BI·STATE DEVELOPMENT

2027 Benefits Guide Union Participants

NEW BENEFITS INSIDE

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About This Guide

This guide describes the benefit plans available to you as an employee of Bi-State Development (BSD). The details of these plans are contained in the official plan documents. This guide is meant to cover the major points of each plan only and does not contain all of the terms and conditions of the plans. In the event of a discrepancy between the information in this guide and the information in the plan documents, the plan documents will govern.

2027 OPEN ENROLLMENT INFORMATION

All employees **MUST actively Re-Enroll** in Medical, Dental, Vision, benefits by **the end of Open Enrollment, October 23, 2026**. If you do not, **your coverage will end on December 31, 2026.**

You can re-enroll in your benefits through Oracle Self-Service or by making an appointment with a GES Counselor.

Unum benefits will roll over from 2026 to 2027.

To complete your enrollment, you will need to provide the below documents to the Benefits Department by Friday, November 20, 2026 or your dependent(s)/spouse may not be enrolled.

- Birth Certificates (if not provided before)
- Marriage License (if not provided before)
- Social Security Numbers

5 steps To Re-enroll in Your Benefits:

1. Carefully read the Benefits Guide
2. Schedule Appointment with Benefit Counselor
3. Consult with family to determine needs
4. Attend Appointment with Benefit Counselor
5. Print/Save & Retain Confirmation Statement—see below

Confirmation Statements

Print and retain your 2027 confirmation statement. Your Confirmation Statement will be required if corrections are needed after January 1, 2027. If you don't have a printer available when you enroll or make changes, you can print the statement to a file or save it as a PDF.

AFTER printing your Confirmation Statement, you must click SUBMT to save your enrollment.

Open Enrollment Timeline

Mid-August 2026
Informational letters mailed to employee's home address

Mid September 2026
2027 Benefits Guides mailed to employee's home address

September 28–October 15, 2026
Schedule appointment with a Benefits Counselor

October 5–October 23, 2026
Open Enrollment period when re-enrollment can be completed

October 6-16, 2026
On-site appointments with Benefits Counselors available

October 19-23, 2026
GES Call Center available for BSD employee calls

October 23, 2026
Open Enrollment ends and GES Call Center closes, end of business day.

November 20, 2026
Final day to turn in documentation for Open Enrollment (birth certificates, marriage license/certificate, Social Security Numbers, etc.)

January 1, 2027
New benefits take effect

January 1, 2027
Union's first weekly paycheck with new deduction amounts. Employees should verify deductions are correct.

February 28, 2027
Last day to notify Benefits Department of corrections needed (Confirmation Statement required; missed deductions may be due)

OPEN ENROLLMENT: WHAT'S NEW!

BENEFITS	WHAT'S NEW	COVERAGE/WEEKLY CONTRIBUTION Contributions are in dollars and cents per pay period; medical, dental and vision amounts are Deducted on a pre-tax basis. 2027 has 53 weekly pay periods			
Medical and Pharmacy Coverage Provided by Cigna and Express Scripts	**ATU Contribution Amounts**	**ATU**	**Cigna Premium**	**Cigna Preferred**	**Cigna Economy**
		EE Only	$92.21	$38.33	$11.70
		EE + Sp	$179.79	$74.74	$22.83
		EE + Ch	$165.03	$68.61	$20.94
		EE + Fam	$252.65	$105.02	$32.09
	IBEW Contribution Amounts	**IBEW**	**Cigna Premium**	**Cigna Preferred**	**Cigna Economy**
		EE Only	$89.65	$35.77	$9.15
		EE + Fam	$213.05	$91.92	$32.06

Dental Insurance Provided by Delta Dental of Missouri	High Option: Dental Implants will be covered at 50%, $1,500 annual max.	**Delta Dental**	**High Option**	**Low Option**
		EE Only	$0.00	$0.00
		EE + Fam	$9.19	$5.63

Vision Insurance Provided by EyeMed	Enhanced Benefits at Plus Providers: Target, LensCrafters, Pearl, and Vision Source		**EyeMed Vision**
		EE Only	$0.89
		EE + Sp	$1.68
		EE + Ch	$1.77
		EE + Fam	$2.63

401K Plan	Voluntary Contributions BSD Matching	Employees may elect voluntary basic contributions. BSD matches employee's basic contributions at a rate of 50% (5% employee contributions get 2.5% in BSD matching contributions). Basic contributions, BSD matching contributions and vesting are per union contract.

OPEN ENROLLMENT: WHAT TO DO

Scheduling an appointment with a counselor

Appointments must be scheduled by October 15:

1. Go to www.MyEnrollmentSchedule.com/BiState.
2. Click on "Schedule Your Appointment", select the location and date you want and click "Show Appointments". Available appointments will appear below.
3. A confirmation email/text will be sent to you. This will be needed if you need to cancel.
4. A reminder email/text will be sent prior to your appointment.
5. Show up to your appointment with necessary documentation such as Social Security Numbers, Dates of Birth, Marriage and/or Birth Certificates if you are enrolling a new spouse or child.
6. Make sure you receive a printed Confirmation Statement.

If you are Enrolling in Oracle on Self-Service

1. Log into Oracle Self-Service
2. Click on "Benefits"
3. You will first see Dependents, then you will be able to **add and edit dependents**. You will remove dependent **coverage** later. **You cannot remove dependents from this list**.
4. Then click "Active Metro Benefits". This will show your current benefits.
5. Click "Next" on the upper right hand side
6. The next page will show your coverage options for 2027 and the per pay period cost.
7. Make your selections.
8. You will be asked to *finalize* your plan for 2027, including selecting the dependents to be covered in each of the plans.
9. Finally, you will *confirm* your elections and *print the confirmation page*.
10. **SUBMIT** your changes to save change.

Dependent(s)

You will only be able to add a **Spouse**, **Child**, or **Legal Dependent**. *No other category of dependent will be accepted (Grandchild, etc).*

When **adding** a dependent (spouse or child), you will need to send in:

- A copy of the Marriage Certificate, when adding a spouse
- A Birth Certificate that includes the employee's name, when adding a child
- A valid Social Security Number for all dependents

All documentation needs to be provided to the Benefits Department by **November 20, 2026**, unless it has previously been provided. If documentation is **NOT PROVIDED**, the dependent will NOT be enrolled in the elected coverage.

Current Benefit Enrollment

Please note: these are the benefits you are currently enrolled in. The current benefit coverage will be in effect until December 31, 2026.

Benefit Enrollment for 2027

- Below are the benefit plans that you are able to enroll in for 2027.
- The coverage will begin on January 1, 2027.
- You can click "Active Metro Benefits" to see your current benefits. Once you are finished selecting the plans, click "Next" to go to the next page where you will select who you would like to enroll in the coverage.
- The price listed is the cost per pay period.

Finalization of Benefits for 2027

Before you finalize your benefit elections for 2027:

- Review your plan coverage and cost
- Review your dependent's enrollment in each plan (if applicable)
- Review your dependents information — Name, Date of Birth, Social Security Number
  - ◊ Remember that the Benefits Department requires a Marriage License for spouse
  - ◊ A Birth Certificate with the employee's name or spouse's name on it
  - ◊ A valid Social Security Number to enroll all dependents by November 20, 2026.

Once you have reviewed all of the information and gone back to correct any mistakes, click the "Next" button to go to the Confirmation page to Submit your enrollment. Your enrollment HAS NOT BEEN sent until you **SUBMIT** the Confirmation page.

Confirmation Page

By clicking the Submit button, you are confirming that:

- You are electing the below coverage which will begin January 1, 2027, and go the entire 2027 benefit year.
- You are electing to enroll the selected dependents in the same coverage and will provide any necessary documentation to the Benefits Department within the appropriate time or the coverage will be terminated.
- You are required to pay the premiums for the elected coverage in accordance with the Payment of Premiums policy

Print this page and keep a copy for your records. Verify this information with your January 1, 2027, paycheck. Click Submit to complete the enrollment process.

If you do not click **Submit**,
your changes will not be saved.

COUNSELOR SCHEDULE DATES**

October 6 to October 16, 2026 (For Two Weeks Only)

	HEAD QUARTERS 6th Floor Conf. Room	MAIN SHOP	DEBALIVIERE Breakroom	BRENTWOOD 1st Floor Breakroom	IL BUS 2nd Floor Conf Room	MO METROLINK Training Room	IL METROLINK Breakroom
Tuesday October 6	8a – 5p	8a – 5p 8a – 5p	8a – 5p 8a – 5p	8a – 5p	8a – 5p		
Wednesday October 7	8a – 5p	8a – 5p	8a – 5p	8a – 5p	8a – 5p	8a – 5p	8a – 5p
Thursday October 8	8a – 5p	5a – 2p	5a – 2p	8a – 5p 8a – 5p	5a – 2p		
Friday October 9		8a – 5p	8a – 5p	8a – 5p	8a – 5p	5a – 2p	5a – 2p
Monday October 12		8a – 5p 5a – 2p	5a – 2p	5a – 2p	8a – 5p 5a – 2p		
Tuesday October 13		10a – 7p	8a – 5p 10a – 7p	10a – 7p	10a – 7p	10a – 7p	10a – 7p
Wednesday October 14	8a – 5p	10a – 7p	10a – 7p	10a – 7p	10a – 7p	8 – 5p	8 – 5p
Thursday October 15	8a – 5p	8a – 5p	8a – 5p	8a – 5p	8a – 5p 8a – 5p		
Friday October 16		8a – 5p	8a – 5p	8a – 5p 8a – 5p	8a – 5p	8a – 5p	

IMPORTANT: ***Schedule your appointment for your prefered time.*** **This is our tentative schedule. Please refer to **www.MyEnrollment Schedule.com/BiState** for the most up-to-date schedule. Appointments take priority. Walk-ins may not be available.

**Tentative Schedule

MEDICAL PLAN COMPARISON

January 1, 2027 to December 31, 2027

	PREMIUM		PREFERRED		ECONOMY	
	Network Providers	Non-Network Providers	Network Providers	Non-Network Providers	Network Providers	Non-Network Providers
Annual Deductible	$0 - Individual $0 - Family	$500 - Individual $1,000 - Family	$500 - Individual $1,000 - Family	$700 - Individual $1,400 - Family	$700 - Individual $1,400 - Family	$1,300 - Individual $2,600 - Family
Employee Co-insurance	0%	20%	20%	30%	30%	40%
Out-of-Pocket Max (Includes deductible)	$0 - Individual $0- Family	$2,300 - Individual $4,600 - Family	$2,300 - Individual $4,600 - Family	$3,300 - Individual $6,600 - Family	$3,300 - Individual $6,600 - Family	$5,400 - Individual $10,800 - Family
Office Visit	$30 - Primary Care $40 - Specialist	You pay 20% Plan pays 80% after deductible is met	$20 - Primary Care $30 - Specialist	You pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met	You pay 40% Plan pays 60% after deductible is me
Well Child Care (See SPD for further clarification)	$30 - Primary Care $40 - Specialist	You pay 20% Plan pays 80% after deductible is met	$20 - Primary Care $30 - Specialist	You pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met	You pay 40% Plan pays 60% after deductible is met
Well Adult Care (See SPD for further clarification)	$30 - Primary Care $40 - Specialist	You pay 20% Plan pays 80% after deductible is met	$20 - Primary Care $30 - Specialist	You pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met	You pay 40% Plan pays 60% after deductible is met
Inpatient Hospital (includes physicians services)	No Charge Plan pays 100%	You pay 20% Plan pays 80% after deductible is met	You pay 20% Plan pays 80% after deductible is met	You pay $200 per admission then you pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met	You pay 40% Plan pays 60% after deductible is met
Pre-Certification - Inpatient	A Pre-Certification must be obtained prior to all Inpatient admissions, except in the case of an emergency admission. In the event of an emergency inpatient admission, the provider must notify Cigna Healthcare, Inc. within 48 hours of confinement. Failure to obtain required pre-certification could result in a benefit payment reduction or denial.					
Pre-Certification - Outpatient	A Pre-Certification must be obtained prior to selected outpatient procedures and diagnostic testing. Failure to obtain required pre-certification could result in a benefit payment reduction or denial.					
Outpatient Surgery	No Charge Plan pays 100%	You pay 20% Plan pays 80% after deductible is met	Plan pays 100% No deductible applies	You pay 30% Plan pays 70% No deductible applies	Plan pays 100% No deductible applies	You pay 40% Plan pays 60%
Emergency Room (co-pay waived if admitted from ER)	You pay $150 per visit, then plan pays 100%	You pay $150 per visit, then plan pays 100% after deductible is met	You pay $150 per visit then you pay 20%, plan pays 80% after deductible is met	You pay $150 per visit, then you pay 20%, plan pays 80% after deductible is met	You pay $150 per visit, then you pay 30%, plan pays 70% after deductible is met	You pay $150 per visit, then you pay 30%, plan pays 70% after deductible is met
Urgent Care (co-pay waived if admitted) (See SPD for further clarification)	You pay $40 per visit, then plan pays 100%	You pay $40 per visit, then plan pays 100%	You pay $30 per visit, then plan pays 100% No deductible applies	You pay $30 per visit, then plan pays 100% No deductible applies	You pay 30% Plan pays 70% after deductible is met	You pay 30% Plan pays 70% after deductible is met

This summary was prepared to show the member's copay and member's portion of the co-insurance and deductibles. This is for illustrative purposes only and does not cover all the terms and conditions of the plan. In the event of any discrepancies, the Plan document will prevail.

PRESCRIPTION – EXPRESS SCRIPTS

PARTICIPATING NETWORK PHARMACY	ATU COPAYS	IBEW COPAYS
30-day Retail	You pay $20 – Generic* You pay $25 – Brand You pay $40 – Multi-Source	You pay $8 – Generic* You pay $30 – Brand You pay $45 – Multi-Source
90-day Retail/Mail	You pay $40 – Generic* You pay $50 – Brand You pay $80 – Multi-Source	You pay $20 – Generic* You pay $75 – Brand You pay $112.50 – Multi-Source

*Max amount you can pay on Generic

DENTAL – DELTA DENTAL OF MISSOURI

BENEFITS	HIGH OPTION	LOW OPTION
Calendar Year Deductible	$50 – Individual $150 – Family	$50 – Individual $150 – Family
Calendar Year Plan Maximum	$1,500	$1,500
Preventive Services (Type A Expenses) (includes oral exams, x-rays, cleanings, fluoride treatment, brush biopsy, space maintainers)	No Charge - Plan pays 100% (deductible waived, not counted against annual plan maximum)	No Charge - Plan pays 100% (deductible waived, not counted against annual plan maximum)
Basic Services (Type B Expenses)	You pay 20% PPO Dentist You pay 30% Non PPO Dentist	You pay 20% PPO Dentist You pay 30% Non PPO Dentist
Major Services (Type C Expenses) (includes bridges, dentures, veneers,inlays, onlays, oral surgery) **NEW! Dental Implants now covered.**	You pay 50% PPO Dentist You pay 60% Non PPO Dentist	Not Covered
Orthodontia Care Now Covering all Ages (Waived and not subject to calendar year maximum)	50% PPO 50% Non-PPO	Not Covered
Lifetime Orthodontia Plan Maximum	$1,500	N/A

VISION

EyeMed Vision Plan		
SERVICES	**IN-NETWORK MEMBER COST**	**OUT-OF-NETWORK REIMBURSEMENT**
Exam Services		
Exam with Dilation, if necessary	$15 copay	Up to $40
Standard Contact Lens–Fit & Follow-up	Up to $40	N/A
Premium Contact Lens–Fit & Follow-up	10% off retail	N/A
Retinal Imaging	$0	Up to $39
Frames		
Frames	$25 copay; $130 allowance, plus 80% of charge over $130	Up to $45
Lenses		
Single Vision Lenses	$25 copay	Up to $40
Bifocal Lenses	$25 copay	Up to $40
Trifocal Lenses	$25 copay	Up to $60
Standard Progressive Lenses	$25 copay	Up to $80
Premium Progressive Lenses	$25 copay, plus 80% of total charge less $120 allowance	Up to $80
Lenticular Lenses	$25 copay	Up to $80
Lens Options		
UV Treatment	$15	N/A
Tint (Solid & Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $5
Standard Polycarbonate	$40	N/A
Standard Polycarbonate–Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-ons & Services	20% off retail price	N/A
Contact Lenses		
Conventional	$25 copay; $130 allowance, plus 85% of charge over $130	Up to $125
Disposable	$25 copay; $130 allowance, plus full balance over $130	Up to $125
Medically Necessary	$0 copay, paid in full	Up to $210
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A

EyeMed Vision Plan		
SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK REIMBURSEMENT
COVERAGE FREQUENCY		
Examination	Once every calendar year	
Lenses or Contact Lenses	Once every calendar year	
Frames	Once every calendar year	
HEARING AID DISCOUNT PROGRAM		
	40% discount off hearing exams and a low price guarantee on discounted hearing aids	N/A
PLUS PROVIDERS		
Exam with Retinal Imaging	$0	N/A
Frames	$25 copay: $180 allowance plus 80% of charge over $180	N/A

2027 Contribution Rates (per paycheck)		
ATU & IBEW	**Employee Only:**	$0.89
	Employee + Spouse:	$1.68
	Employee + Child(ren):	$1.77
	Employee + Family:	$2.63

Additional Benefits for using a Plus Provider

- **Exam $0** with retinal imaging using a Plus Provider
- **Additional $50** frame allowance at Plus Providers, a total of $180
- **Frame coverage** now every calendar year

*Plus Providers include Target, LensCrafters, Pearl, and Vision Source

BASIC LIFE, AD&D, AND FELONIOUS ASSAULT INSURANCE

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance or Felonious Assault Insurance is provided at no cost to active, full-time employees as follows:

BENEFIT WAITING PERIOD	1 YEAR OF SERVICE	
Basic Term Life Insurance Amount	CAR Employees: O&M/Clerical Employees: IBEW Employees:	$50,000 $50,000 $60,000
Term Life Plan Features	Right to Convert/Port Coverage Accelerated Death Benefit	
AD&D/Felonious Assault Insurance Amount	CAR Employees: O&M/Clerical Employees: IBEW Employees:	$150,000 – Felonious Assault Ins $150,000 – Felonious Assault Ins $60,000

DEPENDENT LIFE INSURANCE

Bi-State Development offers Dependent Life Insurance at employee's cost as follows:

BENEFIT WAITING PERIOD	1 YEAR OF SERVICE	
Dependent Life Insurance Options	Option 1: $10,000 spouse/$2,500 per child Option 2: $20,000 spouse/$5,000 per child Option 3: $25,000 spouse/$7,000 per child	
Dependent Life Insurance Eligibility	CAR Employees: O&M/Clerical Employees: IBEW Employees:	Eligible Not Eligible Eligible

Informational only - Employees are not required to re-enroll in the benefits listed above.

BI-STATE DEVELOPMENT 401(K) RETIREMENT SAVINGS PLAN

Bi-State Development offers employees access to a 401(k) Retirement Savings Plan as follows:

Benefit Eligibility	CAR Employees: O&M/Clerical Employees: IBEW Employees:	Eligible Eligible Eligible
IRS Contribution Limits	• $25,500 per year • Participants age 50+ may contribute “catch up” contributions up to an additional $8,500 per year • Unless designated as a Roth contribution, employee contributions are deducted on a pre-tax basis • Participants age 60-63 may contribute ‘enhanced catch-up’ contributions of $11,750	
Roth Account Feature	Allows contributions to be made on a post-tax basis.	
Vesting	All employee contributions and Bi-State matching contributions are immediately vested.	
Employee Basic Contributions	CAR Employees: O&M/Clerical Employees: IBEW Employees:	6% 5% 5%
Matching	Employee Basic Contributions are matched at a rate of 50%, i.e., BSD funds 50¢ for every $1 of basic contributions made by the employee. **NOTE:** Contributions in excess of the above noted basic contribution percentages and catch-up contributions are not matched.	

*Limits provided are for 2027 and are subject to change.

To Enroll in 401K

Contact Lincoln Financial

LincolnFinancial.com

1.800.234.3500

You are able to enroll, change/update your contributions or beneficiaries at any time online or via phone.

Contact Lincoln Financial for more information about rollovers.

VOLUNTARY BENEFITS OFFERED BY UNUM

The physical and financial health and wellbeing of our employees is very important to Bi-State Development. In order to make it easier for our employees to gain access to and pay for benefits to protect them from the unexpected, we have partnered with Unum to provide employees with access to a variety of voluntary individual insurance options. As a part of that partnership, Bi-State will provide employees with the convenience of payroll deduction to pay their Unum premiums.

The plans offered by Unum are individual products that can only be purchased through an agent licensed in the state where the applicant resides. Each year during open enrollment, we bring licensed Benefits Counselors on-site who are able to assist employees with all of the Unum products, but are also specifically trained to educate and assist employees with our core benefit offerings. Enrollment in any of the Unum products is strictly voluntary.

The next five pages contain high level information on the following products offered by Unum:

- Whole Life Insurance with an optional Long-Term Care Rider available
- Critical Illness Coverage
- Hospital Indemnity
- Pet Insurance
- Off-The-Job Accident Coverage
- Individual Short-Term Disability Coverage (Union employees only)

IF YOU ARE INTERESTED

in learning more about any of the Unum products, or enrolling in coverage, make an appointment to meet with a Benefits Counselor during Open Enrollment.

WHOLE LIFE INSURANCE – UNUM

Unum's Whole Life Insurance is designed to pay a death benefit to your beneficiaries, but it can also gain cash value you can use while you are living. This benefit offers an affordable, guaranteed level of premium that won't increase due to age. Unlike term life insurance offered through the workplace, this coverage can continue into retirement.

Who Can Get Coverage?

- **Individual Spouse Coverage** — **This coverage can be purchased without purchasing employee coverage. The minimum policy amount is $2,000,** but the actual benefit amount is based on the premium amount chosen, age at issue and tobacco usage. If you leave BSD, you can keep your spouse's policy and be billed directly at home.
- **Individual Child Coverage** — **This coverage can be purchased without purchasing employee or spouse coverage. Each policy covers one child or grandchild.** You can purchase coverage for each child/grandchild for as little as $1 per week. Benefit amounts are based on issue age and premium selected. Your children can keep the coverage, even if you leave BSD.

Additional Coverage Options:

- **Living Benefit Option Rider** — Automatically included at no extra charge on this policy is a Living Benefit Option Rider. You can request up to 100% of the death benefit amount (to a maximum of $150,000) if you are diagnosed with a medical condition that limits life expectancy to 12 months or less. Any payout you receive while you are living would reduce the amount of the benefit that would be paid to your beneficiaries when you die.
- **Waiver of Premium** — If you're disabled for at least six months before age 65 and you remain disabled, you won't have to pay premiums until you recover and return to work.
- **Long-Term Care Rider** — If purchased, will pay a percentage of the benefit toward the cost of a nursing home, assisted living facility or adult day care.

Advantages of the Plan

- Coverage is available to eligible employees up to age 80 who are actively at work.*
- You can buy coverage for your spouse and/or dependent children, even if you don't buy coverage for yourself.
- The policy accumulates cash value at a guaranteed rate of 4.5%.** Once your cash value builds to a certain level, you can borrow from the cash value or use it to purchase a smaller "paid-up" policy with no more premiums due.
- You get affordable rates when you purchase this policy through BSD, and it is paid for through convenient payroll deduction.
- You own the policy so you can keep this coverage if you leave the company or retire. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.

* Not on a leave of absence at the time of application.

**The policy's cash value is based on the non-forfeiture interest rate of 4.5% shown in the policy and the 2017 CSO mortality table. The cash value is guaranteed and will be equal to the values shown in the policy. Cash value will be reduced by any outstanding loans against the policy.

CRITICAL ILLNESS INSURANCE – UNUM

Unum's Group Critical Illness Insurance can help protect your finances from the expense of a serious health problem, such as a stroke or heart attack. Cancer coverage is also included. **You can choose a lump-sum benefit up to $30,000 that's paid directly to you at the first diagnosis of a covered condition.**

Lump sum benefits are paid directly to you and can be used any way you choose. You can also use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis. Benefits can be paid for a second occurrence of a benign brain tumor, coma, heart attack or stroke if at least twelve months elapses between occurrences.

Advantages of the Plan

- Coverage is available to eligible employees who are actively at work.*
- You may choose a benefit amount of $10,000, $20,000 or $30,000.
- You can purchase coverage for your spouse with purchase of employee coverage.
- Eligible children ages newborn to 26 years are automatically covered at 50% of employee benefit amount.
- You get affordable rates when you buy this policy through BSD, and the premiums are conveniently deducted from your paycheck.
- You own the policy so you can keep this coverage if you leave BSD or retire. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.

* Not on a leave of absence at the time of application.

What Is Covered?

Illnesses covered by the base plan include:

- Heart attack
- Stroke[1]
- Major organ transplant[2]
- Permanent paralysis due to a covered accident[3]
- End-stage renal (kidney) failure
- Cancer
- Coronary artery bypass surgery (pays 25% of lump-sum benefit)
- Carcinoma in situ[4] (pays 25% of lump-sum benefit)

A $50 ANNUAL WELLNESS BENEFIT IS INCLUDED.

Please refer to the policy for complete definitions of covered critical illnesses.

NOTE: Employee contribution rates will vary depending on amount of coverage purchased, spouse and/or child(ren) covered, employee age and employee tobacco status.

1 Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event.
2 Undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney or pancreas.
3 Complete and permanent loss of the use of two or more limbs for a continuous 180 days as a result of a covered accident.
4 Cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.

HOSPITAL INDEMNITY INSURANCE – UNUM

Unum's Hospital Indemnity Plan is designed to pay covered employees' and their families' expenses while helping them cope with the financial impacts of a hospitalization. The employee is eligible to receive benefits if they or a covered dependent is admitted to the hospital for a covered accident, illness, or childbirth*

Who Can Receive Coverage?

Individual Spouse Coverage

- You can only obtain coverage for your spouse if you have purchased coverage for employee.

Individual Child Coverage

- Dependent children newborn until their 26th birthday are eligible, regardless of marital or student status.

How The Plans Pay:

Hospital Admission

- Payable for a max of 1 day per year - $1,000

Hospital Daily Stay

- Payable per day up to 65 days - $100

ICU Daily Stay

- Payable per day up to 20 days - $200

Maternity Limitation

- *9 months from enrollment

Features You'll Appreciate

- The money is payable directly to you, the employee, not to a hospital or care provider.
- The money can also help you pay the out-of-pocket expenses your medical plan may not cover.
- When purchasing coverage at work, you get accessible rates.
- Premiums are deducted from your paycheck.
- If you would leave the company, you can take the coverage with you, but you will be responsible for the bill.

2027 Contribution Rates (per paycheck)

Employee Only:	$3.69
Employee + Spouse:	$7.56
Employee + Child(ren):	$5.24
Employee + Family:	$9.11

OFF-THE-JOB ACCIDENT INSURANCE – UNUM

Unum's Group **Off-The-Job Accident Insurance can pay lump-sum benefits based on the injury** you receive and the treatment you need, including emergency room care and related surgery. The benefit can help offset the out-of-pocket expenses that medical insurance does not pay, including deductibles and copays.

What Is Covered?

Covered injuries include:

- Fractures
- Dislocations
- Burns
- Lacerations repaired by stitches
- Concussions
- Eye injuries
- Ruptured discs
- Coma

Covered expenses include:

- Ambulance
- Urgent Care visits
- Emergency Room treatment
- Medical Imaging (MRI, CT, etc.)
- Related surgery
- Doctor office visit – follow-up care
- Hospitalization
- Physical therapy

See the schedule of benefits for a full list of covered injuries and expenses.

Features You'll Appreciate

- Coverage is available to all eligible employees who are actively at work.*
- You can buy coverage for your spouse and dependent children.
- Coverage is guaranteed issue if you enroll during 2027 open enrollment.
- This plan includes convenient payroll deduction, so you don't have to remember to write a check for your premiums.
- Coverage is portable. You may take the coverage with you if you leave BSD or retire without having to answer new health questions. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.
- Benefits are paid for off-the-job accidents only.
- A Catastrophic Benefit is included with this plan. This pays an additional sum if a covered individual has a serious injury — such as loss of sight, hearing or a limb.

*Not on a leave of absence at the time of application.

2027 Contribution Rates (per paycheck)

Employee Only:	$1.14
Employee + Spouse:	$2.07
Employee + Child(ren):	$3.69
Employee + Family:	$4.62

INDIVIDUAL SHORT-TERM DISABILITY – UNUM

Unum's Individual Short-Term Disability Insurance **replaces a portion of your income if you are unable to work due to a covered injury or illness.** This coverage can pay a monthly benefit to provide some income replacement during a time of need. Common reasons people use this coverage include **off-the-job injuries, covered pregnancy and scheduled covered surgery.**

You have the opportunity to purchase the amount of individual short-term disability coverage you want based on your budget and the amount of your income you wish to insure. The percentage of your income that you insure is paid to you following a 30-day elimination period for an approved claim. Benefits are paid for up to 6 months.

During this open enrollment period, if you are benefit eligible, age 17 to 69 and actively at work, **you can apply for coverage of up to 60% of your gross monthly salary up to a maximum of $5,000.**

- **Maternity coverage** — Pregnancy is not covered during the first nine months the policy is effective. Medical complications of pregnancy may be considered as any other covered illness subject to the pre-existing condition limitation.
- **Pre-existing condition limitation** — Conditions that were diagnosed and treated in the 12 months immediately prior to the coverage effective date are not covered for the first 12 months the policy is in force.

Features You'll Appreciate

- Payroll deduction — Your premiums are automatically deducted from your paycheck.
- Affordable coverage — Your premiums are based on your age when you buy the insurance and will not increase when you move into the next age band.
- Guaranteed renewable — You own the policy and can take it with you if you leave BSD or retire. As long as you pay the premiums on time, your coverage is guaranteed renewable until age 72.
- Because you pay your premium with post-tax dollars, your benefit will not be taxed (under current tax laws).

PET INSURANCE – UNUM

Unum Pet Insurance provided by Nationwide, the nation's leading pet insurance provider.

What Is Covered?

- Accidents and injuries
- Common Illnesses
- Serious Illnesses
- Chronic Illnesses
- Hereditary conditions
- Testing and diagnostics
- Procedures
- Holistic and alternative care
- And more

3 Plans Available

- **Accident and Illness**
- **Accident, illness, and wellness**
- **Customizable**

Advantages of the Plan

Every policy includes guaranteed issuance and additional benefits to support pet families.

- Prescription drug discounts at participating pharmacies
- Emergency boarding and kenneling fees
- 24/7 Telehealth vet services
- Lost pet due to theft or straying
- Lost pet advertising and reward
- Mortality benefit

What's the difference between accident, illness and wellness coverage?

Accident Coverage

• Support for unexpected injuries

Illness coverage

• Support for when pets get sick

Wellness coverage

• Support for proactive care

• • • • •

What can be reimbursed under the policy?

Accident[1]

• Broken bones • Sprains • Hit by car

• Poisonings • Lacerations • Ingested item

Example: Poisoning, Veterinary Bill: $1,035

Plan reimburses: $828

Illness

• Ear infections • Hip dysplasia • Cancer

• Vomiting • Lacerations • Diabetes

Example: Cancer, Veterinary Bill: $2,266
Plan reimburses: $1,813

Wellness

• Annual exam • Fecal test • Microchip

• Vaccinations • Deworming • Flea control

Example: Flea control, Veterinary Bill: $171

Plan reimburses: $100

1 Example reflects Accident and Illness coverage with 80% reimbursement after annual deductible has been fulfilled and Wellness Level 1 coverage.

FREQUENTLY ASKED QUESTIONS

1. **Who do I contact if I have questions after I enroll?**
   Contact the BSD Benefits Department:
   Phone: 314.982.1400, ext. 3006
   Fax: 314.335.3431
   Email: Benefits@BiStateDev.org
   Monday – Friday | 8:00 a.m. – 4:00 p.m.

2. **What are the documentation requirements for dependents?**
   - To cover a dependent spouse, a copy of the marriage license is required.
   - To cover a dependent child, a copy of their birth certificate is required.
     - ◊ The birth certificate must show the BSD employee name as one of the parents to be considered acceptable.
   - In the case of a stepchild, along with the birth certificate, a marriage license that shows the name of the parent listed on the birth certificate is also required.
   - Social Security Numbers are required for all dependents.

   Documentation must be turned in to the Benefits Department by November 20, 2026.

   Please include the employee's name and badge number on the documentation.

3. **What happens if I don't submit the required dependent documentation by the deadline?**
   If the required dependent documentation is not received by the Bi-State Development Benefits Department by the deadline, the new dependent will not be added to your coverage.

4. **Who do I contact if the deduction from my paycheck is not as expected?**
   Contact the BSD Benefits Department:
   Phone: 314.982.1400, ext. 3006
   Monday – Friday | 8:00 a.m. – 4:00 p.m.

   Submit your Confirmation Statement to the Benefits Department by February 28, 2027, for corrections; missed deductions may be owed.
   Fax: 314.335.3431
   Email: Benefits@BiStateDev.org

5. **Who should I contact if I didn't receive an ID card?**
   Contact the appropriate coverage carrier. Carrier contact information can be found on page 31.

6. **Where can I get instructions on how to enroll via Oracle Self-Service Benefits?**
   Go to www.BiStateDev.org, then click on "Employee Resources" in the lower left corner. Next, click on the "Benefits Information" ribbon and look for "2027 Open Enrollment Resources." (You might need to scroll down.) See the "What To Do" section on page 3.

7. **What happens if I don't enroll?**
   Your current 2026 benefit elections will terminate on December 31, 2026. You will not be able to enroll in benefits until the next Open Enrollment period, which is October 2027, effective January 1, 2028. Unless you have a Qualifying Life Event.

IMPORTANT NOTICE FROM BI-STATE DEVELOPMENT ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

(Medicare Part D Certificate of Creditable Coverage Notice)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bi-State Development 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. Bi-State Development has determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as the 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 decide to join a Medicare drug plan at a later date.

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–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 do decide to join a Medicare drug plan and drop your current Bi-State Development coverage, be aware that you and your dependents will not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Bi-State Development 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 Bi-State Development's Director of Benefits for further information or call the Benefits Department at 314.982.1400, ext. 3006.

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 Bi-State Development changes. You also may request a copy of this notice at any time.

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 online 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:	September 1, 2026
Name of Entity/Sender:	Bi-State Development
Contact–Position/Office:	Benefits Department, Mail Stop 125
Address:	211 North Broadway, Suite 700 St. Louis, MO 63102
Phone Number:	314.982.1400, ext. 3006

Women's Health and Cancer Rights Act Annual Notice

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 1.800.244.6224 for more information.

Notice for Grandfathered Health Plans

Bi-State Development believes its self-funded plan, administered by Cigna, is a "grandfathered health plan" under the Patient Protection and the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from the grandfathered health plan status can be directed to the Plan Administrator at 1.800.244.6224.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

  Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Bi-State Development, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment 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 coverageFor more information visit 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

Bi-State Development
211 N. Broadway,
Suite 700, MS 125
St. Louis, MO 63102

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. 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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ 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/flmedicaidtplrecover y.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (HAWKI)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid I Health & Human ServicesMedicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa I Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084	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
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/care/healthcoverage Phone: 1-800-657-3739
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

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

To see if any other states have added a premium assistance program since July 31, 2026, 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 Labor
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 5/31/2029)

BI-STATE DEVELOPMENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder ("HIPAA") require a health plan to notify participants about its privacy policies and procedures with respect to participants' health information. This document is intended to satisfy HIPAA's notice requirement.

This notice is effective as of September 1, 2026. If you have any questions about this notice, please contact:

Health & Welfare Plan Manager
Bi-State Development
211 North Broadway, Suite 700
St. Louis, Missouri 63102-2759
314-982-1400, ext. 3006

Bi-State Development and its Affiliates (the "Employer") maintain the Bi-State Development Health Plan and the Bi-State Development Employee Assistance Program (individually and collectively referred to as the "Plan" and the "Plans" throughout this notice). The Plans have authorized certain employees of the Employer to have access to your health information (referred to as "employees with access"), so that they may perform certain administrative functions for the Plans. These administrative functions—treatment, payment, and health care operations—are described below. Employees with access also may use and disclose your health information for other purposes, which are outlined in this notice.

Third party "business associates" that perform various services for the Plans also may have access to your health information. However, the Plans' business associates have agreed to safeguard your health information in accordance with HIPAA.

This notice will tell you about the ways in which employees with access to your health information and the Plans' business associates may use and disclose such information. It also describes the Plans' obligations and your rights regarding the use and disclosure of your health information.

The Plans are required by HIPAA to:

- Make sure that your health information is kept private;
- Give you this notice of the Plans' legal duties and privacy practices with respect to your health information; and
- Follow the terms of the notice that is currently in effect.

The Plans also are required to designate a Privacy Officer who is responsible for the development and implementation of the Plans' Privacy Policies and Procedures. The Plans have designated the Director of Benefits as the Privacy Officer. The Privacy Officer may be contacted as follows:

Health & Welfare Plan Manager
Bi-State Development
211 North Broadway, Suite 700
St. Louis, Missouri 63102-2759
314-982-1400, ext. 3006

How Employees with Access and Business Associates May Use and Disclose Your Health Information

The following categories describe different ways in which employees with access and the Plans' business associates are permitted or required to use and disclose your health information. Not every use or disclosure in a category will be listed.

For Treatment. Employees with access and business associates may use and disclose your health information to facilitate medical treatment or services by health care providers. For example, if you are unable to provide your medical history as the result of an accident, a business associate may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. Employees with access and business associates may use and disclose your health information to make coverage determinations and payment in accordance with the terms of the Plan (this includes billing, claims management, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorization). For example, a business associate may tell your health care provider whether you are eligible for Plan coverage. Also, your health information may be shared with another health plan to coordinate benefit payments. Members of the Plan's Claims Review Committee will have access to any of your health information that is relevant to an appeal you file under the Plan.

For Health Care Operations. Employees with access and business associates may use and disclose your health information to enable the Plan to operate or to operate more efficiently. This includes conducting quality assessment and improvement activities, submitting claims for stop-loss coverage, determining employee contributions, conducting or arranging for medical review, legal services, audit services, disease management, case management, planning and development, and general Plan administrative activities. For example, the Plan may use your claims information to refer you to a disease management program, project future benefit costs, or audit the accuracy of its claims processing functions. In addition, the Plan may contact you to provide you information about treatment alternatives or other health-related benefits that may be of interest to you.

Other Permitted Uses and Disclosures.

- The Plan may be required by law to disclose your health information.
- The Plan will make your health information available to you, and to the Secretary of the Department of Health and Human Services for purposes of HIPAA enforcement.
- Your health information may be disclosed to a public health agency. This may include disclosing your health information to report certain diseases, death, abuse, neglect or domestic violence or reporting information to the Food and Drug Administration if you experience an adverse reaction from any of the drugs, supplies or equipment that are involved in your care.
- Your health information may be disclosed to government agencies so they can monitor, investigate, inspect, discipline or license those who work in the healthcare system or for government benefit programs.
- Your health information may be disclosed as authorized by law to comply with workers' compensation laws.
- Your health information may be disclosed in the course of a judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Your health information may be disclosed to law enforcement officials to report or prevent a crime, locate or identify a suspect, fugitive or material witness or assist a victim of a crime.
- Your health information may be used or disclosed to avert a serious threat to health or safety if the use or disclosure is necessary to prevent a serious and imminent threat to the health or safety of a person or to the public, and is disclosed to a person who is reasonably able to prevent or lessen the threat, including the target of the threat.
- Your health information may be used or disclosed for limited research purposes, provided that a waiver of the authorization required by HIPAA has been approved by an appropriate privacy board.
- If you are a member of the armed forces, the Plan may disclose your health information as required by military command authorities or to evaluate your eligibility for veteran's benefits. The Plan may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- Your health information may be disclosed to coroners, health examiners and funeral directors so that they can carry out their duties or for purposes of identification or determining cause of death.
- Your health information may be disclosed to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.
- The Plan may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your health information to the correctional institution or law enforcement official.
- Your health information may be disclosed to your spouse, a family member or a close personal friend if the health information is directly relevant to your spouse's, family member's or close personal friend's involvement with payment related to your health care.

Pursuant to an Authorization. The following uses and disclosures of your protected health information will only be made with your written authorization:

- Uses and disclosures of psychotherapy notes
- Disclosures that constitute a sale of your protected health information
- Uses and disclosures of your protected health information for marketing purposes
- Uses and disclosures of your protected health information beyond the uses and disclosures described in this notice

If you give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer. Disclosures that were made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights with Respect To Your Health Information

You have the following rights with respect to your health information:

Right to Inspect and Copy. You have the right to inspect and copy your coverage, payment and claims record and other health information used by the Plan to make benefit determinations about you. To inspect and copy such information, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may file a complaint regarding the denial.

Right to an Electronic Copy of Electronic Medical Records. If your protected health information is maintained in an electronic format (known as an electronic medical record or electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health information in the form or format that you request, if it is readily producible in such form or format. If the protected health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a reasonable hard copy format. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified if any of your unsecured protected health information is breached.

Right to Amend. You have the right to request that the Plan amend your coverage, payment and claims record and other health information used by the Plan to make benefit determinations about you. You have the right to request an amendment for as long as the information is maintained by or for the Plan.

To request an amendment, you must submit your request in writing to the Privacy Officer. In addition, you must provide a reason that supports your request.

If your request is denied in whole or in part, the Plan will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosure of your health information.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of the Plan's disclosures of your health information during a time period which may be no longer than six years prior to the date of your request. There are exceptions to the types of disclosures for which the Plan is required to account. For example, the Plan is not required to give you an accounting of disclosures of your health information for purposes of treatment, payment or health care operations, and is not required to account for disclosures made prior to April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12 month period will be free. For additional accountings, the Plan may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction on the health information that the Plan may use or disclose about you for treatment, payment or health care operations, or that the Plan may disclose to your spouse, a family member or a close personal friend who is involved with payment related to your health care.

We are not required to agree to your request.

Requests for restrictions must be made in writing to the Privacy Officer. In your request, you must provide: (1) what information you want to restrict; (2) whether you want to restrict use, disclosure or both; and (3) to whom you want the restrictions to apply.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you in a certain way or at a certain location, such as only at work or by mail.

Requests for confidential communications must be made in writing to the Privacy Officer. The Plan will attempt to honor all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes To This Notice

The Plan reserves the right to change the terms of this notice. The Plan reserves the right to make the revised notice effective with respect to all of your health information already maintained by the Plan, as well as any of your health information maintained by the Plan in the future. In the event of a material change to the notice, a revised version of the notice will be provided by mail.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Director of Benefits listed at the beginning of this notice. All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. **Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: *We use health information about you to develop better services for you.*

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date

This notice is effective as of February 16, 2026. If you have questions about this notice, please contact:

BI-State Development
Health & Welfare Plan Manager
211 N. Broadway, Suite 700
St. Louis, MO 63102-2759
314-982-1400 ext. 3006

RESOURCES

BENEFIT	CARRIER	PHONE NUMBER	WEBSITE
Bi-State Development Benefits Hotline	211 N. Broadway, Suite 700 Attn: Benefits St. Louis, MO 63102	314-982-1400, ext. 3006 Fax: 314-335-3431	www.BiStateDev.org Email: Benefits@BiStateDev.org
Medical	Cigna	1-800-244-6224	www.MyCigna.com
Employee Assistance Program (EAP)	Evernorth Behavioral	1-877-622-4327	www.CignaBehavioral.com Employer ID: metrostlouis
Prescriptions	Express Scripts	1-866-509-9660	www.Express-Scripts.com
Dental	Delta Dental of Missouri	1-800-335-8266	www.DeltaDentalMO.com
Vision	EyeMed	1-866-723-0514	www.EyeMed.com
Critical Illness Hospital Indemnity Off-The-Job Accident Whole Life Short-Term Disability Pet Insurance Insurance	Unum	1-800-635-5597	www.Unum.com
401(k)	Lincoln Financial Mike Stelzig	1-800-234-3500 1-866-434-8903	www.LFG.com
Pension Plan Administrator	Milliman	1-877-265-7703	www.MillimanBenefits.com

BI·STATE DEVELOPMENT

metro

GATEWAY ARCH

ST. LOUIS DOWNTOWN AIRPORT

RIVERBOATS AT THE GATEWAY ARCH

ST LOUIS REGIONAL FREIGHTWAY