



2026 ANNUAL COMPLIANCE NOTICES

You will find the following Notices and reminders included in this document. Please read through the information below as some of the notices may directly affect you now while others will be more important at other times in your life. Many of the Notices are required by law and it is important to keep track of these forms whether they apply to you at this time or not. These are required communications and are information only; no action is required on your part.

The notices included in this guide are:

- ***Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)***
- ***Health Insurance Marketplace Coverage Options and Your Health Coverage***
- ***Notice of Privacy Practices***
- ***Medicare Part D Creditable Coverage Notice***
- ***COBRA Rights Notice***
- ***Notice of Special Enrollment Rights***
- ***Women's Health and Cancer Rights Act***
- ***Newborn & Mothers Health Protection Notice***
- ***Your Rights & Protections Against Surprise Medical Bills***

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages 9 and 10 for more details.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

State	Website/E-mail	Phone
Alabama (Medicaid)	http://www.myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	Premium Payment Program: http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx E-mail: CustomerService@MyAKHIPP.com	1-866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
California (Medicaid)	http://dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	Medicaid: https://www.healthfirstcolorado.com/ CHIP: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia (Medicaid)	HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/dfr/ All other Medicaid: https://www.in.gov/medicaid	1-800-403-0864 1-800-457-4584
Iowa (Medicaid and CHIP)	Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: http://dhs.iowa.gov/Hawki HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562

State	Website/E-mail	Phone
Kansas (Medicaid)	https://www.kancare.ks.gov/	1-800-792-4884 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	Medicaid: https://chfs.ky.gov/agencies/dms KI-HIPP: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP E-mail: KIHIPPPROGRAM@ky.gov KCHIP: https://kynect.ky.gov	1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	www.medicaid.la.gov www.ldh.la.gov/la hipp	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	https://www.mymaineconnection.gov/benefits/s/?language=e_n_US https://www.maine.gov/dhhs/ofi/applications-forms	Enroll: 1-800-442-6003 Private HIP: 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	https://www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	https://mn.gov/dhs/health-care-coverage/	1-800-657-3672
Missouri (Medicaid)	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HSHIPPProgram@mt.gov	1-800-694-3084
Nebraska (Medicaid)	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada (Medicaid)	http://dhcfp.nv.gov/	1-800-992-0900
New Hampshire (Medicaid)	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 1-800-852-3345, ext. 15218
New Jersey (Medicaid and CHIP)	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710 (TTY: 711)
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: https://www.pa.gov/en/agencies/dhs/resources/chip.html	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct Rlte)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	Medicaid: https://medicaid.utah.gov/ CHIP: https://chip.utah.gov/ Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/	1-888-222-2542
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/ http://mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.96% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources at 913.253.0183.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Ameri-National Corporation		4. Employer Identification Number (EIN) 48-1055686	
5. Employer address 8320 Ward Parkway		6. Employer phone number 913-253-0183	
7. City Kansas City	8. State Missouri	9. ZIP code 64114	
10. Who can we contact about employee health coverage at this job? Dana Krause			
11. Phone number (if different from above)		12. E-mail address Human.Resources@nbkc.com	

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

- As your employer, we offer a health plan to some employees.

Eligible employees are:

- Fulltime Associates as defined by Ameri-National Corporation
- With respect to dependents, we do offer coverage.

Eligible dependents are:

- Legal spouses as defined by Ameri-National Corporation
- Dependent children as defined by Ameri-National Corporation

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

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

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process.

PRIVACY PRACTICES NOTICE

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.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Ameri-National Bank Health Plan (The Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on January 1, 2025.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. nbkc bank requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of nbkc bank for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Dana Krause | (913) 253-0183 | Dana.Krause@nbkc.com
nbkc bank | 8320 Ward Parkway, Kansas City, MO 64114

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

IMPORTANT NOTICE FROM AMERI-NATIONAL CORPORATION 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 nbkc bank and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. nbkc bank has determined that the prescription drug coverage offered by the Group Health Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are 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 to 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, your current nbkc bank coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current nbkc bank coverage, be aware that you and your dependents may not 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 nbkc bank 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 for further information. **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 nbkc bank 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 "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).

Dated: October 1, 2025

Dana Krause

8320 Ward Parkway

Kansas City, MO 64114

913-253-0183

COBRA RIGHTS NOTICE

You're getting this notice because you recently gained coverage under the Ameri-National Corporation 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."
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When Is COBRA 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 to: Human Resources 913-253-0183.

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 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. In order to determine if you or a covered member of your family qualify for the disability extension, you must send documentation received from SSA verifying the disability determination to Human Resources 913-253-0140.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Dated: October 1, 2025

Dana Krause

8320 Ward Parkway

Kansas City, MO 64114

913-253-0183

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to provide a special enrollment opportunity to an employee (or COBRA enrollee) upon the occurrence of specific events. This Chart summarizes the qualifying events and the corresponding special enrollment rights. This notice is being provided to insure that you understand your right to apply for the Ameri-National Corporation Group Health Care Plan. You should read this notice even if you plan to waive coverage at this time.

EVENT	SPECIAL ENROLLMENT RIGHT
Acquisition of New Dependent(s) due to Marriage	- Employee may enroll the employee (if not previously enrolled). - Employee may also enroll newly-eligible spouse and/or newly-eligible stepchild(ren).
Acquisition of New Child due to birth or adoption (including placement for adoption)	- Employee may enroll the employee (if not previously enrolled). - Employee may also enroll spouse and/or newly-eligible child(ren).
Gain Eligibility for Premium Assistance Subsidy under Medicaid or CHIP	Employee may enroll the employee and the spouse or child(ren) who have become eligible for the premium assistance.
Loss of Other Health Coverage if due to: - Loss of eligibility. - Death of spouse; divorce, legal separation - Child loses status (e.g. reaches age limit) - Employment change (e.g. termination, reduction in hours, unpaid FMLA) - Expiration of COBRA maximum period - Moving out of HMO plan's service area - Other employer terminates its plan (or discontinues employer contributions)	- Employee may enroll the employee (if not previously enrolled). - Employee may also enroll spouse and/or children who have lost other health coverage. Note: Person losing the Other Health Coverage must have had the other coverage since the date of this employer plan's most recent enrollment opportunity.
Loss of Medicaid or CHIP coverage	Employee may enroll the employee and the spouse or child(ren) who have lost Medicaid/CHIP entitlement.

Notes:

- HIPAA Special Enrollees must be given 30 days (from the date of the event) to enroll.
- For events related to Medicaid/CHIP, the special enrollment period is 60 days.
- Special enrollment, if elected, must take effect no later than the first day of the month following the enrollment request. If the event is the birth or adoption of a child, the special enrollment must take effect retroactively on the date of birth or adoption (or placement for adoption).

To request special enrollment or obtain more information, please contact:

Dana Krause
8320 Ward Parkway
Kansas City, MO 64114
913-253-0183

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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 consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact your medical plan administrator.

NEWBORN & MOTHERS HEALTH PROTECTION NOTICE

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

YOUR RIGHTS & PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you obtain emergency care or are 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 receive 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 **cannot** be balance billed for these emergency services. This includes services you may receive after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

See a summary of related state balance billing laws at: <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

When you obtain 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 **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

You are never required to give up your protections from balance billing. Also, you are not required to obtain care out-of-network. You can choose a provider or facility in your plan's network.

In certain states, you may also have related state protections:

Visit The Commonwealth Fund website for updated state balance-billing protections at

<https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>.

Applicable state balance billing laws or requirements for noted states are as follows:

ARIZONA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals at in-network facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a dispute resolution process for claims over \$1000, which must be initiated by the enrollee
- Protections do not apply to:
 - ground ambulance services
 - services at out-of-network facilities
 - enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

CALIFORNIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

COLORADO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals, facilities, and ground ambulance service providers and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care providers
- State provides a payment standard
- Protections do not apply:
 - to enrollees who consent to out-of-network non-emergency services
 - to enrollees of self-funded plans

CONNECTICUT PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
 - State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
 - Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services and (2) non-emergency services provided by out-of-network professionals at in-network facilities
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- Provided by all or most classes of health care professionals
 - State provides a payment standard
 - Protections do not apply to:
 - ground ambulance services
 - out-of-network facility charges for emergency services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

DELAWARE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for emergency services provided
 - by out-of-network professionals
 - at out-of-network facilities
 - by certain out-of-network ground ambulance service providers
- State prohibits providers from balance billing enrollees for non-emergency services provided at in-network facilities unless they obtain consent from the enrollee
- Above protections apply to:
 - HMO and PPO enrollees
 - For services provided by all or most classes of health care professionals
- State provides a payment standard for emergency services
- State provides the option of arbitration
- Protections do not apply to:
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

FLORIDA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- For PPOs, state payment standard applies to (1) emergency services and (2) non-emergency services provided by out-of-network professionals at in-network facilities
- For HMOs, state payment standard only applies to emergency services but the state also has a claim dispute resolution program in place
- Protections do not apply to:
 - ground ambulance services for PPO enrollees
 - PPO enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

GEORGIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
 - State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
 - Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
 - State provides a payment standard for professionals but not facilities
 - State provides a dispute resolution process
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- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

ILLINOIS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by certain specific classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - services received at out-of-network facilities
 - enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

INDIANA PROTECTIONS AVAILABLE

- For HMOs, with respect to emergency services provided by out-of-network professionals and facilities, state (1) requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing; and (2) prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- For HMOs and PPOs, with respect to non-emergency services provided by out-of-network professionals at in-network facilities, state prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing. This prohibition applies to all providers in the state, and therefore might also protect enrollees of self-funded plans.
- Above protections apply to services provided by all or most classes of health care professionals.
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services

IOWA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For emergency services provided by out-of-network professionals and facilities
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - enrollees of self-funded plans
 - non-emergency services

MAINE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
 - State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
 - Above protections apply:
 - To HMO and PPO enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For (1) emergency services by out-of-network professionals, facilities and ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
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- Provided by all or most classes of out-of-network health care professionals
 - State provides a payment standard
 - Protections do not apply to enrollees who consent to out-of-network non-emergency services

MASSACHUSETTS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of out-of-network health care professionals
- Protections do not apply to:
 - ground ambulance services
 - services at out-of-network facilities
 - enrollees who consent to out-of-network services
 - enrollees of self-funded plans

MARYLAND PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To (1) emergency services provided by out-of-network professionals, facilities, and ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all types of out-of-network health care professionals for HMO enrollees
 - Provided by on-call or hospital-based physicians who agree to accept assignment of benefits for PPO enrollees
- State provides a payment standard
- Protections do not apply to enrollees in self-funded plans

MICHIGAN PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of out-of-network health care professionals
- State provides a payment standard
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

MINNESOTA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
 - Above protection applies:
 - To HMO and PPO enrollees
 - For non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of out-of-network health care professionals
 - State provides a dispute resolution process
 - Protections do not apply to:
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- emergency services
 - enrollees of self-funded plans

MISSISSIPPI PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - enrollees of self-funded plans

MISSOURI PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies to:
 - To HMO, PPO, and EPO enrollees
 - For emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - services provided at out-of-network facilities
 - non-emergency services
 - enrollees of self-funded plans

NEBRASKA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network professionals and facilities from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For emergency services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - non-emergency services
 - enrollees of self-funded plans
- State provides a payment standard

NEVADA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
 - State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
 - Above protections apply
 - To HMO and PPO enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For emergency services by out-of-network professionals and facilities
 - Provided by all or most classes of health care providers
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- State provides a dispute resolution process
 - Protections do not apply to:
 - ground ambulance services
 - non-emergency services

NEW HAMPSHIRE PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies:
 - To any network-based major medical health insurance product, including HMO, PPO, EPO and POS products
 - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by certain specific classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - services at out-of-network facilities
 - enrollees of self-funded plans

NEW JERSEY PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO, PPO, EPO and POS enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For (1) emergency services provided by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services

NEW MEXICO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to out-of-network non-emergency services
 - enrollees of self-funded plans

NEW YORK PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
 - State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
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- Above protections apply:
 - To HMO, PPO and EPO enrollees.
 - For (1) emergency services provided by out-of-network facilities, professionals, and ground ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
 - State provides a dispute resolution process
 - Protections do not apply to
 - enrollees who consent to non-emergency out-of-network services[†]
 - enrollees of self-funded plans

NORTH CAROLINA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For emergency services by out-of-network professionals
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - emergency services by out-of-network facilities
 - non-emergency services
 - enrollees of self-funded plans

OHIO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals, facilities, and ground ambulance service providers and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by those classes of health care professionals as defined by regulation
- State provides a payment standard
- State provides a dispute resolution process
- Protections do not apply to:
 - enrollees of self-funded plans
 - enrollees who consent to out-of-network non-emergency services

OREGON PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
 - ground ambulance services
 - services at out-of-network facilities
 - enrollees who consent to non-emergency out-of-network services
 - enrollees of self-funded plans

PENNSYLVANIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
 - Above protection applies:
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- To HMO and PPO enrollees
 - For emergency services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - out-of-network facility emergency service charges, for PPO enrollees only
 - non-emergency services
 - enrollees of self-funded plans

RHODE ISLAND PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO enrollees
 - For (1) emergency services, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - PPO enrollees
 - ground ambulance services
 - enrollees of self-funded plans

TEXAS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO, PPO, and EPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides dispute resolution process
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to out-of-network non-emergency services
 - enrollees of self-funded plans

VERMONT PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For emergency services including ground ambulance services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - out-of-network facility charges for emergency services
 - non-emergency services
 - enrollees of self-funded plans

VIRIGINA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees

- To enrollees of self-funded plans that have opted into the protections
- For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency surgical or ancillary services provided by all or most classes of out-of-network professionals at in-network facilities
- State provides a dispute resolution process
- Protections do not apply to ground ambulance services

WASHINGTON STATE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - To enrollees of self-funded plans that have opted into the protections
 - For (1) emergency services provided by all or most classes of health care professionals and out-of-network facilities and (2) non-emergency surgical or ancillary services provided by all or most classes of out-of-network professionals at in-network facilities
- State provides a dispute resolution process
- Protections do not apply to ground ambulance services

WEST VIRGINIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO enrollees
 - For emergency services including ground ambulance services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - out-of-network facility charges for emergency services
 - non-emergency services
 - enrollees of self-funded plans

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:

Visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act> for more information about your rights under federal law.

Visit <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections> for more information about your rights under your state laws.