Charles City County Public Schools

2019/2020 Employee Benefits Guide

October 1, 2019 – September 30, 2020

MARSH & McLENNAN AGENCY

Charles City Public Schools
Tradition • Technology • Excellence

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WELCOME TO YOUR BENEFITS OPEN ENROLLMENT!

Our 2019 Benefits Guide will provide you with an overview of the comprehensive and rewarding benefits package offered by Charles City County Public Schools. We value your service as an employee and our competitive benefits are one way that we thank you for all that you bring to Charles City County Public Schools. We are proud to offer you a benefits program designed to protect the health and financial security of you and your family.

WE ARE HERE TO HELP

If you have any questions about the employee benefits described herein or would like more information, please refer to your plan documents and insurance booklets or contact:

- Human Resources Department
    - Bea Banks
    - BBanks@ccps.net
    - 804-652-4618

BENEFITS OVERVIEW

Charles City County Public Schools carefully evaluates our employee benefit offerings each year to ensure we are providing our employees a competitive program. Please take note of the following for 2019:

- Medical Benefits are remaining with Anthem with a few minor changes in the plan designs.
- The Pharmacy vendor with Anthem has changed to Ingenio. ***Most prescriptions will transfer over, but you must reorder your prescription for mail order.***
- EAP is remaining with Anthem.
- Health Equity will still be HSA vendor.
- Dental is remaining with Anthem with a slight increase in premiums.
- HSA contribution limits have increased to $3,500/$7,000 in 2019 with a slight increase in 2020 ($3,550/$7,100).
- Voluntary Vision is remaining with EyeMed with no changes.
- Voluntary Accident and Voluntary Critical Illness is remaining with AFLAC.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 24 for more details.

ELIGIBILITY & ENROLLMENT

Benefits Eligibility

If you are a full-time employee, working 30 or more hours per week, you are eligible to enroll in the benefits described in this guide first of the month following your date of hire. Eligible dependents may enroll in medical, dental, and vision coverage. Eligible dependents include:

- Your legal spouse
- Children up to age 26
- Unmarried children over age 26 who are incapable of self-support

How to Enroll

1. Evaluate plan options and make your benefit elections on the Employee Navigator website.
2. Verify your personal and dependent information and make changes as needed.
3. Submit elections through employee navigator by September 6, 2019.

When to Enroll

The open enrollment period runs from August 26, 2019 through September 6, 2019. The deadline for submitting your election is September 6, 2019. The benefits you elect during open enrollment will be effective from October 1, 2019 through September 30, 2020.

Making Changes

Several benefits may only be elected or changed during open enrollment or with a qualified life change. You must log into Employee Navigator **within 30 days** of date of your qualifying event to make the change. After that you will have to wait until the next annual open enrollment.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Open Enrollment is August 26th to September 6th

Elections will take effect on October 1, 2019

MEDICAL COVERAGE

Anthem

For this plan year, you can choose from the following Anthem medical plans. Coverage includes preventative care and prescription drug benefits. Refer to the medical summary of benefits for complete details.

Key Terms

- A **premium** is the amount you pay out of your paycheck for insurance coverage
- A **deductible** is the amount you pay before the plan contributes to the cost for services
- A **copay** is a fixed amount you pay for medical services or prescription drugs
- **Coinsurance** is the percent of charges you pay after you reach the deductible until you reach the plan's out-of-pocket maximum
- The **out-of-pocket maximum** is the most you will pay during the plan year for health care expenses, including your deductible, copays, and coinsurance

Plan Option 1

KeyCare 25 PPO – This is a preferred provider network that has a lower deductible and annual out-of-pocket maximum. You are not required to pick a primary care physician and do not need referrals for specialist visits. Office Visit (PCP/Specialist) has a $25/$50 copay. In exchange for these predictable costs and flexibility, this plan has the highest employee premium. Rx copays will increase slightly effective October 1, 2019.

Plan Option 2

HealthKeepers POS OA 25 – This is a "point of service" plan that allows you to select a primary care physician but you will not need authorized referrals to in-network specialists. Out-of-network care is covered but you will be 30% coinsurance after you have met your deductible. Office Visit (PCP/Specialist) has a $25/$50 copay. Rx copays will increase slightly effective October 1, 2019.

Plan Option 3

HealthKeepers HSA 3000/20%/5000 – This is a high deductible health plan that is paired with a tax-advantaged health savings account (HSA). This option has the highest deductible; however, you can contribute pre-tax funds to your HSA to help offset out-of-pocket costs. If electing employee only coverage, you do not pay a cost. For all other tiers, employees will pay a lower payroll contribution compared to the PPO plan. ***If you enroll in this plan under employee only, your employer will contribute $178.06 ($89.03 per pay) to your HSA.*** You will also automatically receive a $5,000 critical illness benefit. For the first time, Employee + Child coverage will be at no cost and the School will add $1.71 per pay to your Health Savings Account.

Find a Network Doctor

Visit www.anthem.com for a list of In-Network doctors near you

MEDICAL PLAN COMPARISON

2019 Changes noted in red.

	KC 25 500/20%/4000 15/50/85/20% Rx	HK POS OA 25 500/20%/4000 15/50/85/20% Rx	HK HSA 3000/20%5000 Ded 20% Rx
In Network Benefits	**In Network**	**In Network**	**In Network**
Accumulators (Calendar Year or Plan Year)	PY	PY	PY
Deductible (Ind/Fam)	$500/$1,000	$500/$1,000	$3,000/$6,000
Out of Pocket Max (Ind/Fam)	$4,000/$8,000	$4,000/$8,000	$5,000/$10,000
Coinsurance	20%	20%	20%
Office Visit - (PCP/Specialist)	$25/$50	$25/$50	20% after ded
Preventive Care	No Charge	No Charge	No Charge
Urgent Care	$50	$50	20% after ded
Emergency Room	20% after ded	20% after ded	20% after ded
Inpatient Hospital	20% after ded	20% after ded	20% after ded
Outpatient Surgery	20% after ded	20% after ded	20% after ded
Labs/Xrays	20% after ded Pref Diag Lab : no charge	Office: no charge Facility: 20% after ded Pref Diag Lab: No charge	20% after ded
Advanced Diagnostic Imaging	20% after ded	20% after ded	20% after ded
Telemedicine Visit	$15	$15	$49 up to ded 20% after ded
Vision Exam	$15	$15	$15
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**
Deductible (Ind/Fam)	$1,000/$2,000	$1,000/$2,000	$6,000/$12,000
Out of Pocket Max (Ind/Fam)	$8,000/$16,000	$8,000/$16,000	$10,000/$20,000
Coinsurance	40%	30%	30%
Prescription Drug Benefits			
Deductible (Ind/Fam)	n/a	n/a	after medical ded
Retail – Tiers 1,2,3,4	$15/$50/$85/20% to $250	$15/$50/$85/20% to $250	20% after ded
Mail Order - Tiers 1,2,3,4	$38/$125/$213/20% up to $250	$38/$100/$150/20% to max $250	20% after ded

TELEMEDICINE

Anthem's telemedicine benefit allows you to visit with local board-certified doctors online via video using your phone or computer any time, from practically anywhere. Their national network is available 24/7, including holidays to provide affordable quality care. Online physicians can diagnose, treat, and write prescriptions for routine medical conditions.

KC 25 500/20%/4000 15/50/85/20% Rx	HK POS OA 25 500/20%/4000 15/50/85/20% Rx	HK HSA 3000/20%5000 Ded 20% Rx
$15	$15	$49 up to ded 20% after ded

All you have to do is sign up at www.anthem.com or download the free mobile app to get started.

Common Conditions treated include: Allergies, Asthma, nausea, cold & flu, ear aches,

pink eye, rashes, sinus, and urinary tract infections.

Behavioral Health

Seeking help for depression, stress and other types of mental illness is a big step. LiveHealth® Online makes it easier for you to take that step by providing convenient access to licensed therapists in the privacy of your own home or office. The cost is similar to what you'd pay for an office therapy visit. Psychologists and therapists seen through LiveHealth Online Psychology can help you 7 days a week with many conditions. Including:

- Stress
- Anxiety
- Depression
- Relationship or family issues
- Grief
- Panic attacks
- Coping with an illness

Mobile App

Whether you're traveling across the country, across the state, or just away from home, Anthem's Mobile app keeps your health information within reach, wherever you go.

With the mobile app you can:

- ✓ Find a Doctor
- ✓ Get your ID card
- ✓ Estimate your costs
- ✓ Manage Prescription benefits
- ✓ Access your health records
- ✓ And more!

Download the Mobile app today at www.anthem.com!
It is available for iOS and Android devices!

HEALTH SAVINGS ACCOUNT

HealthEquity

If you enroll in the High Deductible Health Plan (HK HSA 3000/20%5000 Ded 20% Rx), you can also open a Health Savings Account (HSA) to help pay for eligible medical expenses. Charles City County Public Schools ***will make a monthly contribution to the Health Savings Account of $178.06 ($89.03 per pay) when you enroll in employee only coverage. This year the Employee plus child tier will be $0 and we will contribute $3.42 a month to your HSA. Employees will pay the $2.35 monthly administration fee.***

→ **What is an HSA?**

An HSA is a deposit account that you can use to pay for current and future qualified medical expenses – tax-free. Money in your HSA earns interest and can be invested to help you build funds faster.

→ **Who is eligible to open an HSA?**

To open an HSA, you must be enrolled in the HDHP plan. You cannot be a dependent on another person's tax return, be enrolled in Medicare if you're over 65, or have received medical care from Veteran's Affairs during the previous 3 months unless the veteran has a service related disability rating.

→ **What is the tax benefit associated with an HSA?**

The money you contribute to your HSA is tax-deductible and can be used for expenses for yourself and your dependents. You can maximize your tax savings by contributing up to the maximum annual amount allowed by the Internal Revenue Service (IRS). Your HSA balance plus investment earnings carry over from year to year – tax-free.

Plus – your HSA funds are yours to keep – even if you switch health plans, change jobs, or retire.

Maximum HSA Contributions*	2019	2020
Individual	$3,500	$3,550
Family	$7,000	$7,100
Catch-up – 55 or older	Additional $1,000	

* Maximums include any employer contribution

→ **What are qualified medical expenses?**

The IRS maintains a list of all eligible medical expenses, common qualified expenses include:

- Acupuncture
- Ambulance services
- Dental treatment
- Contact lenses
- Doctor's fees
- Hearing aids
- Chiropractic Care
- COBRA premiums

View the complete list of qualified expenses at: https://www.irs.gov/publications/p502/index.html

Health Equity is the administrator of our HSA Benefits. See their website at: www.healthequity.com.

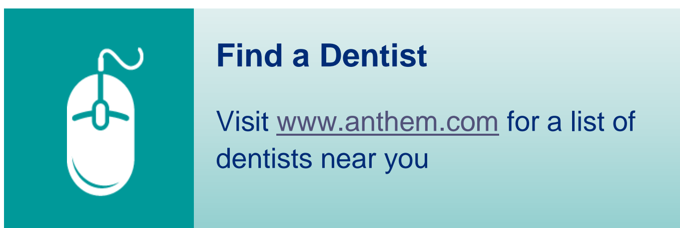
DENTAL

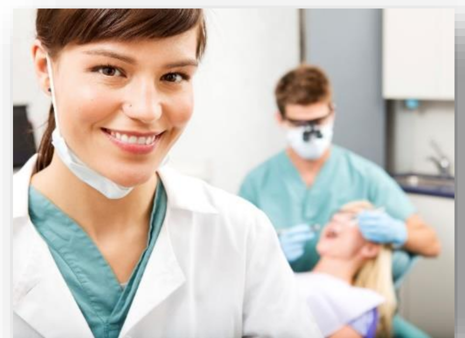
Charles City Public Schools will continue to offer dental coverage through Anthem. The plan allows you and your dependents to visit the dentist of your choice. Preventive services are covered by the plan at 100% and other services are covered with coinsurance. See an overview of the coverage below and view full details in your dental summary of benefits.

	Anthem Dental	
	Employee Pays:	**Employee Pays:**
Class I Services	In Network	Out of Network
Exams	0%	20%
X-Rays	0%	20%
Cleanings	0%	20%
Class II Services	After Deductible	After Deductible
Basic Restorative (Fillings, etc.)	20%	40%
Endodontics	20%	40%
Periodontics (scaling and root planning)	20%	40%
Oral Surgery	20%	40%
Simple Extractions	20%	40%
Class III Services	After Deductible	After Deductible
Crowns	50%	50%
Dentures	50%	50%
Bridges	50%	50%
Prosthetics Repairs/Adjustment	50%	50%
Dental Implants	Not Covered	Not covered
Orthodontics		
Diagnostic, Active, Retention Treatment	Not Covered	Not covered
Deductible	$25 / $75 per calendar year	
Calendar Year Benefit Maximum*	$1,250 per member	

* It is important to realize that your deductible and plan maximum resets January 1 and not at the October 1 plan anniversary date. This differs from the medical plan in which all deductibles and OOP reset on October 1 anniversary date.
If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.





EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) offers confidential resources and referral services through Anthem. This program is provided to you at no cost by Charles City Public Schools.

The EAP provides assistance to you and your dependents on a variety of issues including:

- Relationship counseling
- Financial and legal counseling
- Mental health counseling including depression and anxiety
- Work/life balance resources
- Family assistance including help finding childcare or elder care

Employees can take advantage of this resource with the full confidence that all information discussed with Anthem will be kept confidential.

EMPLOYEE CONTRIBUTIONS IN 2019/2020

Your premium for elected plans will be deducted pre-tax from each paycheck.

Medical Coverage

Employee Bi-Weekly Premium			
Anthem	KC 25 500/20%/4000 15/50/85/20% Rx	HK POS OA 25 500/20%/4000 15/50/85/20% Rx	HK HSA 3000/20%5000 Ded 20% Rx
Employee Only	$24.73	$4.35	$0.00
Employee & Child	$155.78	$127.95	$0.00
Employee & Children	$394.60	$353.18	$157.42
Employee & Spouse	$468.72	$423.08	$206.81
Employee & Family	$771.28	$708.42	$408.41

Dental Coverage

Employee Bi-Weekly Premium	
Anthem	
Employee Only	$3.86
Employee plus One	$15.36
Employee & Family	$29.72

Vision Coverage

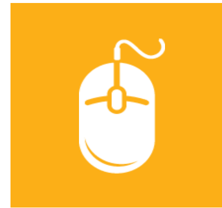
Employee Bi-Weekly Premium	
EyeMed	
Employee Only	$3.43
Employee & Spouse	$6.52
Employee & Child	$6.86
Employee & Family	$10.09

Tips for Keeping Costs Down:

- Choose in-network providers
- Take advantage of preventive care services
- Request generic prescriptions
- Use Urgent Care providers instead of the Emergency Room
- Try telemedicine for non-emergent health consultations

VOLUNTARY VISION

Charles City Public Schools offers the opportunity to enroll in a voluntary vision insurance plan through EyeMed. Our vision plan covers eye exams and helps offset the cost of corrective eyewear. An overview of the plan is provided below; please see your summary of benefits for complete details.



Find an Eye Doctor

Visit www.eyemed.com for a list of eye doctors near you

Benefits	In Network	Out of Network
Exam Copay	$10	Up to $40
Frames	$0 Copay, $130 allowance, 20% off balance over $130	Up to $91
Lenses		
Single	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $70
Contact Lenses		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	Up to $130
Medically Necessary	No Charge	Up to $210
Frequency (Exam/Lense/Frame)	12/12/24	

Additional Discounts

Employees can take advantage of: 40% off complete pair of prescription eyeglasses, 20% non-prescription sunglasses and 20% off remaining balance beyond plan coverage.

Provider Network

For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982. For Lasik providers, call 1-877-5Laser6.

Aflac

VOLUNTARY ACCIDENT AND CRITICAL ILLNESS

Accident (24 hour Coverage)

The Aflac Group Accident plan provides cash benefits ***directly to you*** that help with out-of-pocket expenses - medical and nonmedical - associated with treatment in the event of a covered accident.

- Doctor's office/facility (not ER or Urgent Care) w/or w/out xray- $100/$75
- ER observation (w/in 7 days after accident) - $70 each 24 hour period/ $35 less than 24 hours, but at least 4 hours
- ER w/or w/out x-ray- $200/$150
- Urgent care w/ or w/out x-ray- $200/$150
- Hospital admission (once per accident/within 6 months after accident)- $900 per confinement
- Hospital confinement (max 365 days per accident, within 6 months after accident) - $225 /day

You/Your Spouse and your Child will receive $25 each ($50 in year two) just for completing a wellness test.

Benefits paid include: your initial treatment of an accident, ambulance and emergency room observation. See your AFLAC packet for a full list.

Employee Premium Per Pay Period				
	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee + Family
Accident	$9.16	$18.60	$14.49	$23.93

Critical Illness

The Aflac Group Critical Illness Plan provides cash benefits when you are diagnosed with a covered critical illness-and these benefits are paid ***directly to you.*** The plan provides a lump-sum benefit to help with out-of-pocket medical expenses and the living expenses that can accompany a covered critical illness. For employees that were eligible for this coverage back on October 1, 2018, this will be the last opportunity to sign up with NO evidence of Insurability required.

If you enroll in the HSA plan you automatically receive a $5,000 benefit. If you elect to buy up this would be an additional $15,000 on top of the $5,000 you automatically receive.

Employee Guaranteed Issue: $15,000
Spouse Guaranteed Issue: $7,500 (Covered at 50% of employee coverage for $10,000 and $15,000 plans).
If employee elects $5,000, spouse is not eligible.

100% of base benefits are paid for heart attack, sudden cardiac arrest, major organ transplant, bone marrow transplant, kidney failure and stroke. Coronary artery bypass surgery is paid at 25%. Cancer (Internal or Invasive) is paid at 100%. Non-invasive is 25%. Skin cancer is $250 per calendar year. Refer to your AFLAC packet for a full list.

If you complete a health screening (payable for employee + spouse only) you will receive $50 each calendar year.

Per Paycheck rates can be found on the next page.

Below are your per paycheck rates. They are broken out between employee and spouse, then tobacco and non-tobacco. Tobacco includes the use of cigarettes, e-cigs, and dip.

Rates are based on age at time of issue.

Premium Per Pay Employee Non-Tobacco				Premium Per Pay Tobacco		
Employee				Employee		
Age	**$5,000**	**$10,000**	**$15,000**	**$5,000**	**$10,000**	**$15,000**
18-29	$2.06	$3.36	$4.66	$2.59	$4.42	$6.25
30-39	$2.88	$5.00	$7.13	$4.08	$7.39	$10.70
40-49	$4.90	$9.05	$13.19	$7.28	$13.80	$20.31
50-59	$8.84	$16.93	$25.01	$13.81	$26.86	$39.91
60+	$16.25	$31.74	$47.23	$24.94	$49.11	$73.28

Premium Per Pay Non-Tobacco				Premium Per Pay Tobacco		
Spouse				Spouse		
Age	**N/A**	**$5,000**	**$7,500**	**N/A**	**$5,000**	**$7,500**
18-29	N/A	$2.06	$2.71	N/A	$2.59	$3.51
30-39	N/A	$2.88	$3.94	N/A	$4.08	$5.73
40-49	N/A	$4.90	$6.98	N/A	$7.28	$10.54
50-59	N/A	$8.84	$12.88	N/A	$13.81	$20.34
60+	N/A	$16.25	$24.00	N/A	$24.94	$37.02

ADDITIONAL BENEFITS

Health Advocacy and Medical Bill Saver

Included with your Critical Illness and Accident plans you are also offered Health Advocacy and Medical Bill Saver through Aflac.

With Health Advocacy, you have a team of experts who can help solve your health care and insurance-related questions. They can assist you with a variety of needs like finding specialists, clarifying coverage, addressing claim issues, getting second opinions —and even help negotiating medical bills.

Health Advocacy and Medical Bill Saver is available 24/7 anytime, anywhere to help you:

- Find doctors and treatment centers
- Coordinate care and second opinions
- Untangle medical bill and claim issues
- Negotiate bills $400 or more
- Find providers and schedule appointments
- Work with insurance companies to get approvals or clarify coverage

Financial and Legal Fitness

Included with your Critical Illness and Accident plans you are also offered Financial and Legal Fitness through Aflac.

Sometimes, getting a little guidance just makes life easier. That's where Financial and Legal Fitness comes in. Now you can have phone sessions with licensed, professional counselors who can provide guidance for nearly any financial or legal matter — at no cost to you. And you have unlimited access to online tools, for more help along the way.

CONTACT INFORMATION

Benefit	Provider	Phone	Website
Charles City Public Schools	Bea Banks	804-652-4618	BBanks@co.charles-city.va.us
Employee Navigator	On-line enrollment system	Company Identifier: CHARLESCITY	www.employeenavigator.com/benefits/account/login
Medical	Anthem	800-451-1527	www.anthem.com
Mail Order Pharmacy	Anthem Ingenio	833-419-0530	www.anthem.com
Telemedicine (LiveHealth Online and Behavioral Health)	Anthem Live Health	888-548-3432	www.livehealthonline.com
Health Savings Account	Health Equity	866-346-5800	www.healthequity.com
Dental	Anthem	866-956-8607	https://www11.anthem.com/mydentalvision/
Voluntary Vision	EyeMed	866-299-1358	www.eyemed.com
Employee Assistance Program	Anthem	888-650-5748	www.anthem.com/eap
Accident and Critical Illness	Aflac	800-433-3036 Fax 866-849-2970	www.aflacgroupinsurance.com groupclaimfiling@aflac.com (claims)
Health Advocate	-	866-385-8033	www.healthadvocate.com

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

EMPLOYEE NAVIGATOR

On-Line Enrollment Instructions:

We use an on-line enrollment site for your elections.

New Users:

1. Log on to www.employeenavigator.com/benefits/account/login.
2. Select **"New User Registration"**
3. You will then be asked to complete the following items under "**Create Your Account** "
   a. First and last name
   b. Last 4 digits of your Social Security number
   c. Birth date
   d. Company identifier: **CHARLESCITY**
   e. Click "Next" and you will then be asked to create a
   f. "**User Name and Password"**.
   g. Click "Next" to complete the registration process.

Create Your Account

First, let's find your company record

First Name

Last Name

Company Identifier
(provided by HR)

PIN
(Last 4 Digits of SSN / ID)

Birth Date
(mm/dd/yyyy)

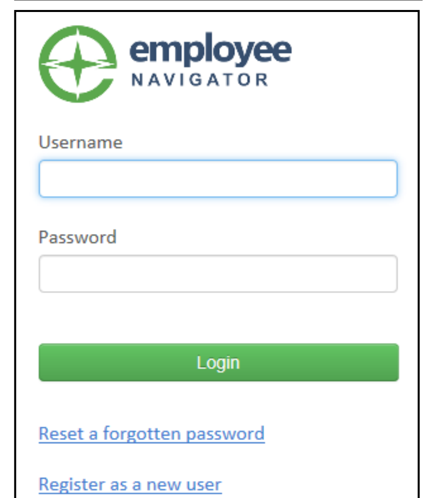
Next »

Current Users:

1. Current users can make elections by logging onto www.employeenavigator.com/benefits/account/login and enter your name and password.
2. If you have forgotten your password, use the "Reset a forgotten password" option.

All Users:

1. Click "**Start Benefits**" on the right hand side of the screen to begin making your enrollment elections.
2. You will be asked to verify your personal information prior to the election process. Be sure to click "**Save and Continue**" at the bottom of the screen.
3. If you do not have any changes, click on "**Dependent Information**" and add any benefit eligible dependents to the dependent screen.
4. Go through your benefit elections and please make sure you select the dependents you would like covered and the desired plan. You can click on the "**Compare**" icon to show the plan(s) and cost for all tier levels and the "**Details**" icon to provide a brief benefit overview.
5. Click the Green **"Select Plan"** button which will elect your option. Then **"Save & Continue"** to go to the next benefit available.
6. If you are declining a benefit, click "**Don't want this Benefit**". It will ask you to provide a reason why you are not electing coverage.
7. At the end, you will be able to view all elections and the cost for each line and you can print a copy for your records. To modify or go back, simply click on the benefit you want to modify/change. Be sure to always select "**Save & Continue**" for any modifications you make.



REQUIRED NOTICES

SUMMARY OF BENEFITS AND COVERAGE

Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Coverage Examples
This summary of benefits and coverage will include a new, standardized health plan comparison tool for consumers called “coverage examples,” much like the Nutrition Facts label required for packaged foods. The coverage examples would illustrate how a health insurance policy or plan would cover care for common benefits scenarios. Using clear standards and guidelines provided by the Center for Consumer Information and Insurance Oversight (CCIIO), plans and issuers will simulate claims processing for each scenario so consumers can see an illustration of the coverage they get for their premium dollar under a plan. The examples will help consumers see how valuable the health plan will be at times when they may need the coverage.

Uniform Glossary of Terms
Under the Affordable Care Act, consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as “deductible” and “co-payment”. To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor will also post the glossary on the new health care reform website, www.HealthCare.gov.

You can access the forms discussed here at http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf

The package of materials posted also includes an example of a completed summary of benefits and coverage, uniform glossary, as well as specific technical information for simulating coverage examples for two benefit scenarios: having a baby and managing type 2 diabetes.

WOMEN’S HEALTH AND CANCER RIGHTS ACT

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the Deductible and the Coinsurance applies.
If you would like more information on WHCRA benefits, call your Plan Administrator.

NEWBORNS’ AND MOTHERS HEALTH PROTECTION ACT ENROLLMENT NOTICE

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).

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**

Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rite Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext.5473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282

To see if any other states have added a premium assistance program since July 31, 2019, 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 12/31/2019)

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

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 the Employer, 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 will 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 for retirees, 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.

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:

<u>Disability extension of 18-month period of COBRA continuation coverage</u>
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.

<u>Second qualifying event extension of 18-month period of continuation coverage</u>
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.

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 Administrator 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.
Please contact the Plan Administrator for additional information.

HIPAA 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.

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 or office 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" if it would affect your care.

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 you have given someone 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 **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- 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. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

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 here 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

This notice is effective as of April 8, 2013.

HIPAA SPECIAL ENROLLMENT MODEL NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.
To request special enrollment or obtain more information, contact your Plan Administrator.

IMPORTANT NOTICE FROM YOUR EMPLOYER ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Employer 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. Your Employer has determined that the prescription drug coverage offered by the Medical Plan(s) is/are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore

considered Creditable Coverage. Because your existing coverage is **Creditable Coverage**, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Employer coverage will be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Employer coverage, be aware that you and your dependents may 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 your Employer 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 your Plan Administrator for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Employer changes. You also may request a copy of this notice at any time.
More detailed information about Medicare plans that offer prescription drug coverage can be found 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:

1. Visit www.medicare.gov

2. 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.

3. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	10/1/19
Name of Entity/Sender:	Charles City Public Schools
Contact--Position/Office:	Human Resources
Address:	10035 Courthouse Road Charles City, VA 23030
Phone Number:	804-652-4618

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*

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

** An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.*

How Can I get More Information?
For more information about the coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is ordered to correspond to the Marketplace application.

Employer Name:	Charles City County Public Schools
Employer EIN:	54-6001196
Employer Address:	10035 Courthouse Road
City:	Charles City
State:	VA
Zip:	23030
Employer Phone Number:	804-652-4618

Who can we contact about employee health coverage at this job? Bea Banks
Email Address: BBanks@ccps.net

Your employer offers a health plan to eligible employees and dependents. See the Plan Information section of the SPD for details. This coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

**An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)*

EMPLOYER CONTRIBUTIONS TO H.S.A.

This notice explains how you may be eligible to receive contributions from your Employer if you are covered by a High Deductible Health Plan (HDHP). Your Employer provides contributions to the Health Savings Account (HSA) of each employee who meets eligibility requirements (“eligible employee”). If you are an eligible employee, you must do the following in order to receive an employer contribution:

(1) establish an HSA on or before the last day in February of the year after the year for which the contribution is being made and; (2) notify your Plan Administrator of your HSA account information on or before the last day in February of 2020. Account information must include the legal name of the account custodian, home address, and account number.

If you establish your HSA on or before the last day of February in the year following the calendar year for which the contributions are being made and notify your employer of your HSA account information, then you will receive employer HSA contributions, plus reasonable interest, by April 15 of the year following the calendar year for which contributions are being made.

If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then we are not required to make any contributions to your HSA for your Plan Year. You may notify us that you have established an HSA by sending an e-mail or a written notice to your Plan Administrator. If you have any questions about this notice, you can contact your Plan Administrator.