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Annual Enrollment Notices & Disclosures

Kimble Company and Kimble Recycling & Disposal, Inc. January 01, 2025

Arthur J. Gallagher & Co.
www.ajg.com

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 11 - 13 where Notice of Creditable Coverage begin for more details.

PATIENT PROTECTIONS DISCLOSURE

The Kimble Company and Kimble Recycling & Disposal, Inc. Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Medical Mutual of Ohio designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Medical Mutual of Ohio at 800.586.4509 or [MedMutual.com/SBC](https://www.MedMutual.com/SBC).

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Medical Mutual of Ohio or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Medical Mutual of Ohio at 800.586.4509 or [MedMutual.com/SBC](https://www.MedMutual.com/SBC).

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

PPO Plan (Individual: 20% coinsurance and \$1,000 deductible; Family: 20% coinsurance and \$2,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 330.343.1226 x 2261 or smcafee@kimblecompanies.com.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, 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 section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900	NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPPA program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	NORTH DAKOTA – Medicaid Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	OREGON – Medicaid and CHIP Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP Website: https://www.pa.gov/en/services/dhs/apply-for-medicare-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid Website: Health Insurance Premium Payment (HIPPA) Program Texas Health and Human Services Phone: 1-800-440-0493	UTAH – Medicaid and CHIP Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid Website: Health Insurance Premium Payment (HIPPA) Program Department of Vermont Health Access Phone: 1-800-250-8427	VIRGINIA – Medicaid and CHIP 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 Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	WEST VIRGINIA – Medicaid and CHIP Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPPA (1-855-699-8447)
WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

Kimble Company and Kimble Recycling & Disposal, Inc. is committed to the privacy of your health information. The administrators of the Kimble Company and Kimble Recycling & Disposal, Inc. Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Stacey McAfee - Benefits Administrator at 330.343.1226 x 2261 or smcafee@kimblecompanies.com.

HIPAA SPECIAL ENROLLMENT RIGHTS

Kimble Company and Kimble Recycling & Disposal, Inc. Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Kimble Company and Kimble Recycling & Disposal, Inc. Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program).

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children’s Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan’s special enrollment provisions, contact Stacey McAfee - Benefits Administrator at 330.343.1226 x 2261 or smcafee@kimblecompanies.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children’s health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan’s annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Kimble Company and Kimble Recycling & Disposal, Inc.

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 Kimble Company and Kimble Recycling & Disposal, Inc. 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. Kimble Company and Kimble Recycling & Disposal, Inc. has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th 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 Medical Mutual coverage will be affected.

A brief description of the Medical Mutual drug plan is as follows:

Generic copay – retail tier 1	\$10	Covers up to a 30 day supply
Generic copay – home deliver tier 1	\$20	Covers up to a 90 day supply
Preferred Brand copay – retail tier 2	\$25	Covers up to a 30 day supply
Preferred Brand copay – home delivery tier 2	\$50	Covers up to a 90 day supply
Non-preferred Brand copay – retail tier 3	\$60	Covers up to a 30 day supply
Non-preferred Brand copay– home delivery tier 3	\$120	Covers up to a 90 day supply
Specialty copay – specialty pharmacy	\$60	Covers up to a 30 day supply

If you do decide to join a Medicare drug plan and drop your current Medical Mutual coverage, be aware that you and your dependents will 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 Kimble Company and Kimble Recycling & Disposal, Inc. 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 Kimble Company and Kimble Recycling & Disposal, Inc. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 01, 2025
Name of Entity/Sender:	Kimble Company and Kimble Recycling & Disposal, Inc.
Contact—Position/Office:	Stacey McAfee - Benefits Administrator
Office Address:	3596 State Route 39 NW Dover, Ohio 44622-7232 United States
Phone Number:	330.343.1226 x 2261

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

**** 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."

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Stacey McAfee.

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 period¹ 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.

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

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

Kimble Company and Kimble Recycling & Disposal, Inc.
Stacey McAfee - Benefits Administrator
3596 State Route 39 NW
Dover, Ohio 44622-7232
United States
330.343.1226 x 2261

MARKETPLACE NOTICE FOR KIMBLE COMPANY

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1 2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Stacey McAfee.

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 Kimble Company		4. Employer Identification Number (EIN) 34-0759804	
5. Employer address 3596 State Route 39 NW		6. Employer phone number 330.343.1226 x 2261	
7. City Dover	8. State Ohio	9. ZIP code 44622-7232	
10. Who can we contact about employee health coverage at this job? Stacey McAfee			
11. Phone number (if different from above)		12. Email address smcafee@kimblecompanies.com	

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

- As your employer, we offer a health plan to:

☒ All employees. Eligible employees are: All full time employees

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are: Spouse without employer group coverage available and children, step-children

☐ We do not offer coverage.

☒ 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, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

☐ **No**

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes (Go to question 15)

☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$39.00

b. How often? ☐ Weekly ☒ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

MARKETPLACE NOTICE FOR KIMBLE RECYCLING & DISPOSAL, INC.

Health Insurance Marketplace Coverage Options and Your Health Coverage

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3. Employer name Kimble Recycling & Disposal, Inc.		4. Employer Identification Number (EIN) 34-0759804	
5. Employer address 3596 State Route 39 NW		6. Employer phone number 330.343.1226 x 2261	
7. City Dover	8. State Ohio	9. ZIP code 44622-7232	
10. Who can we contact about employee health coverage at this job? Stacey McAfee			
11. Phone number (if different from above)		12. Email address smcafee@kimblecompanies.com	

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

- As your employer, we offer a health plan to:

☒ All employees. Eligible employees are: All full time employees

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are: Spouse without employer group coverage available and children, step-children

☐ We do not offer coverage.

☒ 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.

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14. Does the employer offer a health plan that meets the minimum value standard*?

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a. How much would the employee have to pay in premiums for this plan? \$39.00

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☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is “balance billing” (sometimes called “surprise billing”)?

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

Ohio Surprise Billing Law

Ohio has also adopted a surprise billing law. [The surprise billing law](#) was created to protect patients from receiving and paying surprise medical bills above the patient's in-network rate from health care providers for emergency care or, in certain circumstances, unanticipated out-of-network care. Cost sharing amounts, which include coinsurance, copayments, and deductibles, are limited to the patient's in-network amounts.

Before the law, patients were responsible for paying surprise medical bills, oftentimes ranging hundreds to thousands of dollars above the in-network rate, arising from unanticipated out-of-network situations. Price and payment reconciliation is now solely between the patient's health care provider and health insurer.

The law requires the Ohio Department of Insurance to administer and enforce many of the law's provisions. It also gave the department authority to adopt rules to establish the law's operational framework. The department completed this important task, involving stakeholder input, to produce Ohio Administrative Code rule [3901-8-17](#), which implemented sections [3902.50 to 3902.54](#) of the Ohio Revised Code.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Centers for Medicare & Medicaid Services No Surprises Help Desk at (800) 985-3059 from 8 a.m. to 8 p.m. ET, seven days a week, to submit a question or a complaint or the Ohio Department of Insurance through www.insurance.ohio.gov, consumer.complaint@insurance.ohio.gov, or 800-686-1526 to file a complaint.

Visit www.kimblecompanies.com/benefitsfor more information about your rights under federal law. Visit insurance.ohio.gov/strategic-initiatives/surprise-billing for more information about your rights under Ohio law.

Kimble Company & Kimble Recycling & Disposal, Inc. ("Plan Sponsor")

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOUR PLAN SPONSOR (YOUR EMPLOYER WHO SPONSORS)

YOUR GROUP HEALTH PLAN) CAN USE OR DISCLOSE YOUR MEDICAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

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

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

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

Use and Disclosure

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

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

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

- Organ and Tissue Donation, after your death to an organization that handles organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- Military, if you are a member of the armed forces, as required by military command authorities. The Plan Sponsor may also release PHI about foreign military personnel to the appropriate foreign military authority.
- Workers' Compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.
- Public Health Risks for public health activities. These activities generally include the following:
 - to prevent or control disease, injury, or disability;
 - to report births and deaths;
 - to report child abuse or neglect;
 - to report reactions to medications or problems with products;
 - to notify people of recalls of products they may be using;
 - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 - to notify the appropriate government authority if the Plan Sponsor believes that a patient has been the victim of abuse, neglect, or domestic violence. The Plan Sponsor will only make this disclosure if you agree, or when required or authorized by law.

- Health Oversight Activities for activities authorized by law. For example, audits, investigations, inspections, and licensure.
- Lawsuits and Disputes in response to a court or administrative order, including a response to a lawful subpoena, discovery request, or other process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.
- Law Enforcement if asked to do so by a law-enforcement official—
 - in response to a court order, subpoena, warrant, summons, or similar process;
 - to identify or locate a suspect, fugitive, material witness, or missing person;
 - about the victim of a crime if, under certain limited circumstances, the Plan Sponsor is unable to obtain the victim's agreement;
 - about a death that the Plan Sponsor believes may be the result of criminal conduct; and
 - about criminal conduct.
- Coroners, Medical Examiners, and Funeral Directors, for example, to identify a deceased person or determine the cause of death. The Plan Sponsor may also release medical information about patients to funeral directors, as necessary to carry out their duties.
- National Security and Intelligence Activities to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Inmates of a correctional institution or in the custody of a law-enforcement official, to the correctional institution or law-enforcement official if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- Research, to researchers when the individual identifiers have been removed; or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The Plan Sponsor is required to disclose your PHI to:

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

Other Disclosures

The Plan Sponsor may disclose your PHI to:

- Personal Representatives authorized by you, or to an individual designated as your personal representative, or attorney-in-fact. You must provide a written notice/authorization and supporting documents such as a power of attorney. The Plan Sponsor does not have to disclose information to a personal representative if the Plan Sponsor has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or treating such person as your personal representative could endanger you; or in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

- Comply with your Authorization. Other uses or disclosures of your PHI not described above will only be made with your written authorization. The Plan Sponsor may deny a request to disclose your psychiatric notes. The Plan Sponsor will not use or disclose your PHI for marketing; or sell your PHI, unless you provide written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan Sponsor receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Privacy Rights

- Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, the Plan Sponsor will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan Sponsor will work with you to come to an agreement on form and format or provide you with a paper copy. To inspect and copy your PHI, you must submit your request in writing to the Privacy Officer identified below. The Plan Sponsor may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Plan Sponsor may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Privacy Officer identified below.
- Right to Amend. If you feel that your PHI is incorrect or incomplete, you may ask the Plan Sponsor to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer identified below. In addition, you must provide a reason that supports your request. The Plan Sponsor may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Sponsor may deny your request if it:
 - is not part of the medical information kept by or for the Plan;
 - was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
 - is not part of the information that you would be permitted to inspect and copy; or
 - is already accurate and complete.

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

Right to an Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer identified below. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form

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

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact: Privacy Officer, Attn: Stacey McAfee, 3596 State Rt. 39 NW, Dover, OH 44622, 330.343.1226 x 2261

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

NOTICE REGARDING 2026 WELLNESS PROGRAM

The Company wellness program is a voluntary wellness program available to all employees as a part of the Company's Group Health Care Plan. Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resource Department, Stacey McAfee at 330-343-1226 x 2261 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

The wellness program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to attend lectures; watch online videos; meet or make contact with our wellness coaches; provide proof of medical and/or dental preventive visits; participate in a wellness activity; complete a nicotine affidavit and complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which will include a blood test for Glucose, HDL, LDL and Triglycerides. You are not required to complete the HRA, meet with wellness coaches, to participate in the blood test or other medical examinations. Refusing to participate will not result in any adverse employment action or result in a termination of your benefits. Your participation is purely voluntary.

However, employees who choose to participate in the wellness program will receive an incentive of adjusted insurance premiums set forth below for meeting the criteria set forth below. Although you are not required to complete the HRA, meet with wellness coaches, to participate in the blood test or other medical examinations, only employees who do so will receive the incentive.

Program Description: **2026 WELLNESS CRITERIA AND INCENTIVES**

Nicotine Incentive

Employees and their spouses (if covered) who **do not** use nicotine each month in 2026 **will each** be entitled to a wellness incentive in the form of a premium discount of \$30 per pay during that month. To receive the discount the Employee and the Spouse (if covered) must complete a Nicotine Affidavit certifying nonuse of nicotine on a monthly basis in 2026 or complete a nicotine cessation class during the 2026 calendar year. The nicotine incentive is administered on a monthly basis.

"Nicotine Use" is the use of any tobacco product, including cigarettes, cigars, e-cigarettes, smoking vapor cigarettes, using smokeless tobacco, chewing tobacco, snuff, and/or pipe tobacco, four or more times a week anytime within the past 3 months. (Religious or ceremonial use of tobacco is not considered nicotine use to the extent protected by local, state or federal law).

To be eligible for the nicotine premium discount, participants must either:

- 1) Not be a "Nicotine User" each month in 2025; or
- 2) Agree to participate and successfully complete an approved nicotine cessation program in 2025.

One Company approved nicotine cessation program is the MMO Quit Line Program - (866) 845-7702. It can be completed at no cost to the participant. The approved program you select may be started at any time during any month in 2026. Depending on when you submit a nicotine affidavit verifying you are not a nicotine user or begin and complete an approved nicotine cessation program, the difference between your previously paid monthly contribution and the applicable discounted contribution will be credited retroactively to the beginning of the month and your future contributions for health plan coverage for the rest of 2026 will be at the applicable discounted rate. Successful completion of the program does not require that you quit the use of nicotine but does require you meet all requirements of the nicotine cessation program you selected.

General Wellness Incentive

Employees electing Single or Employee + children coverage will receive wellness incentives in the form of a premium discount of \$10 per pay in 2026 if they complete the following items in 2025:

- 1) Two meetings with the Health Coach before 12/15/2025. (As an alternative you may show proof of preventative care which will count as one coach consultation);
- 2) Log into Healthy Ways portal and watch two health related videos on the Wellness Coach website before 12/15/2025; and
- 3) Participate in a biometric screening event with Wellness Coach between August and November 2022 or as an alternative supply a biometric screening from your physician dated between 1/1/2025-11/20/2025.

Employees electing Family coverage or Employee + Spouse coverage will receive a wellness incentive in the form of a premium discount of \$10 per pay for the Employee completing the items set for above; AND a premium discount of \$5 per pay for their Spouse who completes the following items in 2025:

- 1) One meeting/call with the Health Coach before 12/15/2025; and
- 2) Log into Healthy Ways portal and watch two health related videos on the Wellness Coach website before 12/15/2025.

The above benefits are the sole consideration provided for participation in the wellness program and discounts provided above may not be exchanged or converted into cash payments or applied to items other than the insurance premiums identified above. Some employees may not utilize the Company offered health insurance plan, but they are free to continue participating in the wellness program although they will not be able to receive any incentive since they are not on the Company health insurance plan.

Who is eligible? All full time and part time employees, and their respective spouses, are entitled to participate in the wellness program. All full time and part time employees, and their respective spouses, are eligible to participate in the wellness program so long as the employee is an active, full time or part time, employee of the Company. Employees must be eligible to participate in the wellness program to receive the incentives described above, and spouses of employees must sign this

disclosure and also have a spouse who is an eligible employee of the Company to be eligible for the incentives.

How to access the program: Posters and paycheck stuffers are issued advertising the wellness program. For additional information please contact the Human Resource Department, Stacey McAfee at 330-343-1226 x2261

Alternative standards are available:

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. The recommendations of an individual's personal physician will be accommodated. You may request a reasonable accommodation or an alternative standard by contacting the Human Resource Department, Stacey McAfee at 330-343-1226 x 2261

The information from your HRA and the results from your biometric screening will be used by the vendor to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program and MMO Disease Management. You also are encouraged to share your results or concerns with your own doctor. Please note the wellness program is not a specifically tailored for any individual, and all participants are advised to consult their physician for specific guidance on a personal wellness program.

Protections from Disclosure of Medical Information:

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. **The only individual(s) who will receive your personally identifiable health information are Kimble Company and Kimble Recycling & Disposal, Inc. and their health insurance company (currently Medical Mutual), their benefits advisors and agents (currently A.J. Gallagher), their wellness coach (currently Ramp Health), their data support and analytics providers (currently HC Cube) and their wellness vendors (collectively "Wellness Team"), all for the sole purpose of administering Kimble's wellness program.**

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision.

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Human Resource Department, Stacey McAfee at 330-343-1226 x2261. The Company reserves the right to discontinue or modify the wellness program at any time if it determines the wellness program is not fulfilling its obligations to promote employee health and prevent disease or is otherwise determined to violate any state, local or federal law.

THE UNDERSIGNED ACKNOWLEDGE(S) RECEIVING THE ATTACHED NOTICE REGARDING 2026 WELLNESS PROGRAM DISCLOSURE

_____ Employee Signature	_____ Print Name	_____ Date
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_____ Employee Spouse Signature	_____ Print Name	_____ Date
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(Your spouse only needs to sign this form if you are seeking a wellness incentive which includes the nicotine use discount and general wellness discount)

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.



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