2025-26 Health Plan Compliance Notices

IMPORTANT PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES, ERISA, MEDICARE, EEOC WELLNESS, HIPAA NOTICES, AND CONTACTS FOR MORE INFORMATION

Manatt, Phelps and Phillips, LLP is providing these important notices to you at no fee. The notices in this package describe important rights that you have under the terms of the Manatt, Phelps and Phillips, LLP Group Health Plan. If you have any questions or need additional information regarding these notices you can contact:

Your Employer Representative
Cindy Mendoza: CMendoza@manatt.com
Colleen Shelley: CShelley@manatt.com
Rebecca Lally Phillips: RLallyPhillips@manatt.com
Sandra Mostert: SMostert@manatt.com

or by mail at
2049 Century Park East, Suite 1700
Los Angeles, CA 90067

The following notices are included in this communication in this order:

- **WHCRA Notice (Women's Health and Cancer Rights Act)**
- **CHIPRA Notice (Children's Health Insurance Program Reauthorization Act)**
- **HIPAA Special Enrollment Rights Notice**
- **Grandfathered Health Plans**
  - Grandfathered Health Plan Notice – Kaiser CA and Kaiser DC Plans Only
- **Non-Grandfathered Health Plans**
  - Patient Protection Choice of Providers Notice – Aetna Plans Only
- **Creditable Coverage Disclosure to CMS Guidance**
- **Medicare Part D Prescription Drug Coverage**
- **EEOC Notice Regarding Wellness Program**
- **Paperwork Reduction Act Statement**
- **Patient Protection Against Surprise Medical Bills**
- **HIPAA Notice of Privacy Practices**

Notice of Rights Under The Women's Health and Cancer Rights (WHCRA)

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and co-insurance particulars that are applicable to other medical and surgical benefits provided under this Plan. Manatt, Phelps and Phillips, LLP has provided the detailed information regarding deductible and co-insurance for the Manatt, Phelps and Phillips, LLP Group Health Plan. For more information or to get a copy of the Summary Plan Description containing these details contact your Employer Representative.

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	Healthy Indiana 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 Center for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

HIPAA Special Enrollment Rights Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Employer Representative.

Grandfathered Health Plans

Grandfathered Health Plan Notice- Kaiser CA & Kaiser Wash DC Plans Only

This Group Health Plan coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Manatt, Phelps and Phillips, LLP. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Non-Grandfathered Health Plans

Patient Protections Choice of Providers – Aetna Plans Only

In cases where the Manatt, Phelps and Phillips, LLP Group Health Plan allows or requires a participant to designate a primary care provider, the participant has the right to designate any primary care provider who participates in the network and who is available to accept the participant or participant's family members.

Until you make this designation, Manatt, Phelps and Phillips, LLP Group Health may designate a primary care provider automatically. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact your Employer Representative.

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

You do not need prior authorization from the Manatt, Phelps and Phillips, LLP Group Health 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 your Employer Representative.

CREDITABLE COVERAGE DISCLOSURE TO CMS GUIDANCE

INTRODUCTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare. Regulations to implement Medicare prescription drug coverage were published January 28, . 2005 (70 Fed. Reg. 4193 (2005)). This guidance pertains to Section 1860D-13 of the MMA and 42 CFR §423.56(e).

Under those provisions, most entities that currently provide prescription drug coverage to Medicare Part D-eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage" (Disclosure to CMS). Disclosure to CMS is required whether the entity's coverage is primary or secondary to Medicare. Entities that must comply with these provisions are listed at 42 CFR §423.56(b) and are also referenced on the creditable coverage homepage at http://www.cms.hhs.gov/CreditableCoverage. Meanwhile, entities that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure to CMS requirement. See 42 CFR 423.56(e).

Per 42 CFR §423.56(e), CMS will provide additional information concerning the disclosure to CMS, including the required form and manner of disclosure. This guidance provides such additional information concerning those rules, including the form, manner, and timing of providing the disclosure to CMS.

OVERVIEW OF REGULATORY REQUIREMENTS

Creditable Coverage Definition and Determination

Per 42 CFR §423.56(a), drug coverage is defined as creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, this actuarial determination measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit. See 70 Fed. Reg. 4225 (2005).

This determination is identical to the first step (the "gross test") in calculating actuarial equivalence for purposes of 42 CFR §423.884, which applies when an employer or union applies for the Retiree Drug Subsidy (RDS). The gross test does not consider the extent to which the coverage is financed by the beneficiary or by the entity. See 42 C.F.R. §423.884(d)(5)(ii)(A).

For plans with multiple benefits options, the regulation requires that entities apply the gross test separately for each benefit option. See 42 CFR §423.884(d)(5)(iv). A "benefits option" is defined at 42 CFR §423.882 as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan, such as different categories of benefits and different plan design options under a given type of coverage (e.g., HMO, PPO, Indemnity). Benefit options are referenced on the Disclosure to CMS Form as "Options".

For purposes of the disclosure to CMS, we require a separate Disclosure to CMS Form for each type of coverage sponsored by an entity (e.g., Medicaid, SPAP, employer plan, church Plan, Standardized Medigap Plan, Pre-standardized Medigap Plan).

POLICY GUIDANCE

Clarifications and other guidance relating to the above requirements follow.

Creditable Coverage Disclosure to CMS Form from Entity to CMS

Per 42 CFR §423.56(e), all entities described in 42 CFR §423.56(b) must disclose to CMS whether the prescription drug coverage that is offered to a Medicare Part D-eligible individual is creditable or non-creditable.

Form and Manner of Creditable Coverage Disclosure to CMS from Entity

An entity is required to provide a disclosure to CMS through completion of the Disclosure to CMS Form (Form CMS-10198) posted on the CMS Creditable Coverage Web Page at http://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp#TopOfPage.
This method of transmission is convenient, takes little time to complete, and is the sole method for compliance with the requirement, unless the entity has no internet access.

Required data fields on the Disclosure to CMS Form must be populated to generate a disclosure to CMS. For detailed descriptions of these data fields and instructions about how to complete the Disclosure to CMS Form, please reference the Disclosure to CMS Form Instructions which are posted on the CMS website at: http://www.cms.hhs.gov/CreditableCoverage.

Who Must Provide the Disclosure to CMS Form

The Disclosure to CMS Form must be provided to CMS by certain entities listed at 42 CFR §423.56(b) that are not excluded at §423.56(e). These entities include the following:

1. Group health plans, including those offered by employers; union/Taft-Hartley plans; church plans; federal, state, and local government plans; and other group-sponsored plans;
2. Government sponsored plans, including Medicaid; State Pharmaceutical Assistance Programs (SPAPs); State High Risk Pools;
3. Military coverage, including the United States Department of Veterans Affairs (VA) coverage and TRICARE;
4. Individual health insurance;
5. Indian Health Service; Tribe or other Tribal Organizations; Urban Indian Organizations; and
6. Medigap (Medicare Supplement) plans, including standardized plans H, I or J; pre- standardized plans; waiver state plans; and plans with innovative benefits.

The entities exempted under 42 CFR §423.56(e) include PDPs, MA-PDs, and PACE or cost-based HMOs or CMPs that provide "qualified Part D coverage" as defined in 42 CFR §423.100.

Per 42 CFR §423.884(c)(2)(iv), a Plan Sponsor must provide an attestation that its prescription drug coverage is at least actuarially equivalent to the standard prescription drug coverage under Part D as part of the application for the Retiree Drug Subsidy (RDS).

Therefore, because the actuarial equivalence standard includes the creditable coverage standard, a sponsor approved for the RDS is exempt from filing the Disclosure to CMS Form with respect to those qualified covered retirees for which the Sponsor is claiming the RDS. The sponsor's RDS application serves as its Disclosure to CMS under 42 CFR §423.56(e). For example: If a plan option has 100 retired beneficiaries and the plan claims RDS for 97 of them, the plan must report the 3 non-RDS participants on the Disclosure to CMS Form, in addition to reporting the non-RDS participants on other plan options.

Timing of Creditable Coverage Disclosure to CMS Form from Entity

The Disclosure to CMS Form must be submitted to CMS annually and upon any change that affects whether the drug coverage is creditable.

At a minimum, the Disclosure to CMS Form must be provided at the following times:

1. For Plan Years that end in 2007 and beyond, the Disclosure to CMS Form must be provided within 60 days after start of Plan Year for which the entity is providing the Disclosure to CMS Form;
2. Within 30 days after the termination of the prescription drug plan; and
3. Within 30 days after any change in the creditable coverage status of the prescription drug plan.

Additional Guidance

CMS may release Questions and Answers relating to Creditable Coverage issues from time to time under the Questions link on the CMS website at: http://www.cms.hhs.gov/.

CONTACT FOR FURTHER INFORMATION

Visit the CMS website link related to creditable coverage issues at:
http://www.cms.hhs.gov/CreditableCoverage

MEDICARE PART D PRESCRIPTION DRUG COVERAGE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Manatt, Phelps and Phillips, LLP Sponsored Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get th 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. **Manatt, Phelps and Phillips, LLP** has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from **October 15th through December 7th.**

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

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

If you decide to join a Medicare drug plan while you are covered under the **Manatt, Phelps and Phillips, LLP** Sponsored Health Plan, your **Manatt, Phelps and Phillips, LLP** Sponsored Health Plan may be affected. Your employer sponsored coverage cannot be cancelled due to your Medicare enrollment (See the COBRA Note below.). Medicare and your employer sponsored coverage will coordinate benefits so that you will not receive duplicate benefits.

The Medicare, Who Pays First handbook available from your Medicare representative or online https://www.medicare.gov/publications/02179-how-medicare-works-with-other-insurance.pdf, has detail on how Medicare coordinates benefits.

Typically, your employer sponsored coverage will pay its benefits without regard to payments that may be made by Medicare. In these cases, your employer sponsored coverage is considered 'primary' and Medicare is 'secondary' coverage. Medicare will only pay after the primary employer sponsored coverage has paid its benefits. Your Medicare coverage will have no effect on your employer sponsored coverage cost sharing such as copayments, deductibles, exclusions or other plan limits.

HOWEVER, there are three instances where Medicare is primary and your employer sponsored coverage is secondary. In these cases Medicare will pay its benefits without regard to payments that may be made under the employer sponsored coverage. The employer sponsored coverage will coordinate benefits so that it does not duplicate benefits paid by Medicare. This will reduce the benefits paid by your employer sponsored coverage. These three instances are when:

- your employer employs less than 20 employees
- your coverage is from a former employer, a retiree plan or COBRA coverage
- you are disabled and the employer sponsored coverage is due to another person working for the employer (examples when allowed – the coverage is under your spouse, your domestic partner, your dependent or grandchild), and the employer has less than 100 employees. When the employer has 100 or more employees then Medicare is secondary.

Notes:

1. If you have end stage renal disease then the employer sponsored coverage is primary for the first 30 months and Medicare is primary after that 30 month period has expired.)

2. If you are enrolled in Medicare prior to electing COBRA, then your Medicare enrollment cannot be used to limit or deny COBRA. If you enroll in Medicare after you elect COBRA then the Medicare enrollment is a terminating event for your COBRA coverage.

If you do decide to join a Medicare drug plan and drop your current **Manatt, Phelps and Phillips, LLP** Sponsored Health Plan, be aware that you and your dependents will have to wait for the next Open Enrollment period, if any are offered by your Employer, or HIPAA Special Enrollment Right be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with **Manatt, Phelps and Phillips, LLP** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below at the bottom of this Notice for further information or to receive the contact information for someone at the insurance company, third party administrator or service provider who administers the prescription drug program for the **Manatt, Phelps and Phillips, LLP** Sponsored Health Plan.

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 **Manatt, Phelps and Phillips, LLP** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: December 24, 2024

Name of Entity/Sender: Sandra Mostert, Colleen Shelley, Cindy Mendoza, Rebecca Lally Phillips

Contact-Position/Office: Benefits@manatt.com

Address: 2049 Century Park East, Suite 1700
Los Angeles, CA 90067

EEOC NOTICE REGARDING WELLNESS PROGRAM

The Vitality Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for Height; Weight; Blood Pressure; Cholesterol; Triglycerides; Glucose; and HbA1c. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $800.00, depending on wellness goal level achieved. Wellness incentive is paid out in June, you must be active employee in June to be eligible for wellness incentive. The incentive is taxable.

Additional incentives may be available for employees who participate in certain health-related activities, such as designated rewards for winners of wellness challenges to be coordinated throughout the wellness year. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources Benefits team at Benefits@manatt.com.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Manatt may use aggregate information it collects to design a program based on identified health risks in the workplace, The Vitality Group will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Human Resources benefits at Benefits@manatt.com.

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.

PATIENT PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balanced billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

There are some states that have surprise bill or balance billing laws. These laws apply to fully insured plans and may impact self-funded plans, including state or municipal government plans and church group plans. Please check with your plan administrator and/or insurance certificate/booklet to see if state law applies to your coverage.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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

There are some states that have surprise bill or balance billing laws. These laws apply to fully insured plans and may impact self-funded plans, including state or municipal government plans and church group plans. Please check with your plan administrator and/or insurance certificate/booklet to see if state law applies to your coverage.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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

- The US Department of Health and Human Services at:

  Phone: 800-985-3059
  Website: https://www.cms.gov/nosurprises/consumers

- Your state agency, which can be found at:
  https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants

MANATT, PHELPS AND PHILLIPS, LLP
("PLAN SPONSOR")
HIPAA NOTICE OF PRIVACY PRACTICES
UPDATED DATE: 3/1/2025

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOUR PLAN SPONSOR (YOUR EMPLOYER WHO SPONSORS YOUR GROUP HEALTH PLAN) CAN USE OR DISCLOSE YOUR MEDICAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) place important restrictions on sharing your medical information and provide you with important privacy rights. This Notice of Privacy Practices (the "Notice") replaces all prior notices provided by the Plan Sponsor and is effective on the Date Distributed noted above. This Notice describes the legal obligations of the Plan Sponsor and your legal rights regarding your "protected health information" ("PHI") held by your Plan Sponsor and Group Health Plan. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or other purposes permitted by law.

Generally, PHI includes your personal information collected from you or created by your Group Health Plan, or the Plan Sponsor on behalf of a Group Health Plan, that relates to your past, present, or future physical or mental health or condition; the provision of health care; or the past, present, or future payment for the provision of health care, and includes your elections to enroll in the Plan. If you have any questions about this Notice or about our privacy practices, please contact your Privacy Officer identified below.

The Plan Sponsor may retain agents, service providers and third-party administrators to administer all or part of your Group Health Plan such as claims payment and enrollment management. The term Plan Sponsor as used in this Notice includes all entities that provide services related to your Group Health Plan that have access to your PHI. The Plan Sponsor and contracted service providers are required by law to follow the terms of this Notice.

The Plan Sponsor is required by law to maintain the privacy of your PHI, provide you with certain rights with respect to your PHI, provide you with a copy of this Notice, and follow the terms of this Notice. The Plan Sponsor reserves the right to change the terms of this Notice and its practices regarding your PHI. If there is any material change to this Notice, the Plan Sponsor will provide you with a copy of the revised Notice of Privacy Practices.

Use and Disclosure

The Plan Sponsor may use or disclose your PHI under certain circumstances without your permission. All of these certain circumstances will fall within one of the categories listed below.

- **For Treatment,** to facilitate medical treatment or services by providers including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.
- **For Payment,** to determine your eligibility for Plan benefits, to facilitate payment for the treatment or services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.
- **For Health Care Operations,** uses and disclosures necessary to run the Plan.
- **Treatment Alternatives or Health-Related Benefits and Services** that might be of interest to you.
- **To Business Associates** to perform various functions on our behalf or to provide certain types of services. A Business Associate will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with the Plan Sponsor to implement appropriate safeguards regarding your PHI.
- **As Required by Law** when required to do so by federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety** to you, or the health and safety of the public, or another person, limited to someone able to help prevent the threat.
- **Reproductive Health Care Privacy.** This final rule, effective June 25, 2024, establishes a ban on the use or disclosure of PHI by a HIPAA covered entity or their business associates for any of the following:
  - Criminal, civil, or administrative investigations into any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care.
  - Imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care.
  - Identifying any person for any purpose described above.

  The prohibition applies only when a covered entity or Business Associate has reasonably determined that one or more of the following conditions exist.
  - The reproductive health care is lawful in the state in which it is provided. For example, the prohibition will apply if a resident of one state traveled to another state for an abortion that is lawful in the state where the health care was provided.
  - The reproductive health care is protected, required, or authorized by federal law, including the U.S. Constitution, regardless of the state in which it is provided. For example, the prohibition applies to PHI that relates to contraception, which is protected by the Constitution.

  A covered entity or Business Associate must obtain a written attestation that the information is not for a prohibited purpose before PHI potentially related to reproductive health care can be used or disclosed in the following circumstances:
  - Health oversight activities;
  - Judicial and administrative proceedings;
  - Law enforcement purposes;
  - Disclosures to coroners and medical examiners to identify a deceased person, determine cause of death, or other duties as authorized by law.

  Disclosure for these purposes is permissive, not mandatory under HIPAA, except in instances where the United States Department of Health and Human Services (HHS) requests information as part of a compliance investigation. A new attestation is required for each specific use or disclosure request and covered entities (and Business Associates, if they have access to or hold PHI) must maintain a copy and any relevant supporting documents. A valid attestation must contain the following:
  - A description of the information requested, including the name of any individual(s) whose PHI is sought (if practicable) or a description of the class of individuals whose PHI is sought.
  - The name of the person who has been asked to make the PHI use or disclosure and the name of the person to whom it should be made.
  - A statement that obtaining, using or disclosing individually identifiably health information in violation of HIPAA may be subject to criminal penalties.
- **Substances Use Disorder (SUD)**
  - Information that was previously permissible disclosed, may be redisclosed, and no longer protected by HIPAA.
  - SUD treatment records, or testimony relaying the content of such records, will not be used or disclosed in civil, criminal, administrative or legislative proceedings against the individual, absent patient consent or a court order.

In addition, the following categories describe other ways that the Plan Sponsor may use and disclose your PHI without your specific authorization. All of the ways the Plan Sponsor is permitted to use and disclose information will fall within one of the categories listed below.

- **Organ and Tissue Donation,** after your death to an organization that handles organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military,** if you are a member of the armed forces, as required by military command authorities. The Plan Sponsor may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation** or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks** for public health activities. These activities generally include the following:
    - to prevent or control disease, injury, or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - to notify the appropriate government authority if the Plan Sponsor believes that a patient has been the victim of abuse, neglect, or domestic violence. The Plan Sponsor will only make this disclosure if you agree, or when required or authorized by law.
- **Health Oversight Activities** for activities authorized by law, e.g., audits, investigations, inspections, and licensure.
- **Lawsuits and Disputes** in response to a court or administrative order, including a response to a lawful subpoena, discovery request, or other process by someone involved in a legal dispute, but only if efforts have been made to tell you about their request or to obtain a court or administrative order protecting the information requested.
- **Law Enforcement** if asked to do so by a law-enforcement official:
    - in response to a court order, subpoena, warrant, summons, or similar process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime if, under certain limited circumstances, the Plan Sponsor is unable to obtain the victim's agreement;
    - about a death that the Plan Sponsor believes may be the result of criminal conduct; and
    - about criminal conduct.
- **Coroners, Medical Examiners, and Funeral Directors,** for example, to identify a deceased person or determine the cause of death. The Plan Sponsor may also release medical information about patients to funeral directors, as necessary to carry out their duties.
- **National Security and Intelligence Activities,** to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates** of a correctional institution or in the custody of a law-enforcement official, to the correctional institution or law-enforcement official if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- **Research,** to researchers when the individual identifiers have been removed; or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The Plan Sponsor is required to disclose your PHI to:

- **The United States Secretary of Health and Human Services,** when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- **You,** on your request, the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

Other Disclosures

The Plan Sponsor may disclose your PHI to:

- **Personal Representatives** authorized by you, or to an individual designated as your personal representative, or attorney-in-fact. You must provide a written notice/authorization and supporting documents such as a power of attorney. The Plan Sponsor does not have to disclose information to a personal representative if the Plan Sponsor has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or treating such person as your personal representative could endanger you; or in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.
- **Comply with your Authorization.** Other uses or disclosures of your PHI not described above will only be made with your written authorization. The Plan Sponsor may deny a request to disclose your psychiatric notes. The Plan Sponsor will not use or disclose your PHI for marketing; or sell your PHI, unless you provide written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan Sponsor receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Privacy Rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, the Plan Sponsor will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan Sponsor will work with you to come to an agreement on form and format or provide you with a paper copy. To inspect and copy your PHI, you must submit your request in writing to the Privacy Officer identified below. The Plan Sponsor may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Plan Sponsor may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Privacy Officer identified below.

- **Right to Amend.** If you feel that your PHI is incorrect or incomplete, you may ask the Plan Sponsor to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer identified below. In addition, you must provide a reason that supports your request. the Plan Sponsor may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Sponsor may deny your request if it:
  - is not part of the medical information kept by or for the Plan;
  - was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
  - is not part of the information that you would be permitted to inspect and copy; or
  - is already accurate and complete.

  If your request is denied, you have the right to file a statement of disagreement with the Plan Sponsor and any future disclosures of the disputed information will include your statement.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer identified below. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan Sponsor may charge you for the costs of providing the list. The Plan Sponsor will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions or limitation on your PHI** that the Plan Sponsor uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that is disclosed to someone who is involved in your care or the payment for your care, such as a family member or friend. Except as provided in the next paragraph, the Plan Sponsor is not required to agree to your request. However, the Plan Sponsor will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to the Privacy Officer identified below. In your request, you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, e.g., disclosures to your spouse. If the Plan Sponsor honors the request, it will stay in place until you revoke it or the Plan Sponsor notifies you.
- **Right to Request Confidential Communications** about medical matters in a certain way or at a certain location. For example, you can ask that the Plan Sponsor only contact you at work or by mail. Your request must be made in writing to the Privacy Officer identified below and specify how or where you wish to be contacted. The Plan Sponsor will accommodate all reasonable requests.
- **Right to Be Notified of a Breach** in the event that the Plan Sponsor (or a Business Associate) discover a breach of unsecured PHI.
- **Right to a Paper Copy of This Notice.** You may request a paper copy of this notice at any time from the Privacy Officer identified below, even if you have agreed to receive this notice electronically.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the HHS Office for Civil Rights (OCR). To file a complaint with the Plan, contact:

Company:	MANATT, PHELPS AND PHILLIPS, LLP
Title:	Privacy Officer
Address:	2049 Century Park East, Suite 1700 Los Angeles, CA 90067
Phone:	(310) 231-5406 or Benefits@manatt.com

All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the OCR or with us.