2019 Health and Welfare Plan Compliance

Initial Eligibility/Enrollment (New Hire) Notices

September 25, 2019

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NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in the PeopleShare's Health Plan's health coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Plan's health coverage, provided that you request enrollment within 30 days after you or your dependent's other coverage ends in certain circumstances.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan's health coverage, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You may also enroll yourself and your dependents in the PeopleShare Health Plan's health coverage if your or one of your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, or if you or one of your eligible dependents become eligible for premium assistance (that could be used toward the Plan costs) under a Medicaid or state child health plan under CHIP. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP.

To request special enrollment or obtain more information, contact Human Resources at 610-489-1400.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymph edemas.

These benefits shall be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For more information, please contact the Plan Administrator at 610-489-1400 or refer to the Summary Plan Description.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2019 for coverage starting January 1, 2020.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.69% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

If you work full-time and are eligible for coverage under your employer's health plan, the plan satisfies the minimum value standard, and the cost is intended to be affordable based on employee wages.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resource department at 610-489-1400.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through

[1] 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 at least 60 percent of such costs.

the Marketplace and its costs. Please visit **Healthcare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to 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: Human Resources.

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. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under the group health plan due to a qualifying event, and before 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. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later.

End of Continuation Coverage

Continuation coverage will end earlier than the period elected if:

- Timely payment of premiums for the continuation coverage is not made;
- The qualified beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise;
- The qualified beneficiary first becomes entitled to benefits under Medicare, after the COBRA election;
- The Plan Sponsor ceases to provide any group health plan to any employee;
- You, as the covered employee, cease to be disabled, if continuation coverage is due to your disability; or
- The period of continuation coverage expires.

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, Medicaid, 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.

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

PeopleShare
Human Resources
100 Springhouse Drive
Suite 200
Collegeville, PA 19426
610-489-1400

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

Revised Date: September 24, 2013

THIS NOTICE OF PRIVACY PRACTICES ("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 AND SHARE IT WITH YOUR SPOUSE AND OTHER DEPENDENTS WHO ARE COVERED UNDER THE PeopleShare GROUP HEALTH PLAN.

Introduction

This Notice applies to the medical, dental, prescription drug, vision, and EAP benefits under the PeopleShare Group HEALTH PLAN], which are collectively referred to as the "Plan" in this Notice. The Plan contracts with a number of outside service providers to provide you the benefits just described. Blue Cross Blue Shield and Metlife are examples of the Plan's service providers. You may receive separate notices from the Plan's service providers regarding their particular privacy practices.

This Notice does not apply to PeopleShare (the "Company") in its role as your employer or to any non-health benefit plan or programs sponsored by the Company, such as sick leave, worker's compensation, short- or long-term disability, or life insurance, even though such plans or programs might involve the use or disclosure of your health-related information.

The Plan is required by the HIPAA Privacy Rules to maintain the privacy of participants' protected health information and to provide participants with notice of its legal duties and privacy practices regarding protected health information. In many cases the Plan has contracted with its outside service providers to assist the Plan in fulfilling these legal obligations.

This Notice summarizes the main provisions of the Plan document governing how the Plan may use and disclose your protected health information for:

- your treatment,
- payment of your claims,
- health care operations functions of the Plan, and
- other uses and disclosures of such information allowed by law.

It also describes the Plan provisions related to your ability to access and control the use and disclosure of your protected health information.

The Plan must abide by the terms of this Notice as currently in effect. The terms of this Notice may change and new notice provisions effective for all protected health information held by or on behalf of the Plan may be added. In the event of a significant change to this Notice, you will receive an updated Notice. You may also request a copy of this Notice at any time by contacting PeopleShare at 610-489-1400.

The Plan is required by law to:

- Make sure that your protected health information is kept private;
- Provide you with this Notice of our legal duties and privacy practices with respect to your protected health information;
- Notify affected individuals following a breach of unsecured protected health information; and

- Follow the terms of this Notice (as currently in effect or subsequently amended).

Protected Health Information

"Protected health information," (PHI) as the term is used in this Notice, means health information maintained or transmitted by or on behalf of the Plan that identifies you or creates a reasonable basis to believe that it could be used to identify you, including information relating to your past, present or future physical or mental health, the health care that you have received or payment for your health care, including your name, address, date of birth and Social Security number. Health information that is merely in summary form and that does not identify you as its subject is not protected and may be used or disclosed by the Plan without restriction under the HIPAA Privacy Rules. For example, the Plan may use aggregated data regarding claims paid for all Plan participants to help project benefit costs for the next year.

Use or Disclosure of Your Protected Health Information for Plan Administration

The following paragraphs describe different ways that the Plan may use and disclose protected health information without your authorization. Not every possible use or disclosure is listed.

Treatment

Your protected health information may be used or disclosed to carry out medical treatment or services by health care providers, including physicians, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, in carrying out treatment functions, the Plan (or service providers acting on behalf of the Plan, (or service providers acting on behalf of the Plan) could use or disclose your protected health information to protect you from receiving inappropriate medications or share information about prior prescriptions if a newly prescribed drug could cause problems for you. In the event of an emergency where you are unable to give your physician your medical history, the Plan may share that history (if know to the Plan) with the physician so that the physician can most appropriately provide medical services to you. The Plan also may share information about prior treatment with a health care provider who needs such information to treat you or your family properly.

Payment

Your protected health information may be used or disclosed for payment purposes, such as to determine your eligibility for Plan benefits, to coordinate coverage between this Plan and another plan, to facilitate payment for services you receive and similar purposes related to the Plan's determination and payment of benefits. The Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational or medically necessary, or to determine whether the Plan will cover the treatment. Your information may be shared with an outside vendor that the Plan has hired to review use of certain services or medications, or with an outside company hired to help the Plan ensure that it is properly reimbursed if a third party is responsible for medical costs the Plan would otherwise pay.

Health Care Operations

Your protected health information may be used for various administrative purposes that are called "health care operations" of the Plan. For example, your information might be included as part of an audit designed to ensure that the Plan's outside claims administrator is performing its job as well as it should for the Plan. And your information, along with that of all other participants, may be used each year to set appropriate premiums for the Plan or to help secure insurance that is needed to protect the Plan or Plan sponsor financially.

Disclosures to Business Associates

The Plan often relies on outside service providers (generally known as "business associates") to handle important treatment, payment and health care operations tasks on behalf of the Plan. When these tasks involve the use or disclosure of protected health information, the Plan is permitted to share your information with these outside providers (for example, the companies that may process claims for benefits under the Plan or administer your prescription drug benefits under the Plan). Whenever an arrangement between the Plan and a business associate involves the use or disclosure of your protected health information, the Plan and the business associate will have a written agreement that requires that the business associate keeps your information confidential.

Disclosures to Company Personnel

The Plan may disclose your protected health information to Company personnel who are involved in the administration of the Plan. These disclosures will be made in connection with the Company's role as the sponsor of the Plan, and will be made to enable Company personnel to carry out their duties in administering the Plan. Information may also be shared among the various health benefit programs that make up the Plan for purposes of each program's treatment, payment and health care operations functions. The Company has amended the Plan documents and instituted policies and procedures to help ensure that your protected health information is made available only to those individuals who need it to perform important Plan functions. Such individuals have received training in the proper handling of protected health information and have been informed of the sensitivity of this information. It is the policy of the Company that protected health information received from the Plan is not to be used for employment-related purposes or other purposes not related to the Company's sponsorship or administration of the Plan.

Disclosures to the Employer

The Plan may disclose the Plan's enrollment information to the Company. This information merely indicates whether you are enrolled in the Plan and shows your specific Plan benefit options. Your employer requires such information for payroll withholding and other purposes. In addition, the Plan may disclose "summary health information" to the Company for obtaining premium bids or modifying, amending or terminating the benefits provided under the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experience by individuals for whom a plan sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.

Additional Uses and Disclosures Required or Allowed by Law

The HIPAA Privacy Rules also allow covered health care entities, including our Plan, to use and disclose protected health information without obtaining written authorization for a variety of governmental, public health and similar purposes, such as the following:

- As authorized by and to the extent necessary to comply with workers' compensation or similar laws;
- For judicial and administrative proceedings, such as lawsuits or other disputes in response to a court order or subpoena; or
- For public health activities, such as preventing or controlling disease and reporting reactions to medications.

Uses and Disclosures Requiring That You Receive an Opportunity to Agree or Object

Certain circumstances might arise where the Plan needs to disclose your protected health information to family members and other appropriate persons in order to ensure that you are receiving appropriate care and to notify certain persons of your medical condition or your location. The Plan will make such disclosures only if you have agreed (or have not objected) to the disclosure. Specifically, the Plan may disclose your protected health information to your family member, relative, or another person designated by you, but only to the extent the information is directly relevant to

such individual's involvement with your care or payment for care. In addition, you may authorize a personal representative to receive your PHI and to act on your behalf.

Incidental Uses and Disclosures

The HIPAA Privacy Rules allow for incidental uses and disclosures that occur as a by-product of a permissible or required use or disclosure. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a result of another use or disclosure that is permitted by the HIPAA Privacy Rules. The Plan has instituted reasonable safeguards to protect against uses and disclosures not permitted by the HIPAA Privacy Rules and to limit incidental uses or disclosures. However, those safeguards cannot totally guarantee the prevention of incidental uses and disclosures. The Plan is not required to obtain your authorization or notify you if an incidental disclosure occurs.

Uses or Disclosures of PHI That Require Your Written Authorization

The Plan will not use or disclose your PHI for the following purposes without your prior written authorization:

Psychotherapy Notes: Except for certain narrow exceptions permitted by law (such as legal defense in a proceeding you bring against the Company or the Plan) the Plan will not use or disclose any mental health professional's psychotherapy notes (discrete notes that document the contents of conversations during counseling sessions) without your prior written authorization.

Marketing or Sales: Unless you give the Plan your prior written authorization, the Plan will not use or disclose your PHI for any paid marketing activities or sell your PHI.

No Other Uses or Disclosures Without Your Authorization

Other than the uses and disclosures described in this Notice, the Plan may not disclose your protected health information or make any other use of it without your written authorization. You may revoke any such authorization in writing except to the extent that the Plan has already taken action in reliance on your authorization.

No Use or Disclosure of Genetic Information for Underwriting

The Plan is prohibited by law from using or disclosing PHI that is genetic information of an individual for underwriting purposes. Generally, genetic information involves information about differences in a person's DNA that could increase or decrease his or her chances of getting a disease (for example, diabetes, heart disease, cancer or Alzheimer's disease).

Additional Special Protections

Additional special privacy protections, under federal or state law, may apply to certain sensitive information, such as genetic information, HIV-related information, alcohol and substance abuse treatment information, and mental health information.

Reservation of the Plan's and the Company's Rights

Generally, it is the Plan's policy to avoid the use and disclosure of your protected health information whenever possible. Therefore, the Plan will not normally use or disclose your protected health information, except when necessary for treatment, payment, or health care operations or to comply with the HIPAA Privacy Rules or other applicable law. Similarly, the Company will seek to avoid the use and disclosure of any summary health or enrollment information

whenever possible. However, the Company and the Plan reserve the right to use or disclose your protected health information in any manner permitted by the HIPAA Privacy Rules.

Your Rights

You have the following rights regarding the PHI that the Plan maintains:

Right to Inspect and Copy: You have the right to review and receive copies of your enrollment, payment, claims adjudication, and case or medical management records maintained by the Plan. If the information you request is maintained electronically, and you request an electronic copy, the Plan 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 will work with you to come to an agreement on form and format. If you and the Plan cannot agree on an electronic form and format, the Plan will provide you with a paper copy.

If you request copies of this information, you may be charged a reasonable, cost-based fee for the copies. The Plan may deny your request to inspect and copy your PHI in certain limited circumstances. If your request is denied, you will receive a written explanation of the reasons for the denial. Please remember that the Plan is only responsible for providing you with information contained in its records. Hospital records and other records not maintained by the Plan must be procured directly from the individual or institution that maintains those records.

Right to an Accounting of Disclosures: You have the right to receive an accounting (i.e., list) of instances where the Plan or the Company disclosed your protected health information to third parties (in the six years prior to the date of your request for such accounting) for reasons other than treatment, payment, or health care operations, except in cases where you have authorized the disclosure, the disclosure was merely incidental to a disclosure that is otherwise permitted under the HIPAA Privacy Rules, or the disclosure was required for certain law enforcement or national security purposes. You may request one such accounting at no charge every 12 months. For any additional requests, you may be charged a reasonable, cost-based fee for the copies.

Right to Amend: If you believe that information in your record is incorrect or if important information is missing, you have the right to request that the Plan correct existing information or add missing information. Your request must include reasons supporting your request for a correction or addition. The Plan has 60 days to respond to your request, subject to a possible 30-day extension. If your request is denied, you will receive a written explanation of the reasons for the denial.

Right to Request Restrictions: You have the right to request restrictions on the Plan's use or disclosure of your protected health information for treatment, payment and health care operations. You may also request restrictions on disclosures to your family members or other individuals who are involved in your care or payment for your care. The Plan will consider your request, but is not required to agree to such restrictions if the disclosure of your protected health information is otherwise permitted under the HIPAA Privacy Rules. Any restriction agreed to by the Plan will not apply if the use or disclosure is necessary to provide you with emergency treatment or if the disclosure is required by law. If the Plan accepts your request, you will receive written notification that your request has been accepted. The Plan will also accommodate reasonable requests for you to receive communications of your protected health information at alternate locations or by alternate methods, if the normal method of communication could endanger you.

To initiate any request for access to your information, an accounting of disclosures, correction or amendment of your information, or restrictions on disclosures, as described above, you must contact the PeopleShare at 610-489-1400, which may then refer you to the appropriate outside provider.

Copy of Notice

You may obtain a paper copy of this Notice at any time upon request to PeopleShare at 610-489-1400, even if you have previously agreed to accept the Notice electronically.

Complaints and Additional Information

If you believe the Plan or its outside service providers has violated your rights under the HIPAA Privacy Rules, you may file a complaint with the Plan or with the Secretary of Health and Human Services. Such complaints must be filed in writing. For further information about the issues covered by this Notice, or to file a complaint, please contact Human Resources at 610-489-1400 or in writing at 100 Springhouse Drive, Suite 200, Collegeville, PA 19426. Neither the Plan nor the Company may retaliate against you in any way for filing such a complaint.

This notice and the privacy policies of the Plan and the Company do not create any legal rights, contractual or otherwise, under state or federal law, but simply give you notice of the Plan's obligations, and your rights, under the HIPAA Privacy Rules.

The information contained herein has been provided by the Company and is solely the responsibility of Company.