2022 Legal Notices

SUMMARY OF BENEFITS COVERAGE (SBC)

To see key features of the medical plan, review the medical plan summary on www.blockbenefits.com.

HIPAA SPECIAL ENROLLMENT NOTICE

If you decline enrollment in an H&R Block medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in an H&R Block medical plan without waiting for the next Open Enrollment period if you:

- Lose other coverage. You must request enrollment within 45 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request enrollment within 45 days after the marriage, birth, adoption or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request enrollment within 60 days after the loss of such coverage.

In addition, you may enroll in H&R Block's medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain such coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

Any deductibles, copayments or other plan requirements that normally apply to surgical procedures covered by your health plan will also apply to these procedures. If you would like more information on WHCRA benefits, contact the People Center at 877-222-5547.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

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 program. 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, 2021. Contact your state for more information on eligibility.

Alabama – Medicaid	**Florida** – Medicaid
Website: www.myalhipp.com **Phone:** 1-855-692-5447	**Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268
Alaska – Medicaid	**Georgia** – Medicaid
The AK Health Insurance Premium Payment Program **Website:** https://myakhipp.com/ **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	**Website:** https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp **Phone:** 1-678-564-1162 ext. 2131
Arkansas – Medicaid	**Indiana** – Medicaid
Website: http://myarhipp.com **Phone:** 1-855-MyARHIPP (1-855-692-7447)	**Healthy Indiana Plan for low-income adults 19-64** **Website:** http://www.in.gov/fssa/hip/ **Phone:** 1-877-438-4479 **All other Medicaid** **Website:** https://www.in.gov/medicaid/ **Phone:** 1-800-457-4584
California – Medicaid	**Iowa** – Medicaid and CHIP (Hawki)
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp **Phone:** 1-916-445-8322 **Email:** hipp@dhcs.ca.gov	**Medicaid Website:** https://dhs.iowa.gov/ime/members **Medicaid Phone:** 1-800-338-8366 **Hawki Website:** http://dhs.iowa.gov/Hawki **Hawki Phone:** 1-800-257-8563 **HIPP Website:** https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp **HIPP Phone:** 1-888-346-9562
Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**Kansas** – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943/ State Relay 711 **CHP+:** https://www.colorado.gov/pacific/hcpf/child-health-plan-plus **CHP+ Customer Service:** 1-800-359-1991/ State Relay 711 **Health Insurance Buy-In Program (HIBI):** https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program **HIBI Customer Service:** 1-855-692-6442	**Website:** https://www.kancare.ks.gov/ **Phone:** 1-800-792-4884

Kentucky – Medicaid	**Nevada** – 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://kidshealth.ky.gov/Pages/index.aspx **Phone:** 1-877-524-4718 **Kentucky Medicaid Website:** https://chfs.ky.gov	**Medicaid Website:** http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900
Louisiana – Medicaid	**New Hampshire** – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp **Phone:** 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	**Website:** https://www.dhhs.nh.gov/oii/hipp.htm **Phone:** 1-603-271-5218 **Toll free number for the HIPP program:** 1-800-852-3345, ext. 5218
Maine – Medicaid	**New Jersey** – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms **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	**Medicaid Website:** http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ **Medicaid Phone:** 1-609-631-2392 **CHIP Website:** http://www.njfamilycare.org/index.html **CHIP Phone:** 1-800-701-0710
Massachusetts – Medicaid and CHIP	**New York** – Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa **Phone:** 1-800-862-4840	**Website:** https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831
Minnesota – Medicaid	**North Carolina** – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp **Phone:** 1-800-657-3739	**Website:** https://medicaid.ncdhhs.gov/ **Phone:** 1-919-855-4100
Missouri – Medicaid	**North Dakatoa** – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 1-573-751-2005	**Website:** http://www.nd.gov/dhs/services/medicalserv/medicaid/ **Phone:** 1-844-854-4825
Montana – Medicaid	**Oklahoma** – Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084	**Website:** http://www.insureoklahoma.org **Phone:** 1-888-365-3742
Nebraska – Medicaid	**Oregon** – Medicaid
Website: http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633 **Lincoln:** 1-402-473-7000 **Omaha:** 1-402-595-1178	**Website:** http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html **Phone:** 1-800-699-9075

Pennsylvania – Medicaid	**Vermont** – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx **Phone:** 1-800-692-7462	**Website:** http://www.greenmountaincare.org/ **Phone:** 1-800-250-8427
Rhode Island – Medicaid and CHIP	**Virginia** – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)	**Website:** https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp **Medicaid Phone:** 1-800-432-5924 **CHIP Phone:** 1-800-432-5924
South Carolina – Medicaid	**Washington** – Medicaid
Website: https://www.scdhhs.gov **Phone:** 1-888-549-0820	**Website:** https://www.hca.wa.gov/ **Phone:** 1-800-562-3022
South Dakota – Medicaid	**West Virginia** – Medicaid
Website: http://dss.sd.gov **Phone:** 1-888-828-0059	**Website:** http://mywvhipp.com **Phone:** 1-855-MyWVHIPP (1-855-699-8447)
Texas – Medicaid	**Wisconsin** – Medicaid and CHIP
Website: http://gethipptexas.com/ **Phone:** 1-800-440-0493	**Website:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **Phone:** 1-800-362-3002
Utah – Medicaid and CHIP	**Wyoming** – Medicaid
Medicaid Website: https://medicaid.utah.gov/ **CHIP Website:** http://health.utah.gov/chip **Phone:** 1-877-543-7669	**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, 2021, 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.

IMPORTANT NOTICE FROM H&R BLOCK 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 H&R Block Management, LLC (H&R Block) 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. H&R Block has determined that the prescription drug coverage offered by the H&R Block medical plan (the H&R Block Core 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 H&R Block coverage will not be affected. If you decide to enroll in a Medicare prescription drug plan and you are an active associate or family member of an active associate, you may also continue your H&R Block coverage. In this case, the H&R Block coverage will continue to pay primary, as it had before you enrolled in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop or waive your current H&R Block coverage, be aware that you and your dependents will not be able to re-enroll in the H&R Block plan until the next annual enrollment period unless you have a special enrollment event for the H&R Block plan.

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 H&R Block 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 H&R Block changes. You also may request a copy of this notice at anytime.

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, 2021

Name of Entity/Sender: H&R Block People Center
One H&R Block Way
Kansas City, MO 64105
877-2CALLHR (877-222-5547)

HIPAA NOTICE OF PRIVACY PRACTICES

THIS HEALTH INFORMATION PRIVACY NOTICE ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the health plans—whether received in writing, in an electronic medium, or as an oral communication. This Notice describes the privacy practices of the following health plans:

- H&R Block Health and Welfare Plan (with respect to health benefits only)
- H&R Block Cafeteria Plan
- H&R Block Associate Assistance Program

The plans covered by this Notice may share health information with each other to carry out Treatment, Payment or Health Care Operations. These plans are collectively referred to as the "Plan" in this Notice, unless specified otherwise.

The Plan's Duties with Respect to Health Information About You

The Plan is required by law to maintain the privacy of your health information and to provide you with this Notice of the Plan's legal duties and privacy practices with respect to your health information. The Plan is also required to notify you if there has been a breach of your unsecured health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It is important to note that these rules apply to the Plan, not your employer—that is the way the HIPAA rules work. Different policies may apply to other plans or programs maintained by your employer or to data unrelated to the Plan.

How the Plan May Use or Disclose Your Health Information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment and Health Care Operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share health information about you with physicians who are treating you.
- **Payment** includes activities by the Plan, other plans or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection or reinsurance. For example, one health plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.
- **Health Care Operations** include activities by this Plan (and in limited circumstances other plans or providers) such as well-being and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Health Care Operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. (Note that the Plan is prohibited from using or disclosing your health information that is

genetic information for underwriting purposes.) For example, the Plan may use information about your claims to review the effectiveness of well-being programs.

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules.

How the Plan May Share Your Health Information with H&R Block

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to H&R Block Management LLC, the official plan administrator for the Plan, for plan administration purposes. H&R Block Management LLC has delegated some of its plan administration responsibilities to certain of its affiliates ("Affiliates"). H&R Block Management LLC and its Affiliates are collectively referred to as "H&R Block" in this Notice, unless specified otherwise. H&R Block may need your health information to administer benefits under the Plan. H&R Block agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Departments of H&R Block (and associates of such departments) will have access to your health information for plan administration functions.

Here is how additional information may be shared between the Plan and H&R Block, as allowed under the HIPAA rules:

- The Plan, or its Insurer or HMO, may disclose "summary health information" to H&R Block if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information have been removed.
- The Plan, or its Insurer or HMO, may disclose to H&R Block information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance benefit option or HMO offered by the Plan.

In addition, you should know that H&R Block cannot and will not use health information obtained from the Plan for any employment related actions. However, health information collected by H&R Block from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other Allowable Uses or Disclosures of Your Health Information

Except as described in this Notice, uses and disclosures of your health information will be made only with your written authorization. Specifically, your written authorization generally is required before the Plan may use or disclose any psychotherapy notes about you from your psychotherapist, use or disclose health information for marketing (other than a face-to-face communication or provision of a promotional gift of nominal value) or sell your health information. (Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose psychotherapy notes without your authorization when needed by the Plan to defend against litigation filed by you.)

You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the Plan has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Plan has already made.

In certain cases, your health information can be disclosed without authorization to a family member, close friend or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide compensation benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); Includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you will be notified of the Plan's disclosure if informing you will not put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death donation
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS Investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your Individual Rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the Notice describes how you may exercise each individual right. See the table at the end of this Notice for information on how to submit requests.

Right to Request Restrictions on Certain Uses and Disclosures of Your Health Information and the Plan's Right to Refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the

use and disclosure of your health information to family members, close friends or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition or death—or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing. The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to Receive Confidential Communications of Your Health Information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations. If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to Inspect and Copy Your Health Information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by the Plan; or a group of records the Plan uses to make decisions about individuals. You do not, however, have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If your health information is held in an electronic record, you may request access in the electronic form (if the information is readily producible in that form). If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage. If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to Amend Your Health Information That Is Inaccurate or Incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to Receive an Accounting of Disclosures of Your Health Information

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this Notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request. You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment or Health care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to Obtain a Paper Copy of This Notice from the Plan Upon Request

To obtain a paper copy of this Privacy Notice contact the People Center at 1-877-2CALLHR (1-877-222-5547). This notice is also posted on your employer's Intranet web-site dedicated to associate benefits. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the Information in This Notice

The Plan must abide by the terms of the Privacy Notice currently in effect. This updated Notice takes effect on September 23, 2013. However, the Plan reserves the right to change the terms of its privacy policies as described in this Notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this Notice, the revised Notice will be posted on your employer's Intranet web-site dedicated to associate benefits and you will also receive the revised notice in the Plan's next annual mailing to participants.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, it must be in writing and addressed to the Benefits Department at One H&R Block Way, Kansas City, MO 64105.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact the People Center at 1-877-2CALLHR (1-877-222-5547). Alternatively, if you wish to exercise one or more of the rights listed in this Notice with respect to a particular benefit, you may contact the representative listed on the Additional Contacts supplement to this Notice for the appropriate benefit.

ADDITIONAL CONTACTS

The following is a list of key persons or offices you may need to contact to exercise your rights under the HIPAA privacy rule for different benefit plans offered by H&R Block:

BENEFIT	VENDOR/BUSINESS ASSOCIATE	CONTACT INFORMATION
Medical	Anthem Blue Cross Blue Shield	**Anthem** Attention: Privacy Officer One Liberty Plaza New York, NY 10006 **Telephone:** 866-510-4736 **Website:** www.anthem.com
Engage	Anthem Blue Cross Blue Shield	**Anthem Engage** Telephone: 855-271-4548 **Email:** support@engage-wellbeing.com **Website:** engage-wellbeing.com
Medical	Kaiser Permanente (Hawaii)	**Kaiser Foundation Health Plan Inc.** Customer Service Center 711 Kapi'olani Blvd. Honolulu, Hawaii 96813 **Telephone:** 808-432-5424 (Oahu) 800-966-5955 (Neighbor Islands) **Website:** https://healthy.kaiserpermanente.org
Mental Health Hub (effective Jan. 1, 2022)	Lyra Health	**Lyra Health** **Telephone:** 877-505-7147 **Website:** www.lyrahealth.com
Prescription Drugs	Express Scripts	**Express Scripts, Inc.** Attention: Privacy Officer PO Box 6561 St. Louis, MO 66561-6561 **Telephone:** 877-239-7158 **Website:** www.express-scripts.com
Health Advocate Concierge Service	Health Advocate	**Health Advocate** 866-799-2728 **Email:** answers@healthadvocate.com **Website:** healthadvocate.com/members

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice applies to H&R Block associates and their spouses/domestic partners. Please share this notice with your spouse/domestic partner.

NOTE: Although COBRA is only required to be provided to spouses and dependent children of associates, H&R Block voluntarily offers COBRA-like coverage to domestic partners of associates who have coverage under the H&R Block Health and Welfare Plan (the Plan).

Introduction

This notice generally explains COBRA continuation coverage, which is a temporary extension of coverage under the H&R Block Health & Welfare Plan (the Plan), including when it may become available to you and your family, and what you need to do to protect your right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional 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 People Center at One H&R Block Way, Kansas City, Missouri 64105, 877-222-5547. COBRA continuation coverage for the H&R Block Health and Welfare Plan is administered by The Taben Group, the address and phone number for which is: 10777 Barkley, Suite 200, P.O. Box 7330, Shawnee Mission, Kansas 66207-0330; telephone number 800-675-7341.

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 temporary continuation of Plan coverage when it would otherwise end because of a life event. This is called a "qualifying event." 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." Depending on the type of qualifying event, "qualified beneficiaries" can include the employee, covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. Specific qualifying events are listed later in this notice. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

NOTE: Although COBRA continuation coverage is only required to be provided to spouses and dependent children of employees, H&R Block voluntarily provides COBRA-like coverage to domestic partners of employees (and their dependents) who have medical, prescription drug, dental or vision coverage under the H&R Block Health and Welfare Plan. Thus, domestic partners have rights and responsibilities similar to spouses as outlined in this notice. Please share this notice with your eligible dependents.

What are COBRA "Qualifying Events?"

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happen:

- 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 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. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 provide written notice to the Plan Administrator **within 60 days after the qualifying event** occurs. If timely notice is not received, the Employee and his/her spouse and dependents are not entitled to continuation coverage. You must provide this notice in writing to: the People Center, One H&R Block Way, Kansas City, Missouri 64105. Notice of qualifying event must include the following information: identification of the qualifying event (i.e. divorce or loss of dependent status); the date of the qualifying event; and, all dependents who would otherwise lose coverage because of the qualifying event.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts up to a total of 36 months. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as outlined below.

NOTE: COBRA continuation coverage with respect to the medical reimbursement program is available only through the end of the calendar year in which the qualifying event occurs.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. **You must provide this notice in writing to: the People Center, One H&R Block Way, Kansas City, Missouri 64105. Notice of determination of disability must include the following information: identification of the disabled qualified beneficiary, the date of the determination by the Social Security Administration, and all dependents who would be affected by the determination.**

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

How do you elect COBRA continuing coverage?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation of coverage will be offered to each of the qualified beneficiaries. Each individual eligible for COBRA coverage may independently elect to receive COBRA coverage. An individual eligible for COBRA coverage will be sent an application for continued coverage within 14 days after the Plan Administrator is notified of a qualifying event. If the individual wishes to continue coverage, he or she must complete the application and return it within 60 days from the later of the date it is sent to him or her or the date his or her coverage would otherwise terminate. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children. If an employee, spouse and/or covered dependent elects COBRA coverage, he/she must make the first payment for COBRA coverage within 45

days of the date the individual elects COBRA coverage. The first payment must include the cost of COBRA coverage from the date coverage would have terminated because of the qualifying event up to the date of the first payment. If an individual does not pay the full amount of the first payment for COBRA coverage within the 45-day period, he/she loses all COBRA coverage rights under the Plan. After the first payment for COBRA coverage, payments must be made by the first day of each month for which coverage is provided subject to a 30-day grace period. Failure to make a monthly payment before the end of the grace period will result in termination of COBRA coverage as of the end of the month for which the last payment was made.

What does COBRA cost?

COBRA coverage is the same as the coverage given to other participants or beneficiaries who are not receiving COBRA coverage. Each individual who elects COBRA coverage will have the same rights with respect to Benefits as other participants or beneficiaries covered under the Plan. The level of coverage that an Employee and his/her spouse and covered dependents are entitled to continue under COBRA will be the level of coverage in effect for the Employee on the day before the qualifying event. The monthly charge for COBRA coverage will be 102% of the cost of coverage. The Plan Administrator or COBRA Administrator will advise you of the cost of COBRA coverage when you receive your Notice of Right to Elect Continuation Coverage.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage; or
- The employer ceases to provide a group health plan for its employees Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit **https://www.medicare.gov/medicare-and-you**.

You must notify the Plan Administrator of any change in address or contact information

It is your responsibility to keep the Plan Administrator informed of any change in address or contact information. If you should have a change in address or telephone number, you must notify the People Center at One H&R Block Way, Kansas City, Missouri 64105. You may contact the People Center at 877-222-5547.

Additional Information about Continuation Coverage and the Plan

This Notice does not fully describe continuation coverage or the other rights you may have under the Plan. To obtain additional information regarding your rights under the Plan, please refer to the Summary Plan Description or contact the People Center at One H&R Block Way, Kansas City, Missouri 64105.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at **www.dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

[1] **https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**