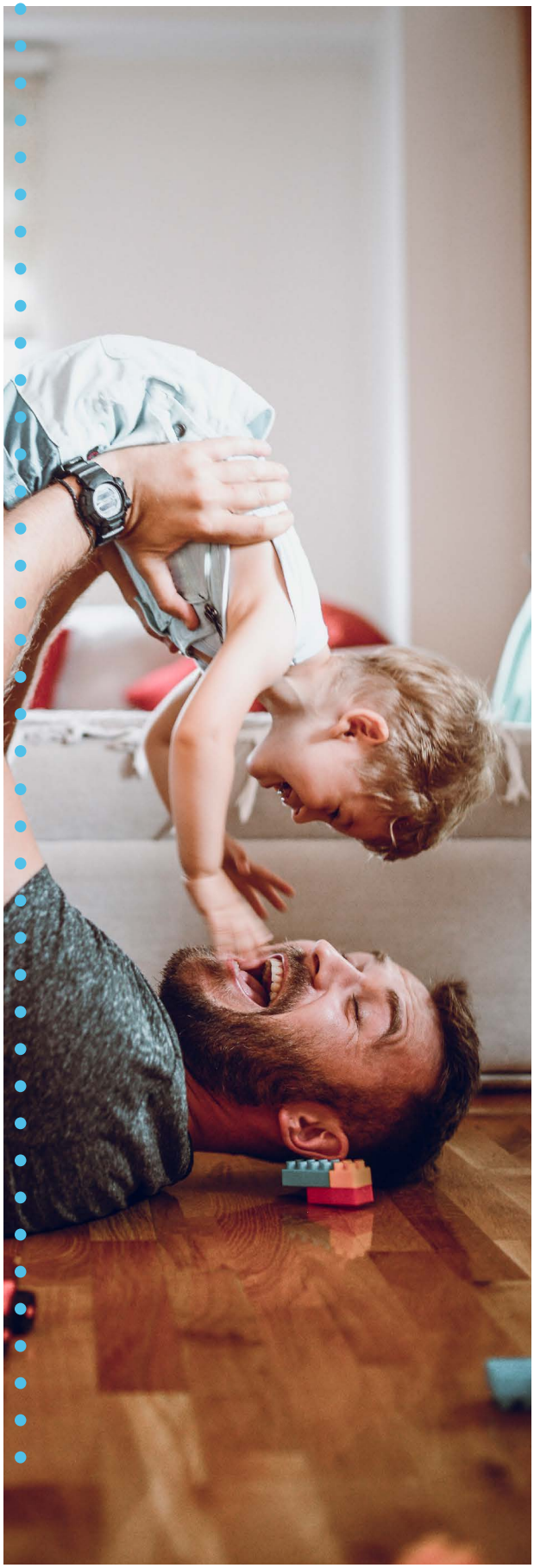
Volunteer Time Off

HIMSS volunteer program is designed to support volunteer activities that enhance and serve the communities in which we live and work. The intention of this program is to create community engagement opportunities for HIMSS employees that are meaningful, purposeful and helps those in need. At the same time, HIMSS recognizes that participating in these activities will also enrich and inspire the lives of our employees.

After successfully completing 90 days of employment, all regular full-time employees can volunteer up to one day per calendar year. Part-time employees are also eligible. See Human Resources for specifics related to part-time employee participation.

Vacation

In addition to discretionary time and paid holidays, HIMSS also offers unlimited vacation time to eligible employees. Please see the U.S. Employee Handbook for further details.



Caregiver Paid Leave

In our ongoing pursuit to provide highly competitive benefits that meet diverse needs, we review our Total Rewards Package frequently. We know that some life events, whether planned or unforeseen, can create financial stress and impact your overall health.

With this in mind, we're pleased to offer HIMSS US staff Caregiver Paid Leave.

Caregiver Paid Leave enables you to receive 100% of your regular salary for up to four weeks while you are on an authorized FMLA leave to care for your:

- Child during the first 12 months following the child's birth
- Child under the age of 18 within 12 months of the child's placement via adoption, surrogacy, or foster care
- Spouse, domestic partner, child, or parent with a serious health condition
- Spouse, child, parent, or next of kin who is a member of the Armed Forces, in accordance with provisions of Military Caregiver Leave and/or Military Exigency Leave

Caregiver Paid Leave is available to HIMSS staff who qualify under FMLA eligibility requirements.

See the Caregiver Paid Leave Policy for further details.

Additional Benefits

Employee Assistance Program

If you find yourself in need of some professional support to deal with personal, work, financial or family issues, your Employee Assistance Program (EAP) can help. The EAP is a 24/7 confidential service staffed with compassionate professionals. You and your immediate family (spouse or domestic partner, dependent children, parents and parents-in-law) can use the EAP for help with:

- Marriage and family problems
- Job-related issues
- Stress, anxiety, and depression
- Parent and child relationships
- Legal and financial counseling

You can call **800.344.9752** for assistance 24/7, or visit **guidanceresources.com**.First time visitor? click "Register" and enter "NYLGBS" as the Organization Web ID.

Dell Member Purchase Program

As part of our commitment to provide benefits that help you even while away from work, HIMSS offers a valuable discount program through Dell:

- Special pricing for Dell PCs, electronics, and accessories
- Personal financing with Dell Preferred Account
- Optional payroll deduction
- All major credit cards and Dell gift cards

Call **800.999.3355** or visit **www.dell.com/mpp/himss** (Member ID: GS123045728).

NEW! Workplace Options (WPO)

We are excited to announce the shift to Workplace Options (WPO) as our new provider for comprehensive wellbeing services, now offering an 8-session model for personalized support. WPO delivers care through wellness coaching, counseling, and a variety of work-life resources to help you navigate challenges and enhance your wellbeing. Whether you're seeking help with stress, health management, or everyday challenges, WPO provides confidential support via phone, text, or video, all designed to help you thrive both at work and in life. For more information, visit **www.workplaceoptions.com**.

Tuition Reimbursement

HIMSS realizes that quality education is an integral part of employee development and wants to provide financial support to eligible employees to assist with their career development. The tuition reimbursement program reimburses regular, full-time employees with at least nine months of service, for eligible tuition costs for approval educational courses that will benefit them and HIMSS.

Pet Insurance

Let's not forget about our furry friends! The My Pet Protection suite of pet insurance plans is specifically designed for employees and provides superior protection at an unbeatable price, including:

- Up to 90% back on vet bills
- One set price, regardless of the pet's age
- A wellness plan option that includes spay/neuter and preventive dental cleanings

For a quote for dogs and cats, visit **petinsurance.com/affiliates/himss**. For other pets, call **888.899.4874**.

My Secure Advantage

You have access to a full-service financial wellness program that offers solutions to all types of personal financial challenges.

- **Money Coach:** You and members of your household can work with a Money Coach for 30 days at no additional cost to you. Your Money Coach can help you handle any and every type of financial challenge, including but not limited to: basic money management, getting out of debt, saving for college or retirement, purchasing a home, marriage or divorce, loss of income, death in the family and more. If you would like to continue working with your Money Coach after the first 30-day coaching period you may do so on a self-pay basis of $39.95 per month.
- **Identity theft protection:** Receive a fraud resolution kit and free 30-minute consultation with a Fraud Resolution Specialist for victims of identity theft or to learn how to better protect yourself from identity theft.
- **Legal documents:** Create and execute state-specific wills, powers of attorney and a variety of other important legal documents online, and use your legal consultation benefits to obtain a qualified attorney's review.

Learn more by calling **833.920.3895** or visiting **cigna.mysecureadvantage.com**.

Healthy Rewards

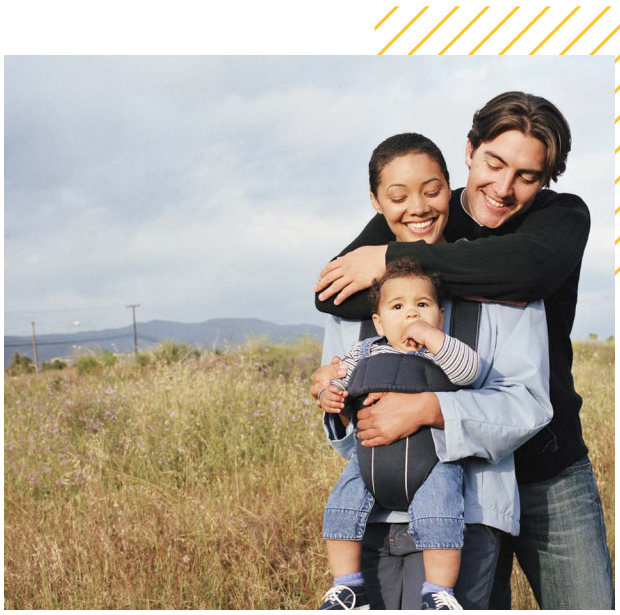
Easy access to discounts on a wide variety of health and wellness programs and services such as fitness club memberships, weight management and nutrition programs, alternative medicine such as chiropractic and acupuncture, physical and occupational therapy, vision and hearing, and podiatry. Visit **www.cigna.com/rewards** (password: savings) or call **800.258.3312** to get information on participating providers.

Health Advocacy Services

Get professional help with a wide range of healthcare and health insurance challenges, such as finding a doctor, picking a medical or dental plan, understanding test results, locating a nursing home, managing doctors' bills and more. Services are available to the entire family—including parents and parents-in-law. For 24/7 assistance, call **866.799.2725**.

Travel Assistance Program

Your wellbeing is important whether you're at home or away. New York Life Group Benefit Solutions (NYL GBS) Secure Travel provides emergency medical transportation benefits for covered persons traveling 100 miles or more from home. This service is available 24/7/365—in an emergency you can even call collect! From the U.S. and Canada, call **888.226.4567**; from all other locations, call collect **202.331.7635**. New York Life Secure Travel can also be reached via email to **ops@us.generaliglobalassistance.com**. When calling, indicate you are you are a member of the New York Life Secure Travel program and group #57.



Contact Information

Medical
Blue Cross Blue Shield
PPO and HSA Plans: **800.828.3116**
HMO Plan: **800.892.2803**
www.bcbsil.com

Critical Illness and Accident Insurance
Cigna
800.754.3207
www.cigna.com/customer-forms

Health Savings Account
Flexible Spending Accounts
Commuter Benefits
WEX
866.451.3399
https://benefitslogin.wexhealth.com

Dental
Blue Cross Blue Shield
800.367.6401
www.bcbsil.com

Vision
EyeMed
866.665.8437
www.eyemed.com

Life and AD&D Disability
New York Life
800.644.5567
www.newyorklife.com/group-benefit-solutions/employees

401(k) Retirement
Empower
888.411.4015
www.empowermyretirement.com

Behavioral Health Platform
Workplace Options (WPO)
service@workplaceoptions.com
www.workplaceoptions.com

Employee Assistance Program
New York Life — Employee Assistance and Wellness Support
800.344.9752
www.guidanceresources.com
Web ID: NYLGBS

Remember: You can download the HIMSS Mobile Wallet for information on the go! Use this QR code to download the site to your phone or tablet for insurance info at your fingertips.

SCAN ME

Healthcare Information and Management Systems Society

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Healthcare Information and Management Systems Society About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE
IMPORTANT NOTICE FROM HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY 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 Healthcare Information and Management Systems Society and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Healthcare Information and Management Systems Society has determined that the prescription drug coverage offered by the Healthcare Information and Management Systems Society Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules
As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty
If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of

the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Healthcare Information and Management Systems Society Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Healthcare Information and Management Systems Society Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Healthcare Information and Management Systems Society Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Healthcare Information and Management Systems Society prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information, or call 312-638-9404. **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 Healthcare Information and Management Systems Society changes. You also may request a copy.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Liz Osmun
Contact—Position/Office:	Total Rewards & HRIS Manager
Address:	550 W VanBuren St. Suite 1110 Chicago, Illinois 60607
Phone Number:	312-638-9404

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

Healthcare Information and Management Systems Society Group Benefits Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Healthcare Information and Management Systems Society is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its

representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to

the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right

to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Liz Osmun
Total Rewards & HRIS Manager
312-638-9404

Effective Date

The effective date of this notice is: January 1, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY EMPLOYEE HEALTH CARE PLAN

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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:

Liz Osmun
Total Rewards & HRIS Manager
312-638-9404

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

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 must 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 notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the 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. If you believe you are eligible for this extension, contact the Plan Administrator.

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[1] 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

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Liz Osmun
Total Rewards & HRIS Manager
550 W VanBuren St. Suite 1110
Chicago, Illinois 60607
312-638-9404

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Healthcare Information and Management Systems Society Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 312-638-9404.

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

You do not need prior authorization from Healthcare Information and Management Systems Society Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Healthcare Information and Management Systems Society Employee Health Care Plan at:

Liz Osmun
Total Rewards & HRIS Manager
312-638-9404

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Healthcare Information and Management Systems Society Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 Healthcare Information and Management Systems Society Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

HDHP	In-Network	Out-of-Network
Individual Deductible	$3,300	$6,000
Family Deductible	$6,000	$12,000
Coinsurance	80%	60%
PPO	In-Network	Out-of-Network
Individual Deductible	$1,500	$3,000
Family Deductible	$3,000	$6,000
Coinsurance	80%	60%

HMO	In-Network	Out-of-Network
Individual Deductible	$0	$0
Family Deductible	$0	$0
Coinsurance	100%	100%

If you would like more information on WHCRA benefits, please refer to your Policy Booklet or contact your Plan Administrator at:

Liz Osmun
Total Rewards & HRIS Manager
312-638-9404

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, 2024. 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, 2024, 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.

Illinois Essential Health Benefit List— PPO & HSA

Employer Name:	HIMSS
Employer State of Situs:	Illinois
Name of Issuer:	BCBSIL
Plan Marketing Name:	PPO & HSA
Plan Year:	2025

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2024 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Covered
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Covered
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Covered
4	Durable Medical Equipment	Ambulatory	Pg. 13	Covered
5	Hospice	Ambulatory	Pg. 28	Covered
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Covered
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Covered
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Covered
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Covered
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Covered
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Covered
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Covered
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Covered
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Covered
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Covered
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Covered
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Covered
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Covered
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Covered
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Covered
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Covered

22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Covered
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Covered
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Covered
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Covered
26	Tele-Psychiatry	MH/SUD	Pg. 11	Covered
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Covered
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Covered
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Covered
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Covered
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Covered
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Covered
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Covered
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Covered
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Covered
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Covered
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Covered
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Covered
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Covered
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Covered
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Covered
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Covered

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Illinois Essential Health Benefit List—HMO

Employer Name:	HIMSS
Employer State of Situs:	Illinois
Name of Issuer:	BCBSIL
Plan Marketing Name:	HMO
Plan Year:	2025

Ten (10) Essential Health Benefit (EHB) Categories:

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- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

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4	Durable Medical Equipment	Ambulatory	Pg. 13	Covered
5	Hospice	Ambulatory	Pg. 28	Covered
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Covered
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Covered
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Covered
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Not Covered
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Covered
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Covered
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Covered
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Covered
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Covered
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Covered
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Covered
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Covered
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Covered
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Covered
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Covered
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Covered
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Covered

23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Covered
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Covered
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Covered
26	Tele-Psychiatry	MH/SUD	Pg. 11	Covered
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Covered
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Covered
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Covered
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Covered
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Covered
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Covered
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Covered
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Covered
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Covered
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Covered
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Covered
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Covered
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Covered
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Covered
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Covered
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Covered

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

This Benefit Enrollment Guide is only intended to highlight some of the major benefit provisions of the Company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's Summary Plan Descriptions and insurance certificates for further detail. Should this guide differ from the Summary Plan Descriptions and insurance certificates, the Summary Plan Descriptions and insurance certificates prevail.

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