Regulatory Notices

City National Bank is required by law to provide you with certain notices that inform you about your rights regarding eligibility, enrollment, and coverage of health care plans.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Notice of Availability

The City National Bank Employees' Welfare Benefits Plan (the "Plan") provides health benefits to eligible employees of City National Bank and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains, and discloses health information about participating employees and dependents in the course of providing these health benefits. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan is required to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so through this Notice of Privacy Practices ("Notice") to participating employees and covered COBRA qualified beneficiaries which describes the ways that the Plan uses and discloses protected health information.

This Notice is available online via *InfoLink* > Human Resources> Benefits. Covered individuals may request a paper copy of the Notice by contacting the City National Bank Human Resources/Benefits Department at (213) 673-9127 or by email Benefits@cnb.com. To the extent that the Plan contains benefits other than those covered under HIPAA's privacy rules, this Notice pertains only to those health care benefits that are covered under HIPAA's privacy rules.

Note: If you are covered by one of the Plan's fully insured group health plans, you will receive a separate communication regarding the availability of the Notice and how to obtain a copy of the Notice directly from the insurance carrier of the City National Bank Benefits group health plan.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice only pertains to those benefits under the Plan which are covered under the Health Insurance Portability and Accountability Act of 1996.

Please Review It Carefully

As we work every day to operate your health plan, protecting the confidentiality of your personal medical information has always been an important priority. The Plan has adopted policies to safeguard the privacy of your medical information and comply with federal law (specifically, the Health Insurance Portability and Accountability Act, known as "HIPAA").

Note: "We" or "Plan" refers to the City National Bank Employees' Welfare Benefits Plan. "You" or "yours" refers to the individual participants in the Plan. If you are covered by an insured health option under the Plan, you may have or will also receive a separate notice from your insurer or HMO.

This Notice explains:

- How your personal medical information may be used, and what rights you have regarding this information.

It is not feasible in this Notice to describe in detail all the specific uses and disclosures the Plan may make, so this Notice describes the categories of uses and disclosures of protected health information.

How the Plan May Use Your Information

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. In order to manage your health plan effectively, the Plan is permitted by law to use and disclose your PHI in certain ways without your authorization:

- **For Treatment**. So that you receive appropriate treatment and care, providers may use your Protected Health Information to coordinate or manage your health care services. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

- **For Payment**. To make sure that claims are paid accurately and you receive the correct benefits, we may use and disclose your Protected Health Information to determine plan eligibility and responsibility for coverage and benefits. For example, we may use your information when we confer with other health plans to resolve a coordination of benefits issue. We may also use your Protected Health Information for utilization review activities.

- **For Health Care Operations**. To ensure quality and efficient plan operations, we may use your Protected Health Information in several ways, including plan administration, quality assessment and improvement, and vendor review. Your information could be used, for example, to assist in the evaluation of a vendor who supports us. We also may contact you with appointment reminders or to provide information about treatment alternatives or other health-related benefits and services available under the Plan.

The Plan may also disclose your Protected Health Information to City National Bank (the plan sponsor) or to a third party administrator (Business Associate) in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose Protected Health Information to the plan sponsor in connection with payment, treatment or health care operations.

The Plan is prohibited from using or disclosing genetic information for underwriting purposes, and will not use or disclose any of your Protected Health Information, which contains genetic information for underwriting purposes.

Other Permitted Uses and Disclosures

Federal regulations allow us to use and disclose your Protected Health Information, without your authorization, for several additional purposes, in accordance with law:

- Public health
- Reporting and notification of abuse, neglect or domestic violence
- Oversight activities of a health oversight agency
- Judicial and administrative proceedings
- Law enforcement
- Research, as long as certain privacy-related standards are satisfied
- To a coroner or medical examiner
- To organ, eye or tissue donation programs
- To avert a serious threat to health or safety
- Specialized government functions (e.g., military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- Workers' compensation or similar programs established by law that provide benefits for work- related injuries or illness
- Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law.

In Special Situations

We may disclose your Protected Health Information to a family member, relative, close personal friend, or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care.

We also may use your Protected Health Information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your bestinterest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.

Uses and Disclosures for which an Authorization is Required

Your authorization is required for most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures, which constitute a sale of Protected Health Information. We will make any other uses and disclosures not described in this Notice only after you authorize them in writing. You may revoke your authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization.

Your Rights Regarding Protected Health Information

You have the right to:

- Inspect and copy your Protected Health Information
- Amend or correct inaccurate information
- Receive a paper copy of this Notice, even if you agreed to receive it electronically
- Receive an accounting of certain disclosures of your information made by us

However, you are not entitled to an accounting of several types of disclosures including, but not limited to:

- Disclosures made for payment, treatment or health care operations
- Disclosures you authorized in writing
- Disclosures made before April 14, 2003.

Right to Request Restrictions

You may ask us to restrict how we use and disclose your Protected Health Information as we carry out payment, treatment, or health care operations. You may also ask us to restrict disclosures to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. However, we are not required to agree to these requests.

Right to Request Confidential Communications

You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have information sent by mail or to an address other than your home.

For more information about exercising these rights, contact the office noted below.

Complaints

If you believe that your privacy rights have been violated, or that the privacy or security of your unsecured Protected Health Information has been compromised, you may file a written complaint without fear of reprisal. Direct your complaint to City National Bank Human Resources/Benefits Department (see below) or to the appropriate regional office of the Office of Civil Rights, U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

About This Notice

We are required by law to maintain the privacy of your Protected Health Information, to provide you with a copy of this Notice regarding our legal duties and privacy practices with respect to Protected Health Information, and to notify you following a breach of your unsecured Protected Health Information. We reserve the right to change the terms of this Notice and to make the new notice provisions effective for all Protected Health Information we maintain. If we change this Notice, you will receive a copy of the new Notice from the Plan. A copy of the current Notice will be maintained by City National Bank's Human Resources Department/Benefits Department at all times.

Contact Information

You may exercise the rights described in this Notice by contacting the City National Bank office identified below, which will provide you with additional information. The contact is:

City National Bank
Human Resources - Attention: HIPAA Privacy Officer 555 South Flower Street, 18th Floor
Los Angeles, CA 90071
Telephone: (213) 673-9127 or Fax: (213) 673-9100

HIPAA Notice of Special Enrollment Rights

THIS NOTICE DESCRIBES SPECIAL CIRCUMSTANCES THAT MAY ALLOW YOU AND YOUR ELIGIBLE DEPENDENTS TO ENROLL IN CITY NATIONAL BANK GROUP HEALTH COVERAGE DURING THE YEAR. PLEASE REVIEW IT CAREFULLY.

City National Bank sponsors a group health plan (the "Plan") to provide coverage for health care services for our employees and their eligible dependents. Our records show that you are eligible to participate, which requires that you complete enrollment in the Plan and pay your portion of the cost of coverage through payroll deductions or decline coverage. The HIPAA law requires we notify you about your right to later enroll yourself and eligible dependents for coverage in the Plan under "special enrollment provisions" described below.

Special Enrollment Provisions

Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you had other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must submit your request for enrollment online Me@CNB within 31 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage. Please contact the Benefits Helpline at (213) 673- 9127 for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents in the Plan. You must submit your request for enrollment online via Me@CNB within 31 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse in the Plan, if your spouse was not previously covered. Please contact the Benefits Helpline at (213) 673-9127 for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in the Plan, you may be able to enroll yourself and your eligible dependents in the Plan if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must submit your request enrollment online via Me@CNB within 60 days from the date of the Medicaid/CHIP event. Please contact the Benefits Helpline at (213) 673-9127 for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

Contact Information

If you have any questions about this Notice or about how to enroll in the Plan, please contact the Benefits Helpline at (213) 673-9127 or by writing to: City National Bank Attn: HR/Benefits 555 South Flower Street, 18th Floor Los Angeles, CA 90071.

Notice Availability

A copy of this notice is available in the Regulatory Notices and Information document located in the HR Benefits Section of InfoLink. Additional information regarding your rights to enroll in the Plan are found in the applicable summary plan description(s) for the Plan located online on InfoLink or you may contact the **Benefits Helpline at (213) 673-9127** as provided above for more information.

Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an innetwork facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

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

Please contact your medical insurance provider, if you have any questions.

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

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

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

Please contact your carrier regarding any balance billing discrepancies:

- Anthem members please contact the Customer Service number behind your medical ID card.
- Kaiser members, please contact Member Services on your medical ID card.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact [Insert contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. The federal phone number for information and complaints is: **1-800-985-3059**. Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

IMPORTANT NOTICE

To All California-Based Subscribers and Enrollees

Members of vision service plans are entitled to receive annual notification of their vision service plans' complaint process and timely access to care. As a result, the enclosed notice contains information regarding VSP's complaint system, access to care and the methods by which VSP members can communicate their comments to VSP.

At VSP, we're dedicated to continually providing exceptional service to our members. By listening to the needs of our customers—whether they have complaints or compliments—VSP can deliver the kind of personalized care and service we'd expect for ourselves.

VSP does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

You may file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

Mail to:
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F HHH Bldg.
Washington, D.C. 20201
Email to: OCRComplaint@hhs.gov

Grievance Process

If a VSP member has a complaint/grievance regarding VSP and/or a VSP network provider, you may immediately call VSP Member Services at **800.877.7195,** Monday through Saturday, 6:00 a.m. to 5:00 p.m. (Pacific Time). If a complaint is called in and not satisfactorily resolved within five (5) calendar days, you will receive a written acknowledgment letter and a written resolution letter within thirty (30) calendar days after receipt.

For written complaints, you may log on to **vsp.com** and complete the Member Grievance/Complaint Form and send it to: VSP Complaints and Grievances, P.O. Box 2350, Sacramento, CA 95741. VSP will respond by mail to acknowledge receipt and/or provide the status of the complaint within five (5) business days. VSP will resolve your complaint within thirty (30) calendar days from the date of receipt and keep a copy of your complaint and the response on file for seven (7) years.

If the thirty (30) calendar day standard appeal process seriously threatens a covered person's health or ability to function, the covered person can request an expedited, 24-hour, review of the complaint.

In accordance with State and Federal regulations, VSP will not discriminate against a member on the basis of filing a complaint or grievance.

Language assistance services are available. Call **800.877.7195** if you need assistance reading this letter, would like this letter written in your language, or need your cultural and/or linguistic needs met.

Auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, are available free of charge and in a timely manner when those aids and services are necessary to ensure equal opportunity to participate for individuals with disabilities. Call **800.877.7195 (TTY: 800.428.4833).**

Timely Access to Care

As a VSP member, you have the right to receive care and services in a timely manner.

Appointment Type	Timeframe
Routine Eye Exam	Within 15 business days
Non-Urgent Medical	Within 10 business days
Urgent Care	If call is received during office hours, and the doctor determines the need of the member to be urgent, member should be seen within 48 hours

Telephone Wait Times

- If you call your plan's customer service phone number, someone should answer the phone within 25 seconds during normal business hours.

Exceptions

- The purpose of the timely access law is to make sure you get the care you need. Sometimes you need appointment even sooner than the law requires. In this case, your doctor can request that the appointment be sooner.
- Sometimes waiting longer for care is not a problem. Your provider may give you a longer wait time if it would not be harmful to your health. It must be noted in your records that a longer wait time will not be harmful to your health.
- If you cannot get a timely appointment in your area because there are not enough providers, your health plan must help you get an appointment with an appropriate provider.

Language Interpreter Services
Covered Persons have the right to receive language interpreter services. When scheduling an appointment, they can tell the provider's office that they need an interpreter at the time of their visit.

Notice from the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll-free at **800.877.7195** and use your health plan's grievance process before contacting the Department.

Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**), a TDD line (**1-877-6889891**) for the hearing and speech impaired and its Internet Web site (http://www.dmhc.ca.gov) has complaint forms online.

The Department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Language Assistance

ATTENTION: If you speak another language, language assistance services, including oral interpretation and translated written materials, are available to you free of charge and in a timely manner. Call 1-800-877-7195 (TTY: 1-800-428-4833).

EEOC Notice Regarding CNB's Wellness Program

Wellness Counts is a voluntary wellness program available to colleagues eligible for City National Bank Benefits. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, you may be asked to complete a voluntary health risk assessment or "HA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which will include a blood test for total cholesterol, HDL, LDL, triglycerides, total cholesterol ratio, glucose, blood pressure, waist circumference, body mass index, and body fat percentage. You are not required to complete the HA or to participate in the blood test or other medical examinations. The HA is available throughout the whole plan year.

Incentives of up to $240 may be available for colleagues who participate in certain health-related activities, including, but not limited to, health coaching and health challenges. Although colleagues are not required to participate and complete certain health-related activities, only those who do so will be eligible to receive an incentive. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation, alternative standard or waiver. You may request a reasonable accommodation or an alternative standard by contacting Virgin Pulse at (888) 671-9395 or email support@virginpulse.com.

The information from your HA and the results from your past and future biometric screenings will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You are also encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual who will receive your personally identifiable health information is a health coach (including clinical staff such as physicians, nurses, screeners, and registered dietitians) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event, a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the CNB Benefits Helpline at **(213) 673-9127.**

Medical Exchange Notice: New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, a key provision of the Patient Protection and Affordable Care Act, also known as health care reform law, offered a new way for U.S. citizens and legal residents to buy health insurance -- the Health Insurance Marketplace (the "Marketplace"). The Marketplace is also referred to as the Exchange.
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 City National Bank.

What Is the Health Insurance Marketplace?

It's where individuals can go to buy individual health insurance when it's not available or desired through their employer or the employer of their spouse / domestic partner or parent. Each state will have its own Marketplace. Each Marketplace will offer various health plan options from which individuals can choose in order to meet their health care needs and their budget. The Marketplace is intended to offer "one-stop shopping" to find and compare private health insurance options.

Can Individuals Save Money on Health Insurance Premiums in the Marketplace?

Savings, in the form of reduced premium or cost sharing in the Marketplace, will depend on an individual's household income and if they qualify for any federal subsidy. Some people who do not have access to affordable, minimum value health care coverage through their employer may be eligible for a federal subsidy in order to make buying insurance through the Marketplace more affordable. The premium savings these individuals would be eligible for depends on household income. Certain income levels will not qualify for federal subsidy regardless of the availability of employment-based health coverage.

Because City National Bank's health plans meet the government's standards for minimum value and affordability, colleagues eligible for City National Bank health coverage likely will not qualify for a federal subsidy.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. Individuals who are eligible for health coverage through their employer that meets certain standards (as does City National Bank's health coverage) are not eligible for a tax credit through the Marketplace.

Some individuals may be eligible for a tax credit that lowers their monthly premiums or a reduction in cost- sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer *for employee-only coverage in the lowest cost option* is more than 8.39% of an employee's household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the health care reform law, an employee may be eligible for a tax credit.

Note: If you are eligible for health benefits through City National Bank and you purchase a health plan through the Marketplace instead of enrolling in health coverage offered by City National Bank, then you may lose City National's contribution (if any) to bank-sponsored coverage. In addition, the bank's contribution – as well as your contribution to bank-sponsored coverage – is often excluded from income for federal and state income tax purposes. Payments for coverage through the Marketplace are made on an after-tax basis.

What If I am Not Eligible for City National Bank's Health Plans?

If you are not eligible for City National Bank's health plans, or those plans are unaffordable, you should consider other options that may be available to you, such as coverage through your spouse's/domestic partner's employer plan, your parent's employer plan (if you are under age 26), Medicaid, Medicare or your state's Marketplace.
If you decide to enroll through the Marketplace, you will need to provide the Marketplace with the following information about City National Bank and our plans:

Employer name: City National Bank
Employer Identification Number EIN: 95-1780067
Employer address: 555 South Flower Street, 18th Floor,
City, State, Zip Code: Los Angeles, CA 90071
Employer telephone number: (213) 673-9127
Name of contact for employee health coverage: Benefits Manager
Phone number of contact (if different from above): (213) 673-9127
Email address of contact: Benefits@cnb.com

Can I Get More Information?

For information about City National Bank sponsored health plans, please visit InfoLink > Human Resources > Benefits > Benefits Site or Me@CNB > Myself > Benefits Resources. You may also contact the City National Bank's Benefits Department at (213) 673-9127 or by email at Benefits@cnb.com

For more information about the Marketplace in your state, please visit www.HealthCare.gov, the website sponsored by the Department of Health and Human Services. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost.

Medicare Part D Notice of Creditable Prescription Drug Coverage

Applies to Medicare-eligible Individuals Covered by a City National Bank Medical Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City National Bank 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. City National Bank has determined that the prescription drug coverage offered by its City National Bank Benefits group medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing City National Bank 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 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current prescription drug coverage under the City National Bank Benefits group medical plan will not be affected.

If you do decide to join a Medicare drug plan and drop your current City National Bank Benefits group medical plan coverage, be aware that you and your dependents may have to wait until the next Annual Enrollment period to get City National Bank Benefits group medical and prescription coverage back, provided you are eligible for City National Bank Benefits at that time.

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 City National Bank and do not 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 City National Bank HR/Benefits Department at (213) 673-9127 or by email Benefits@cnb.com.

NOTE: You will get this notice each year either separately or with your Annual Enrollment materials. You will also get it if this coverage through City National Bank changes. You also may request a copy of this notice through City National HR/Benefits Department at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will 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 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).

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. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prosthesis and physical complications at all stages of mastectomy, including lymphedemas

These benefits are subject to the City National Bank Benefits group medical plan's regular copayments and deductibles.

Newborns' and Mothers' Health Protection Act

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

Michelle's Law Notice

When a dependent child loses student status for purposes of City National Bank group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the City National Bank group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the City National Bank group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

The City National Bank group health plan must receive written certification by a treating physician of the dependent child, which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. To obtain additional information, please contact **Benefits@cnb.com**.

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

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

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

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

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

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

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

General Notice of COBRA Continuation Coverage Rights Introduction

COBRA continuation coverage is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you are an employee, you will 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 are the spouse of an employee, you will 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 becomes 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 is losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. In this case you should submit the change (e.g., remove your former spouse from coverage) online through Me@CNB. If you fail to submit the change timely, any right to continue coverage under COBRA may be lost.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

You may contact the Benefits Helpline at (213) 673-9127 or Benefits@cnb.com if you have questions about your or your dependent's right to coverage continuation under COBRA.