LTD EMPLOYEES

2025
BENEFITS GUIDE

CONTENTS

About This Guide

This guide describes the benefit plans available to you as a LTD participant of Bi-State Development (BSD). The details of these plans are contained in the official plan documents. This guide is meant to cover the major points of each plan only and does not contain all of the terms and conditions of the plans. In the event of a discrepancy between the information in this guide and the information in the plan documents, the plan documents will govern.

2025 OPEN ENROLLMENT INFORMATION

If you are not making any changes to your plan, no action is needed.

Your current benefits will roll over to 2025 automatically at the new contribution rates.

Bi-State Development (BSD) is pleased to offer generous benefit plan options to our employees approved for Long-Term Disability (LTD) benefits. This benefits guide will provide you with summary information about your benefit plan choices and what options you have for making changes during the Open Enrollment period.

Open Enrollment for 2025 Benefits will run from October 7-25, 2024.

An enrollment/change form has been included with this guide in the event you wish to make a change. If you don't submit a form with changes by the end of Open Enrollment, your current benefit elections will carry over to 2025 at the new contribution rates.

Changing Medical Plans

If you want to change your health plan elections, the enclosed enrollment/change form should be completed, signed and dated before sending it back to BSD for processing. Forms must be received by the BSD Benefits Department no later than 4:00 p.m. on Friday, October 25, 2024 in order for the change(s) to be made. Benefit changes will take effect on January 1, 2025.

See the FAQs on page 8 for detailed information on how completed enrollment forms can be submitted to BSD.

It is important that you take the time to review this guide prior to making any changes to your benefit plan option so that you can make an informed choice regarding which option best meets your needs. Please note that this guide contains information on all benefits available to employees on LTD and, therefore, may contain information on benefits that you are not enrolled in. Employees on LTD cannot enroll in new benefits or benefits that they previously dropped. Please also take the time to review the annual plan notices located on pages 9-20 of this guide.

If you are not making any changes, you do not need to complete and return the form. Your medical benefits will automatically rollover to 2025 at the new contribution rates.

MEDICAL PLAN COMPARISON

Plan Year January 1, 2025 – December 31, 2025

	PREFERRED		ECONOMY	
	Network Providers	**Non-Network Providers**	**Network Providers**	**Non-Network Providers**
Annual Deductible	$500 - Individual $1,000 - Family	$700 - Individual $1,400 - Family	$700 - Individual $1,400 - Family	$1,300 - Individual $2,600 - Family
Employee Co-Insurance	20%	30%	30%	40%
Out-of-Pocket Max (IncludesDeductible)	$2,300 - Individual $4,600 - Family	$3,300 - Individual $6,600 - Family	$3,300 - Individual $6,600 - Family	$5,400 - Individual $10,800 - Family
Office Visit	$20 - Primary Care $30 - Specialist	You pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met	You pay 40% Plan pays 60% after deductible is met
Well Child Care (See SPD for further clarification)	$20 - Primary Care $30 - Specialist	You pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met	You pay 40% Plan pays 60% after deductible is met
Well Adult Care (See SPD for further clarification)	$20 - Primary Care $30 - Specialist	You pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met	You pay 40% Plan pays 60% after deductible is met
Inpatient Hospital (Includes physicians services)	You pay 20% Plan pays 80% after deductible is met	You pay $200 per admission then you pay 30%. Plan pay 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met	You pay 40% Plan pays 60% after deductible is met
Pre-Certification: Inpatient	A Pre-Certification must be obtained prior to all Inpatient admissions, except, in the case of an emergency admission. In the event of an emergency inpatient admission, the provider must notify Cigna Healthcare, Inc. within 48 hours of confinement. Failure to obtain required pre-certification could result in a benefit payment reduction or denial.			
Pre-Certification: Outpatient	A Pre-Certification must be obtained prior to selected outpatient procedures and diagnostic testing. Failure to obtain required pre-certification could result in a benefit payment reduction or denial.			
Outpatient Surgery	Plan pays 100% No deductible applies	You pay 30% Plan pays 70% after deductible is met	Plan pays 100% No deductible applies	You pay 40% Plan pays 60% after deductible is met
Emergency Room (Co-pay waived if admitted from ER)	You pay $150 per visit, then you pay 20%, plan pays 80% after deductible is met	You pay $150 per visit, then you pay 20%, plan pays 80% after deductible is met	You pay $150 per visit, then you pay 30%, plan pays 70% after deductible is met	You pay $150 per visit, then you pay 30%, plan pays 70% after deductible is met
Urgent Care (Co-pay waived if admitted) (See SPD for further clarification)	You pay $30 per visit, then plan pays 100%. No deductible applies	You pay $30 per visit, then plan pays 100%. No deductible applies	You pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met

This summary was prepared to show the member's copay member's portion of the co-insurance and deductibles. This is for illustrative purposes only and does not cover all the terms and conditions of the plan. In the event of any discrepancies, the Plan document will prevail.

PRESCRIPTION PLAN

Provided by Express Scripts	SALARIED
30-day Retail	$20 – Generic* $25 – Brand $40 – Multi-Source
90-day Retail/Mail	$40 – Generic* $50 – Brand $80 – Multi-Source

* Max amount you can pay on Generic.

LONG TERM DISABILITY (LTD) RATES

Monthly Contribution Rates - Medical/Rx, Dental & Vision
Plan Year 2025: January 1, 2025 – December 31, 2025

2025 Monthly LTD Medical/RX Rates				
	PREFERRED		ECOMOMY	
	Single	Family	Single	Family
Non-Medicare	$172.31	$447.02	$34.26	$136.48
Medicare	$108.20	$244.70	$25.89	$103.24

2025 Monthly LTD Dental Rates				
	HIGH		LOW	
	Single	Family	Single	Family
Dental	$0	$39.79	$0	$24.39

2025 Monthly Vision Rates	
Employee Only:	$3.84
Employee + Spouse:	$7.30
Employee + Child(ren):	$7.68
Employee + Family:	$11.40

TERMS TO KNOW

Non-Medicare: Not eligible for Medicare, Part A and Part B

Medicare: Eligible for Medicare, Part A and Part B. Must provide Benefits Department with Medicare Card

DENTAL — DELTA DENTAL OF MO

HIGHTLIGHTS	High Option	Low Option
CALENDAR YEAR DEDUCTIBLE	$50 – Individual $150 – Family	$50 – Individual $150 – Family
CALENDAR YEAR PLAN MAXIMUM	$1,500	$1,500
PREVENTIVE (TYPE A EXPENSES) (includes oral exams, x-rays, cleanings, fluoride treatment, brush biopsy, space maintainers)	No Charge - Plan pays 100% (Deductible waived, not counted against annual plan maximum)	No Charge - Plan pays 100% (Deductible waived, not counted against annual plan maximum)
BASIC (TYPE B EXPENSES) (includes fillings, basic and surgical extractions, root canals, periodontics, endodontics, sealants for children under age 18)	You pay 20% PPO Dentist You pay 30% Non PPO Dentist	You pay 20% PPO Dentist You pay 30% Non PPO Dentist
MAJOR (TYPE C EXPENSES) (includes bridges, dentures, veneers, inlays, onlays, oral surgery)	You pay 50% PPO Dentist You pay 60% Non PPO Dentist	Not Covered
ORTHODONTIA CARE — *NOW COVERING ALL AGES* (deductible waived and not subject to calendar year maximum)	50% PPO / 50% Non-PPO	Not Covered
ORTHODONTIC LIFETIME PLAN MAXIMUM	$1,500	Not Applicable

VISION

EyeMed Vision Plan		
Services	**In-Network Member Cost**	**Out-of-Network Reimbursement**
EXAM SERVICES		
Exam with Dilation, if necessary	$15 copay	Up to $40
Standard Contact Lens–Fit & Follow-up	Up to $40	N/A
Premium Contact Lens–Fit & Follow-up	10% off retail	N/A
Retinal Imaging	$0	Up to $39
FRAMES		
Frames	$25 copay; $130 allowance, plus 80% of charge over $130	Up to $45
LENSES		
Single Vision Lenses	$25 copay	Up to $40
Bifocal Lenses	$25 copay	Up to $40
Trifocal Lenses	$25 copay	Up to $60
Standard Progressive Lenses	$25 copay	Up to $80
Premium Progressive Lenses	$25 copay, plus 80% of total charge less $120 allowance	Up to $80
Lenticular Lenses	$25 copay	Up to $80
LENS OPTIONS		
UV Treatment	$15	N/A
Tint (Solid & Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $5
Standard Polycarbonate	$40	N/A
Standard Polycarbonate–Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-ons & Services	20% off retail price	N/A
CONTACT LENSES		
Conventional	$25 copay; $130 allowance, plus 85% of charge over $130	Up to $125
Disposable	$25 copay; $130 allowance, plus full balance over $130	Up to $125
Medically-Necessary	$0 copay, paid in full	Up to $210
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A

VISION (CONT.)

EyeMed Vision Plan		
Services	**In-Network Member Cost**	**Out-of-Network Reimbursement**
COVERAGE FREQUENCY		
Examination	Once every calendar year	
Lenses or Contact Lenses	Once every calendar year	
Frames	Once every calendar year	
HEARING AID DISCOUNT PROGRAM		
	40% discount off hearing exams and a low price guarantee on discounted hearing aids	N/A
PLUS PROVIDERS		
Exam with Retinal Imaging	$0	N/A
Frames	$25 copay: $180 allowance plus 80% of charge over $180	N/A

Additional Benefits for using a Plus Provider

- **Exam $0** with retinal imaging using a Plus Provider
- **Additional $50** frame allowance at Plus Providers, a total of $180
- **Frame coverage** now every calendar year

*Plus Providers include Target, LensCrafters, Pearl, and Vision Source

BASIC LIFE INSURANCE

Bi-State Development provides Basic Life insurance at no cost to LTD participants as follows:

Basic Term Life Insurance Amount	One-time annual salary (as of the date of disability), rounded up to next higher multiple of $1,000 + $25,000
Term Life Plan Features	• Right to Convert/Port Coverage • Accelerated Death Benefit
AD&D Insurance Amount	One-time annual salary (as of the date of disability), rounded up to next higher multiple of $1,000 + $25,000

SUPPLEMENTAL AND DEPENDENT LIFE

Employees on LTD may retain any Supplemental and Dependent Life Insurance they had on the date they transitioned into LTD status as long as the premiums are paid by the employee.

Supplemental Employee Term Life Insurance Amount Options	0.5 times Annual Salary in additional coverage 1 times Annual Salary in additional coverage 2 times Annual Salary in additional coverage
Dependent Life Insurance Options	Option 1: $10,000 spouse/$2,500 per child Option 2: $20,000 spouse/$5,000 per child Option 3: $25,000 spouse/$7,000 per child

Informational only - Employees are not required to re-enroll in the benefits listed above.

It is important to keep your beneficiary information up-to-date. A beneficiary form is included and may be submitted to the BSD Benefits department at any time.

FREQUENTLY ASKED QUESTIONS

1. **Who do I contact if I have questions?**
   Contact the BSD Benefits Department:
   Phone: 314.982.1400, ext. 3006
   Fax: 314.335.3431
   Email: Benefits@BiStateDev.org
   Monday – Friday | 8:00 a.m. – 4:00 p.m.

2. **How do I submit my completed enrollment form?**
   Completed forms can be emailed to: Benefits@BiStateDev.org (preferred), faxed to 314.335.3431, or mailed via USPS to:

   ATTN: Mail Stop 125
   Bi-State Development
   211 N. Broadway, Suite 700
   St. Louis, MO 63102

   Mailing via USPS is not recommended as the Bi-State Benefits Department is not responsible for delayed or misdirected mail.

3. **I don't currently have vision coverage. Can I add vision coverage during Open Enrollment?**
   No. You may only change plan options or drop current coverage. New coverage cannot be added after an employee transitions to LTD. Once coverage has been dropped, it may not be re-elected at a later date.

4. **What happens if BSD's Benefits Department doesn't receive my completed enrollment/change form by October 25?**
   Forms received after the deadline will not be honored. The next opportunity to submit the change will be during Open Enrollment for 2026 benefits.

5. **What happens if I don't submit an enrollment change form?**
   Your current benefit elections will roll over to 2025 at the new contribution rates.

Important Notice from Bi-State Development about Your Prescription Drug Coverage and Medicare

(Medicare Part D Certificate of Creditable 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 with Bi-State Development 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. Bi-State Development has determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as the 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 decide to join a Medicare drug plan at a later date.

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 15–December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (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 do decide to join a Medicare drug plan and drop your current Bi-State Development coverage, be aware that you and your dependents will 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 Bi-State Development 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 Bi-State Development's Director of Benefits for further information or call the Benefits Department at 314.982.1400, ext. 3006.

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 Bi-State Development changes. You also may request a copy of this notice at any time.

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 online 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:	September 1, 2024
Name of Entity/Sender:	Bi-State Development
Contact–Position/Office:	Benefits Department, Mail Stop 125
Address:	211 North Broadway, Suite 700 St. Louis, MO 63102
Phone Number:	314.982.1400, ext. 3006

Women's Health and Cancer Rights Act Annual Notice

Did 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? Call your plan administrator at 1.800.244.6224 for more information.

Notice for Grandfathered Health Plans

Bi-State Development believes its self-funded plan, administered by Cigna, is a "grandfathered health plan" under the Patient Protection and 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 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 the grandfathered health plan status can be directed to the Plan Administrator at 1.800.244.6224.

Model General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Bi-State Development, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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: Bi-State Development – Benefits Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period 1 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Bi-State Development – Benefits Dept.
211 N. Broadway, Suite 700
St. Louis, MO 63102-2759
314.982.1400, ext. 3006
benefits@bistatedev.org

Bi-State Development Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder ("HIPAA") require a health plan to notify participants about its privacy policies and procedures with respect to participants' health information. This document is intended to satisfy HIPAA's notice requirement.

This notice is effective as of September 1, 2023. If you have any questions about this notice, please contact:

Director of Benefits
Bi-State Development
211 North Broadway, Suite 700
St. Louis, Missouri 63102-2759
314.982.1400, ext. 3006

Bi-State Development and its Affiliates (the "Employer") maintain the Bi-State Development Health Plan and the Bi-State Development Employee Assistance Program (individually and collectively referred to as the "Plan" and the "Plans" throughout this notice). The Plans have authorized certain employees of the Employer to have access to your health information (referred to as "employees with access"), so that they may perform certain administrative functions for the Plans. These administrative functions—treatment, payment, and health care operations—are described below. Employees with access also may use and disclose your health information for other purposes, which are outlined in this notice.

Third party "business associates" that perform various services for the Plans also may have access to your health information. However, the Plans' business associates have agreed to safeguard your health information in accordance with HIPAA.

This notice will tell you about the ways in which employees with access to your health information and the Plans' business associates may use and disclose such information. It also describes the Plans' obligations and your rights regarding the use and disclosure of your health information.

The Plans are required by HIPAA to:

- Make sure that your health information is kept private;
- Give you this notice of the Plans' legal duties and privacy practices with respect to your health information; and
- Follow the terms of the notice that is currently in effect.

The Plans also are required to designate a Privacy Officer who is responsible for the development and implementation of the Plans' Privacy Policies and Procedures. The Plans have designated the Director of Benefits as the Privacy Officer. The Privacy Officer may be contacted as follows:

Director of Benefits
Bi-State Development
211 North Broadway, Suite 700
St. Louis, Missouri 63102-2759
314.982.1400, ext. 3006

How Employees with Access and Business Associates May Use and Disclose Your Health Information

The following categories describe different ways in which employees with access and the Plans' business associates are permitted or required to use and disclose your health information. Not every use or disclosure in a category will be listed.

For Treatment. Employees with access and business associates may use and disclose your health information to facilitate medical treatment or services by health care providers. For example, if you are unable to provide your medical history as the result of an accident, a business associate may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. Employees with access and business associates may use and disclose your health information to make coverage determinations and payment in accordance with the terms of the Plan (this includes billing, claims management, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorization). For example, a business associate may tell your health care provider whether you are eligible for Plan coverage. Also, your health information may be shared with another health plan to coordinate benefit payments. Members of the Plan's Claims Review Committee will have access to any of your health information that is relevant to an appeal you file under the Plan.

For Health Care Operations. Employees with access and business associates may use and disclose your health information to enable the Plan to operate or to operate more efficiently. This includes conducting quality assessment and improvement activities, submitting claims for stop-loss coverage, determining employee contributions, conducting or arranging for medical review, legal services, audit services, disease management, case management, planning and development, and general Plan administrative activities. For example, the Plan may use your claims information to refer you to a disease management program, project future benefit costs, or audit the accuracy of its claims processing functions. In addition, the Plan may contact you to provide you information about treatment alternatives or other health-related benefits that may be of interest to you.

Other Permitted Uses and Disclosures.

- The Plan may be required by law to disclose your health information.
- The Plan will make your health information available to you, and to the Secretary of the Department of Health and Human Services for purposes of HIPAA enforcement.
- Your health information may be disclosed to a public health agency. This may include disclosing your health information to report certain diseases, death, abuse, neglect or domestic violence or reporting information to the Food and Drug Administration if you experience an adverse reaction from any of the drugs, supplies or equipment that are involved in your care.

- Your health information may be disclosed to government agencies so they can monitor, investigate, inspect, discipline or license those who work in the healthcare system or for government benefit programs.
- Your health information may be disclosed as authorized by law to comply with workers' compensation laws.
- Your health information may be disclosed in the course of a judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Your health information may be disclosed to law enforcement officials to report or prevent a crime, locate or identify a suspect, fugitive or material witness or assist a victim of a crime.
- Your health information may be used or disclosed to avert a serious threat to health or safety if the use or disclosure is necessary to prevent a serious and imminent threat to the health or safety of a person or to the public, and is disclosed to a person who is reasonably able to prevent or lessen the threat, including the target of the threat.
- Your health information may be used or disclosed for limited research purposes, provided that a waiver of the authorization required by HIPAA has been approved by an appropriate privacy board.
- If you are a member of the armed forces, the Plan may disclose your health information as required by military command authorities or to evaluate your eligibility for veteran's benefits. The Plan may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- Your health information may be disclosed to coroners, health examiners and funeral directors so that they can carry out their duties or for purposes of identification or determining cause of death.
- Your health information may be disclosed to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.
- The Plan may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your health information to the correctional institution or law enforcement official.
- Your health information may be disclosed to your spouse, a family member or a close personal friend if the health information is directly relevant to your spouse's, family member's or close personal friend's involvement with payment related to your health care.

Pursuant to an Authorization. The following uses and disclosures of your protected health information will only be made with your written authorization:

- Uses and disclosures of psychotherapy notes
- Disclosures that constitute a sale of your protected health information
- Uses and disclosures of your protected health information for marketing purposes
- Uses and disclosures of your protected health information beyond the uses and disclosures described in this notice

If you give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer. Disclosures that were made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights with Respect To Your Health Information

You have the following rights with respect to your health information:

Right to Inspect and Copy. You have the right to inspect and copy your coverage, payment and claims record and other health information used by the Plan to make benefit determinations about you. To inspect and copy such information, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may file a complaint regarding the denial.

Right to an Electronic Copy of Electronic Medical Records. If your protected health information is maintained in an electronic format (known as an electronic medical record or electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health information in the form or format that you request, if it is readily producible in such form or format. If the protected health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a reasonable hard copy format. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified if any of your unsecured protected health information is breached.

Right to Amend. You have the right to request that the Plan amend your coverage, payment and claims record and other health information used by the Plan to make benefit determinations about you. You have the right to request an amendment for as long as the information is maintained by or for the Plan.

To request an amendment, you must submit your request in writing to the Privacy Officer. In addition, you must provide a reason that supports your request.

If your request is denied in whole or in part, the Plan will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosure of your health information.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of the Plan's disclosures of your health information during a time period which may be no longer than six years prior to the date of your request. There are exceptions to the types of disclosures for which the Plan is required to account. For example, the Plan is not required to give you an accounting of

disclosures of your health information for purposes of treatment, payment or health care operations, and is not required to account for disclosures made prior to April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12 month period will be free. For additional accountings, the Plan may charge you for the costs of providing the accounting. We 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. You have the right to request a restriction on the health information that the Plan may use or disclose about you for treatment, payment or health care operations, or that the Plan may disclose to your spouse, a family member or a close personal friend who is involved with payment related to your health care.

We are not required to agree to your request.

Requests for restrictions must be made in writing to the Privacy Officer. In your request, you must provide: (1) what information you want to restrict; (2) whether you want to restrict use, disclosure or both; and (3) to whom you want the restrictions to apply.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you in a certain way or at a certain location, such as only at work or by mail.

Requests for confidential communications must be made in writing to the Privacy Officer. The Plan will attempt to honor all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes To This Notice

The Plan reserves the right to change the terms of this notice. The Plan reserves the right to make the revised notice effective with respect to all of your health information already maintained by the Plan, as well as any of your health information maintained by the Plan in the future. In the event of a material change to the notice, a revised version of the notice will be provided by mail.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Director of Benefits listed at the beginning of this notice. All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

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 (1.877.543.7669) 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 (1.866.444.3272).

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 Fax: 916-440-5676
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/flmedicaidtplrecover y.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra PHONE: 678-564-1162, PRESS 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (HAWKI)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx	A 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
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: http://myalhipp.com/ Phone: 1-855-692-5447 Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820s	Website: https://www.scdhhs.gov Phone: 1-888-549-0820 Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program I Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program I Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

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.

OMB Control Number 1210-0137 (expires 1/31/2026)

RESOURCES

BENEFIT	CARRIER	PHONE NUMBER	WEBSITE
Bi-State Development Benefits Hotline	211 N. Broadway, Suite 700 Attn: Benefits St. Louis, MO 63102	314.982.1400, ext. 3006 Fax: 314.335.3431	www.BiStateDev.org Email: Benefits@BiStateDev.org
Medical	Cigna	1.800.244.6224	www.MyCigna.com
Employee Assistance Program (EAP)	Cigna Behavioral	1.877.622.4327	www.MyCigna.com Employer ID: metrostlouis
Prescriptions	Express Scripts	1.866.509.9660	www.Express-Scripts.com
Dental	Delta Dental of Missouri	1.800.335.8266	www.DeltaDentalMO.com
Vision	EyeMed	1.866.723.0514	www.EyeMed.com
Premium Payment Administration	Paylocity	1.800.631.3539	N/A


BI·STATE
DEVELOPMENT
metro
GATEWAY
ARCH
ST. LOUIS
DOWNTOWN AIRPORT
RIVERBOATS
ST LOUIS REGIONAL
FREIGHTWAY