Eastern Band of Cherokee Indians
HUMAN RESOURCES

PO Box 554
Cherokee, NC 28719
828-359-6388

October 21, 2024

TO: EBCI – Employee Benefit Plan Participants
FROM: EBCI – Benefits & Compensation Office
RE: 2024 Open Enrollment Materials
Enclosed: Benefit Guide, Legal Notices, and 2025 premium rates

Open Enrollment sessions for your 2025 Tribal Employment Benefits Plan will be held **November 5th – 8th**. Employees are ***strongly encouraged*** to attend one of the Tribal Benefits Open Enrollment days listed below to make any changes* and maximize their Tribal Benefit's package for 2025. There will also be giveaways, and the chance to win door prizes! Employee's will have until November 25th to change their benefits outside of the scheduled dates by reaching out to a member of the Benefits Team at the contact information below. Open Enrollment changes made during this period will have an effective date of *January 1, 2025*.

Tribal Open Enrollment Days/Locations

Tuesday, November 5th	1:30pm – 3:00pm	Snowbird Library - Jacob Cornsilk Classroom
Wednesday, November 6th	9:00am – 2:00pm	Cherokee Youth Center – Gymnasium
Thursday, November 7th	2:30pm – 4:00pm	Dora Reed Center
Friday, November 8th	8:30am – 3:00pm	EBCI – Human Resources (GLW)

Don't miss this opportunity to review your benefits to make sure they are right for you and your dependents. This is also a great time to review your beneficiary information and adjust as needed. Representatives from AFLAC and Colonial Life supplemental insurance will also be here to answer questions. You can apply for additional coverage under Dental, Short-Term Disability and Life Insurance at a minimum cost to you.

Must bring social security numbers and dates of birth information with you, if you are making changes to your dependent coverage and/or life insurance.

There are premium rate changes for medical and vision coverage. Please see the enclosed flyer to review the 2025 rates.

Pension Certificates

Pension Certificates will be handed out on the dates and times above. Make sure you come by one of the locations listed above to get the most recent information for your pension.

If you have any questions or need to make an appointment to make changes, please contact a member of the Benefits team:

Letitia George	828-359-6394	letigeor@ebci-nsn.gov
Jay Eagleman	828-359-6392	joseeagl@ebci-nsn.gov
Erin Taylor	828-359-6396	erintayl@ebci-nsn.gov
Whitney Reed	828-359-6380	whitreed@ebci-nsn.gov

2025 PREMIUM RATES

Medical Plan

Medical is taken out bi-weekly (24 pay days in a year) - Premium Increases for 2025

Medical Core Premiums	Current Contributions	**New Contributions Effective 1/1/25**	Increase in payment	Monthly Rates
Employee Only (Paid by the Employer for Employee)	$ 801.14	$ 841.20	$40.06	$ 841.20
Premiums Paid by Employees				
Employee & Spouse	$ 249.16	$ 261.62	$12.46	$ 523.23
Employee & Child(ren)	$ 114.97	$ 120.72	$5.75	$ 241.43
Employee & Family	$ 341.69	$ 358.78	$17.09	$ 717.55

Medical Buy Up Premiums - **Premiums Paid by Employees** - for current enrollees	Current Contributions	**New Contributions Effective 1/1/25**	Increase in payment	Monthly Rates
Employee	$ 82.18	$ 86.29	$4.11	$172.58
Employee & Spouse	$ 382.45	$ 401.58	$19.13	$803.15
Employee & Child(ren)	$ 220.73	$ 231.77	$11.04	$463.53
Employee & Family	$ 564.95	$ 593.18	$28.23	$1,186.35

Dental Plan

Dental is taken out of the first paycheck of the month - No Premium Increases for 2025

Dental Core Premiums	Current Contributions	**New Contributions Effective 1/1/25**	Increase in payment
Employee Only (Paid by the Employer for Employee)	$ 23.29	$ 23.29	$0.00
Premiums Paid by Employees			
Employee & Spouse	$ 19.58	$ 19.58	$0.00
Employee & Child(ren)	$ 29.85	$ 29.85	$0.00
Employee & Family	$ 54.29	$ 54.29	$0.00

Dental Buy Up Premiums

Premiums Paid by Employees	Current Contributions	**New Contributions Effective 1/1/25**	Increase in payment	Emp Additionlal Amount
Employee	$ 5.43	$ 5.43	$0.00	$ 5.43
Employee & Spouse	$ 29.34	$ 29.34	$0.00	$ 9.76
Employee & Child(ren)	$ 41.90	$ 41.90	$0.00	$ 12.05
Employee & Family	$ 71.77	$ 71.77	$0.00	$ 17.48

Vision Plan

Vision is taken out of the first paycheck of the month - Premium Increases for 2025

	Current Contributions	**New Contributions Effective 1/1/25**	Increase in payment
Employee Only (Paid by the Employer for Employee)	$ 4.24	$ 5.09	$0.85
Premiums Paid by Employees			
Employee & Spouse	$ 5.47	$ 6.56	$1.09
Employee & Child(ren)	$ 4.83	$ 5.79	$0.96
Employee & Family	$ 11.49	$ 13.79	$2.30

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

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

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

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

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

A GUIDE TO YOUR BENEFITS

2025

Your EBCI Benefits

We understand the important role that benefits play in the lives of you and your family. As a new hire and then annually during open enrollment in the fall, you have an opportunity to make changes to your benefits package to ensure you and your family have the right coverage.

This benefits guide can help familiarize you with EBCI benefit options. It also provides useful tips, tools and resources to help you think through your options and make wise decisions.

Getting ready to enroll:

- Consider your coverage needs for the upcoming year. For example, do you want to be financially protected if you can't work due to an accident or illness?
- Consider other available coverage.
- Gather information you'll need. If you're covering dependents, you'll need their dates of birth and Social Security numbers.

Getting the most value from your benefits depends on how well you understand your plans and how you choose to use them. Be sure to read this entire guide for important information about your benefit options.

Table of Contents

Benefit Basics

The company pays for some of your benefits and you share the cost for others, as shown below.

Benefit	Tax Treatment	Who Pays
Medical	Pretax	EBCI & You
Dental	Pretax	EBCI & You
Vision	Pretax	EBCI & You
Basic Life* and Accidental Death & Dismemberment (AD&D) Insurance	After-tax	EBCI
Voluntary Life Insurance	After-tax	You
Short-Term Disability	After-tax	EBCI (Core) & You (Buy-Up)
Long-Term Disability	After-tax	EBCI
Employee Assistance Plan (EAP)	N/A	EBCI

*Premium for coverage amounts over $50,000 are shown as imputed income on your W2.

Eligibility

Who's eligible?

Employees

Employees who work at least 30 hours per week are eligible for the benefits described in this guide. Most benefits are effective on the first of the month following the 60th day of employment.

Dependents

- Your legal spouse
- Your children up to age 26

Changing your benefits

Generally, you may only make or change your benefit elections as a new hire or during the Annual Enrollment period. However, you may change your benefit elections during the year if you experience a qualifying event such as:

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

You have 30 days from the qualified life event to make changes to your coverage.

- Depending on the type of event, you may need to provide proof of the event, such as a marriage license.
- If you do not make the changes within 30 days of the qualified event, you will have to wait until the next Annual Enrollment period to make changes (unless you experience another qualified life event).

Medical and Pharmacy Plan Overview

We offer a medical plan through BCBSNC that covers the cost of preventive health services at 100% and includes prescription drug coverage. When electing medical coverage, be sure to consider the cost of coverage including payroll deductions and how the plan covers services throughout the year.

Understanding how your plan works

1. Your deductible

You pay out-of-pocket for most medical expenses until you reach the deductible.

2. Your coverage

Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses with coinsurance. The plan will pay a percentage of each eligible expense, and you will pay the rest.

3. Your out-of-pocket maximum

When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year. Your deductible and coinsurance apply toward the out-of-pocket maximum.

Making the most of your plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers:** You will always pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.
- **Pharmacy coverage:** Medications are placed in categories based on drug cost, safety and effectiveness. These tiers also affect your coverage.
  - **Generic** – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
  - **Brand preferred** – A drug with a patent and trademark name that is considered “preferred” because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
  - **Brand non-preferred** – A drug with a patent and trademark name. This type of drug is “not preferred” and is usually more expensive than alternative generic and brand preferred drugs.
  - **Specialty** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.
- **Mail order pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the Mail Order Pharmacy to save on a 90-day supply.

Medical and Pharmacy Coverage

Medical Plan Provisions	BCBSNC In-Network: 2024		BCBSNC In-Network: 2025	
	Core Plan	Buy-Up Plan*	Core Plan	Buy-Up Plan*
Annual Deductible (Individual/Individual + 1 Child/Family)	$1,200/$2,400/$3,600	$600/$1,200/$1,800	$1,400/$2,800/$4,000	$600/$1,200/$1,800
Out-of-Pocket Maximum (Excludes Deductible) Individual/Individual + Child/Family	$2,800/$5,600/$4,400	$3,400/$6,800/$6,200	$3,000/$6,000/$4,800	$3,400/$6,800/$6,200
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Amount you pay after deductible				
Primary Care Provider Office Visit	$30 Copay	$25 Copay	$30 Copay	$25 Copay
Specialist Office Visit	$60 Copay	$50 Copay	$60 Copay	$50 Copay
X-Ray and Lab	80% after deductible for all	80% after deductible for all	80% after deductible for all	80% after deductible for all
Inpatient Hospital Services	80% after deductible	90% after deductible	80% after deductible	90% after deductible
Outpatient Hospital Services	80% after deductible	90% after deductible	80% after deductible	90% after deductible
Urgent Care	$60 Copay	$50 Copay	$60 Copay	$50 Copay
Emergency Room	$250 Copay + 20% Coinsurance	$150 Copay + 10% Coinsurance	$250 Copay + 20% Coinsurance	$150 Copay + 10% Coinsurance
Retail Pharmacy (up to a 30-day supply)				
Generic	$10 Copay	$0 Copay	$10 Copay	$0 Copay
Brand Preferred	$50 Copay	$40 Copay	$50 Copay	$40 Copay
Brand Non-Preferred	$75 Copay	$70 Copay	$75 Copay	$70 Copay
Specialty	$150 Copay		$150 Copay	
Mail Order Pharmacy (90-day supply)				
Generic	$0 Copay		$0 Copay	
Brand Preferred	$100 Copay		$100 Copay	
Brand Non-Preferred	$175 Copay		$175 Copay	

*This plan is no longer accepting new enrollees.

Dental Plan

It's important to have regular dental exams and cleanings so problems are detected before they become painful – and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health. We offer two dental plan options through Delta Dental of NC.

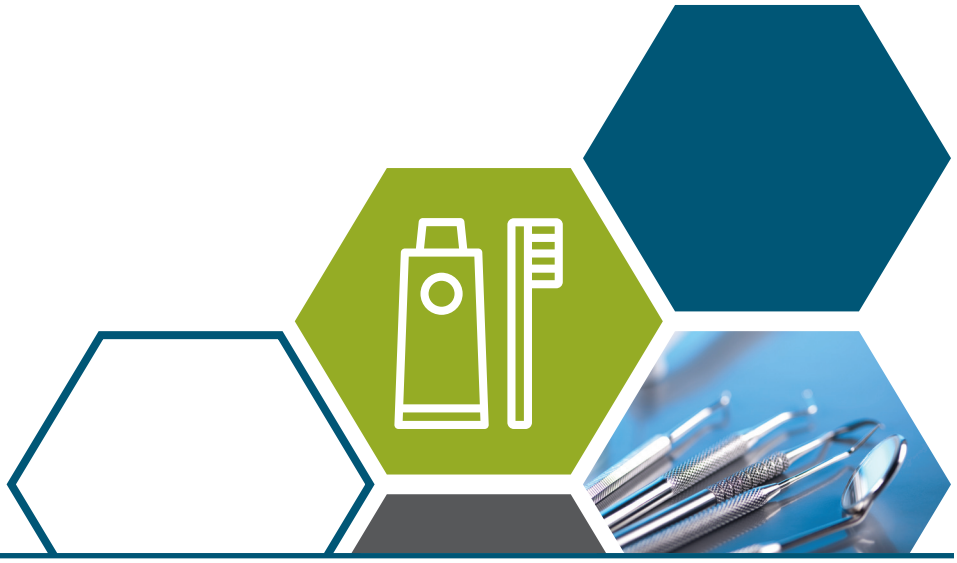
Plan Provisions	In/Out-of-Network	
	Core	Buy-Up
Annual Deductible (Individual/Family)	$100/$300	$50/$150
Calendar Year Maximum	$1,250	$2,500
Orthodontia Lifetime Maximum	$1,250	$2,500
Diagnostic and Preventive Services (e.g., X-rays, cleanings, exams)	100%/100% deductible waived	
	Amount you pay after deductible	
Basic and Restorative Services (e.g., fillings)	10%/20%	10%/20%
Major Services (e.g., dentures, crowns, bridges)	40%/50%	40%/50%
Orthodontia	50%	50%

*After deductible

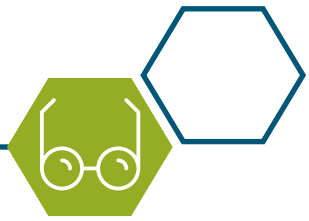
New for 2025: Out of network dentist will be reimbursed at 90% of usual and customary

Get the most from your dental plans

- **Stay in-network** – While you have the option of choosing any provider, you save money when you use in-network dentists. When using an out-of-network dental provider, you pay more because the provider has not agreed to charge you a negotiated rate.
- **Free annual check-up** – Use free preventive care to keep your mouth and gums healthy all year long.



Vision Plan



The vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. We offer a vision plan through Community Eye Care.

Plan Provisions	Community Eye Care In-Network
Exam – Once every 12 months	$0 Copay
Frames – Once every 12 months	$10 Copay $150 Annual Allowance*
Lenses – Once every 12 months	$10 Copay $150 Annual Allowance*
Contact Lens Fitting – Once every 12 months	$10 Copay

*The Annual Allowance of $150 is provided per plan year, not per type of eyewear.

Life Insurance and Disability

Life and AD&D Insurance

Company provides basic life and AD&D insurance for employees and offers voluntary insurance options for employees and their dependents.

Basic Life and AD&D Insurance

Life insurance is an important part of your financial wellbeing, especially if others depend on you for support. The company provides basic life and accidental dismemberment insurance to all eligible associates and their dependents. Coverage for associates is equal to three times your base annual earnings, up to a maximum of $200,000.

Voluntary Life Insurance

You may choose to purchase additional life coverage for yourself and your dependents at affordable group rates. Rates are based on age and the coverage level chosen.

Voluntary Life Insurance for you	Voluntary Life Insurance for your dependents	
Employee	**Spouse**	**Child(ren)**
• Lesser of five times your base annual salary • Up to a $100,000 maximum	• Increments of $5,000 (not to exceed 50% of your voluntary life coverage) • Up to a $20,000 maximum	• $10,000 per child

Disability insurance

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. The company provides eligible associates with short term and long-term disability at no cost as shown below. Employees can elect to buy-up their short term disability.

Coverage	Benefit
Short-Term Disability (Company Paid Core)	• 60% of your weekly salary, to a maximum of $300 per week for the first 26 weeks of a disability after the one-week waiting period
Short-Term Disability (Employee Paid Buy-Up)	• 60% of your weekly salary, to a maximum of $600 per week for the first 26 weeks of a disability after the one-week waiting period
Long-Term Disability (Company Paid)	• 60% of your base salary, to a maximum of $5,000 per month if you are disabled and are unable to work for more than 180 days • Benefits are offset with other sources of income, such as Social Security and Workers' Compensation

Tribal Family Medical Leave (TFML)

If you have been with the company for 12 months, you may be eligible for up to 12 work weeks of unpaid leave per year under the Tribal Family Medical Leave (TFML). TFML can be used for an illness of your own, care needed for a family member, care for a newborn and certain other medical needs.

Employee Assistance Program

Life is filled with change and uncertainty. The responsibilities and demands on our time can be overwhelming. Our Employee Assistance Program (EAP) is here to help you and your family members with life's challenges.

The EAP, administered by ComPsych, provides 24/7 confidential support, resources and information for you and your dependents. You and your family have access to five sessions per calendar year, plus an additional five with a covered disability claim. Services include:

- **Financial services:** Budgeting, credit and financial guidance, retirement planning and assistance with tax issues.
- **Legal services:** Consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, estate planning and more.

Call 1-866-380-1273 or visit www.guidanceresources.com (Web ID: EBCI). When talking on the phone, mention Symetra as your employer sponsor.

Benefit Costs

Your monthly payroll contributions for medical, dental and vision benefits are shown here.

Medical	BCBSNC – Core Medical Plan	BCBSNC – Buy-Up Medical Plan*
Individual	$0.00	$172.58
Employee/Spouse	$523.23	$803.15
Employee/Children	$241.43	$463.53
Family	$717.55	$1,186.35

*This plan no longer accepts new enrollees.

Dental	Delta Dental – Core Dental Plan	Delta Dental – Buy-Up Dental Plan
Individual	$0.00	$5.43
Employee/Spouse	$19.58	$29.34
Employee/Children	$29.85	$41.90
Family	$54.29	$71.77

Vision	Community Eye Care Vision Plan
Individual	$0.00
Employee/Spouse	$6.56
Employee/Children	$5.79
Family	$13.79

Helpful Benefit Terms

- **Brand preferred drugs** – A drug with a patent and trademark name that is considered "preferred" because it's safe and effective and usually less expensive than other brand-name options.
- **Brand non-preferred drugs** – A drug with a patent and trademark name that is "not preferred" because it's usually more expensive than other generic and brand preferred options.
- **Calendar year maximum** – The maximum benefit amount paid each year for each family member enrolled in the dental plan.
- **Coinsurance** – The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met. You will be responsible for the remaining 20% of the cost.
- **Copay** – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service.
- **Deductible** – The amount you have to pay for covered services each year before your health plan begins to pay.
- **Elimination period** – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.
- **Evident of Insurability (EOI)** – EOI is documentation or declaration of good health requested by the insurance company in order for the enrollee to obtain coverage.
- **Flexible Spending Accounts (FSA)** – FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.
- **Generic drugs** – A drug that is equivalent to brand-name drugs in use, dose, strength, quality and performance, but is not trademarked.
- **In-network** – A designated list of health care providers (doctors, dentists, etc.) with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.
- **Inpatient** – Services provided to an individual during an overnight hospital stay.
- **Mail order pharmacy** – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.
- **Out-of-network** – Providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Higher deductibles and coinsurance will apply.
- **Out-of-pocket maximum** – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.
- **Outpatient** – Services provided to an individual at a hospital facility without an overnight hospital stay.
- **Primary Care Provider (PCP)** – A doctor (generally a family or internal medicine practitioner or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.
- **Usual & Customary Charges (U&C)** – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Usual and Customary rates may apply to out-of-network charges.
- **Specialist** – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).
- **Specialty drugs** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Contact Information

Coverage	Carrier	Phone	Website
Medical	BCBSNC	800-487-5522	www.mybcbsnc.com
HealthLine Blue NurseLine	BCBSNC	877-477-2424	www.mybcbsnc.com
Dental Benefits & Claims inquiries	Delta Dental	800-971-4108	www.deltadentalnc.com
Vision Benefits	Community Eye Care	844-357-0358	www.communityeyecare.net
Life/AD&D/VTL Dependent Life	Symetra	877-377-6776	www.Symetra.com
Short-Term Disability Long-Term Disability	Symetra	877-377-6776	www.Symetra.com
Employee Assistance Plan (EAP)	ComPsych	1-866-380-1273	www.guidanceresources.com (Web ID: EBCI)

EASTERN BAND OF CHEROKEE INDIANS

401(K) RETIREMENT PLAN
&
PENSION PLAN

401(k) provider Lincoln Financial Group

All employees are encouraged to participate in the 401(k)-retirement program.
All Employees hired after 1/1/2009 are automatically enrolled in the 401(k) plan.

- EBCI matches up to 5% and the employee is 100% vested.
- Employees are eligible to contribute upon being hired, no waiting period.
- The maximum percentage allowable is 50%.

If you would like to change your contribution amount, please log into your Lincoln Financial Account at LFG.com

Also, be sure your beneficiaries are listed on your account!

Have questions or need help? Contact your retirement consultant to help you.
Lisa Franklin can be reached via email Lisa.Franklin@lfg.com or phone 423-202-4038.

Pension

Pension is a Defined Benefit Plan that is paid for by your employer, if you work for the Tribe or one of the Tribal Entities that participate in the Pension plan. When you reach retirement age (62) and have at least 10 years of service (5 years of service if hired before 1/1/2019), the Tribe will pay you a monthly annuity; this will be for the rest of your life.

You can early retire at any age with 30 years of service or at the age of 55, with at least 10 years of service. If you do not have 30 years of service and wish to early retire, there will be a 6% deduction for every year you are under the age of 62.

The formula for the annuity is 1.5% times your final average compensation, times your years of service. This benefit is 100% employer paid.

October 2024

Patient Protection Model Disclosure

The EBCI Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBSNC at 877-275-9787 or www.mybcbsnc.com. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from EBCI 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 BCBSNC at 877-275-9787 or www.mybcbsnc.com.

Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The [insert "60-day" or any longer period that applies under the plan] period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a [insert "30-day" or any longer period that applies under the plan] period applies to most special enrollments.

To request special enrollment or obtain more information, contact EBCI Human Resources at PO Box 554, Cherokee NC 28719 or at 828-359-6388.

Women's Health and Cancer Rights Act Notices

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 this plan.

If you would like more information on WHCRA benefits, call your plan administrator at 828-359-6388.

Model COBRA Continuation Coverage General Notice Instructions

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; 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: Eastern Band of Cherokee Indians: PO Box 554, Cherokee NC 28719 or contact by phone at 828-359-6388.

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.

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

Benefits Office
Eastern Band of Cherokee Indians
P.O. Box 554
Cherokee, NC 28719
828-359-6388

HIPAA Notice of Privacy Practices

Notice of EBCI Health Information 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 effective date of this Notice of EBCI's Medical Plan Health Information Privacy Practices (the "Notice") is January 1, 2025, revised as of October 15, 2024.

EBCI's Medical Plan (the "Plan") provides health benefits to eligible employees of EBCI (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and

discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates, and any of their subcontractors without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

> Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

> Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.
>
> Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

> Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.
>
> Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

> Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.
>
> Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations

activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.

- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses • Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others. The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation: The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it 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 has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request. However, if you, or a third party requests a copy of your PHI, the fee limitations set out in the rules will apply only to your individual request for access to your own records but these fee limitations will not apply to an individual's request to transmit records to a third party.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the

contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

Benefits Office, Eastern Band of Cherokee Indians P.O. Box 554, Cherokee NC 28719 or 828-359-6388.

Important Notice from Eastern Band of Cherokee Indians (EBCI) 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 Eastern Band of Cherokee Indians 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. Eastern Bank of Cherokee Indians has determined that the prescription drug coverage offered by the Eastern Bank of Cherokee Indians Health Benefit 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 EBCI coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current EBCI 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 Eastern Band of Cherokee Indians 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 Eastern Band of Cherokee Indians 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:	October 1, 2024
Name of Entity/Sender:	Eastern Band of Cherokee Indians (EBCI)
Contact – Position/Office:	EBCI Benefits Department
Address:	PO Box 554, Cherokee NC 28719
Phone Number:	828-359-6388

About this Guide

This benefit summary provides selected highlights of the EBCI benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. EBCI reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.