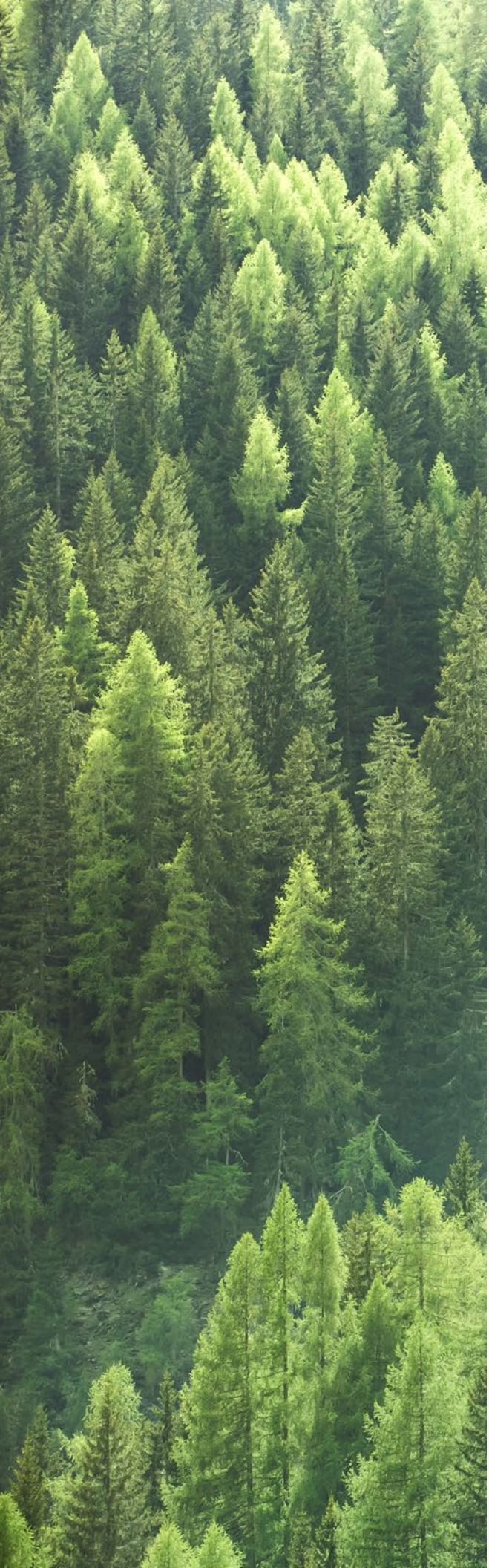
Employee Benefits Guide | 2024

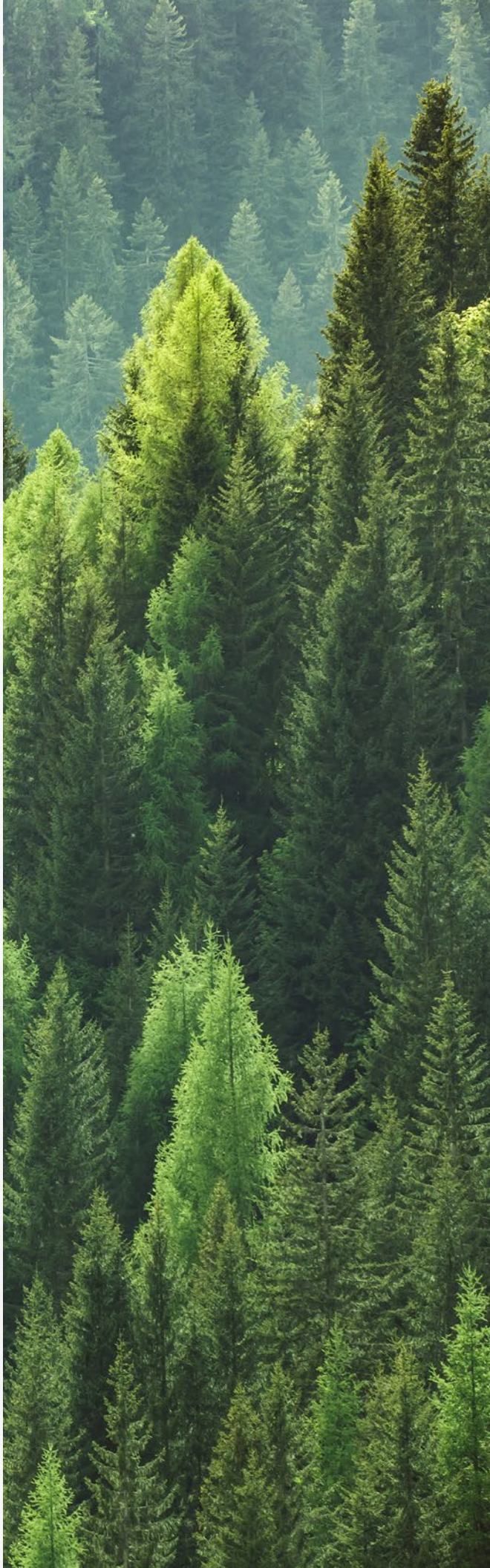


Introduction

Murray County Government's most important asset is our people. That's why we offer you an exceptional benefits program with many options designed to meet your and your family's needs. This booklet will summarize Murray County Government's medical, dental, vision, life, disability, HSA, wellness, and worksite benefits.

TABLE OF CONTENTS

This booklet is intended as a convenient summary of all major points of your benefits plan. This booklet does not cover all provisions, limitations, and exclusions. The official plan documents, policies, and certificates of insurance govern in all cases and are available for your inspection at any time.



ELIGIBILITY & ENROLLMENT

You must complete your enrollment changes in Murray County Government's PlanSource portal between November 27th and December 3rd.

Open enrollment refers to your opportunity to:

- Change plans
- Enroll in benefits
- Cancel benefits
- Change coverage for your dependents

  Eligible dependents are:
  - Your spouse
  - Your legal spouse who resides in the United States
  - Children under the age of 26
  - Children of any age who are mentally or physically incapable of living independently

ELIGIBILITY

All full-time employees are offered benefits. Spouses and dependent children of the employees are also eligible to participate in our benefits plans.

NEW EMPLOYEES

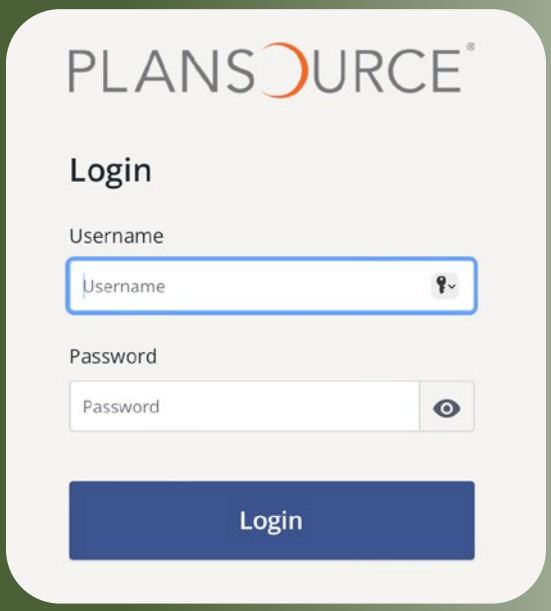
New employee benefits are effective on the first of the month following 30 days for all full-time employees working more than 30 hours per week.

MID-YEAR BENEFITS CHANGES

Outside of your annual open enrollment period, you may be eligible to make certain benefits changes during the middle of the plan year. Please refer to your Summary Plan Description, which is posted on the PlanSource Portal. Some specific examples of when you might be able to make mid-year changes are:

- Marriage or divorce
- Birth, death, or adoption
- Change in eligibility status

HOW TO ENROLL ON PLANSOURCE



Please review the instructions below as you prepare to select your benefits for the 2024 plan year.

To enroll visit https://benefits.plansource.com/

1. Enter your username and password

- First initial of your first name
- First six characters of your last name
- Last four (4) digits of your SSN
- Your password is your birth date in the format YYYYMMDD.

2. Review your profile

- Verify that all information is correct. If you need to modify your information, select **"Edit Info"**.
- Once you have completed your updates, select **"Save"**. Then select **"Next Review My Family".**

3. Add dependents and beneficiaries

- Click the **"Add Family Member"** box. This will open a new page. On the new page, you can enter your dependent information.
- Once you have saved your dependents, you will be sent back to the manage members page to add additional family members. If you are finished adding dependents/beneficiaries, select **"Next: Shop for Benefits".**

4. Shop for benefits

5. Review and checkout

MEDICAL | TRUSTMARK/CIGNA

Your medical plans will be offered through Trustmark/Cigna, and your prescription drug benefits administrator is Maxor Plus for the 2024 plan year. Please review your plan summaries or Summaries of Benefits and Coverage (which are posted on the PlanSource Portal) for coverage information and complete plan details.

Will you be covering family members on your medical plan?

If so, each of your family members would also be subject to the individual deductible, but if the family accumulates to the family deductible, no further deductible is required by any family member. Likewise, each of your family members would also be covered 100% if they reach the individual out-of-pocket maximum, but if the family accumulates to the family out-of-pocket maximum, no further family members are subject to expenses.

Medical | Trustmark/Cigna	Plan 3	Plan 4 HSA	Plan 5	Out-of-Network
Coinsurance (Member pays)	20%	20%	20%	40%
Calendar Year Deductible Individual Family	 $1,000 $3,000	 $1,600 $3,200	 $1,500 $4,500	 $2,000 $6,000
Out-of-Pocket Maximum (Deductible included) Individual Family	 $4,500 $12,500	 $4,500 $9,000	 $4,500 $12,500	 $6,000 $18,000
Office Visit Primary Specialist Preventive Care	 $20 Copay $40 Copay 100% Covered	 Ded. + Coinsurance Ded. + Coinsurance 100% Covered	 $15 Copay $60 Copay 100% Covered	 Ded. + Coinsurance Ded. + Coinsurance Ded. + Coinsurance
Inpatient Services	Ded. + Coinsurance	Ded. + Coinsurance	Ded. + Coinsurance	Ded. + Coinsurance
Outpatient Services	Ded. + Coinsurance	Ded. + Coinsurance	Ded. + Coinsurance	Ded. + Coinsurance
Emergency Room Services (Waived if admitted)	Ded. + Coinsurance	Ded. + Coinsurance	Ded. + Coinsurance	Ded. + Coinsurance
Urgent Care	$60 Copay	Ded. + Coinsurance	$60 Copay	Ded. + Coinsurance
Prescription Coverage (30-Day Supply)	**Plan 3**	**Plan 4 HSA**	**Plan 5**	**Out-of-Network**
Deductible Tier 1 Tier 2 Tier 3	 $5 Copay $30 Copay $60 Copay	Deductible, then: $5 Copay $30 Copay $60 Copay	 $5 Copay $30 Copay $60 Copay	After Ded. for plan 4 $5 Copay $30 Copay $60 Copay
Mail Order (90-Day Supply)	**Plan 3**	**Plan 4 HSA**	**Plan 5**	**Out-of-Network**
Tier 1 Tier 2 Tier 3	$10 Copay $60 Copay $120 Copay	$10 Copay $60 Copay $120 Copay	$10 Copay $60 Copay $120 Copay	$10 Copay $60 Copay $120 Copay

MEDICAL PLAN RATES

Mandatory Tobacco Affidavit

All full-time employees of Murray County Government eligible for benefits on January 1, 2024, are required to complete a Tobacco Affidavit declaring each employee's tobacco use status for the 2024 plan year. Employees using tobacco will be subject to the tobacco surcharge on their bi-weekly premiums.

In the event that an employee elects non-tobacco user rates and it is determined at any later date that the employee willingly misrepresented the Non-Tobacco user status, Murray County Government maintains the right to collect the difference in premiums back to the effective date following the signature of the affidavit. Disciplinary action, including termination, may be taken.

NON-TOBACCO BI-WEEKLY EMPLOYEE CONTRIBUTIONS			
INCLUDES WELLNESS CREDIT	**Plan 3**	**Plan 4 HSA**	**Plan 5**
Employee	$136.56	$50.42	$88.48
Employee + Spouse	$245.12	$94.24	$160.89
Employee + Child(ren)	$184.66	$78.40	$125.34
Family	$297.74	$124.84	$201.20
NON-TOBACCO BASE RATE	**Plan 3**	**Plan 4 HSA**	**Plan 5**
Employee	$182.72	$96.57	$134.63
Employee + Spouse	$337.43	$186.55	$253.20
Employee + Child(ren)	$230.82	$124.56	$171.49
Family	$390.04	$217.14	$293.51

TOBACCO BI-WEEKLY EMPLOYEE CONTRIBUTIONS			
INCLUDES WELLNESS CREDIT	**Plan 3**	**Plan 4 HSA**	**Plan 5**
Employee	$159.64	$73.50	$111.56
Employee + Spouse	$268.20	$117.32	$183.97
Employee + Child(ren)	$207.74	$101.48	$148.41
Family	$320.81	$147.91	$224.28
TOBACCO BASE RATE	**Plan 3**	**Plan 4 HSA**	**Plan 5**
Employee	$205.80	$119.65	$157.71
Employee + Spouse	$360.51	$209.63	$276.28
Employee + Child(ren)	$253.89	$147.64	$194.57
Family	$413.12	$240.22	$316.59

"For more details about Murray County's Wellness Program, see page 9."

HEALTH SAVINGS ACCOUNT (HSA) | HEALTHEQUITY

What is a Health Savings Account?

A Health Savings Account (HSA) is a way for you to save pre-tax dollars that can be used to pay for qualified healthcare expenses like deductibles, copays, coinsurance, prescriptions, vision, and dental expenses. Your payroll contributions are deposited into the account pre-tax for future use. To contribute to an HSA, you must be enrolled in Murray County Government's Plan 4 with HSA.

Who contributes to an HSA?

- You contribute with each paycheck.
- You will also receive a contribution from Murray County Government to help grow your balance faster. Murray County Government contributes up to $600 for employee and $1,200 per family (deposited into your account in per period installments).
- Murray County's HSA Contributions will be deposited in 4 equal installments paid at the beginning of each quarter.

How much can I contribute to an HSA?

- Employee-only coverage: $4,150 per calendar year.
- Employee plus dependent coverage: $8,300 per calendar year.
- If you are 55 or older, you can make an additional annual catch-up contribution of $1,000.

> **Please note:** that the contribution maximums listed above include employer contribution. You must subtract out the Murray County Government HSA contribution to determine the maximum amount that you as the employee can contribute.

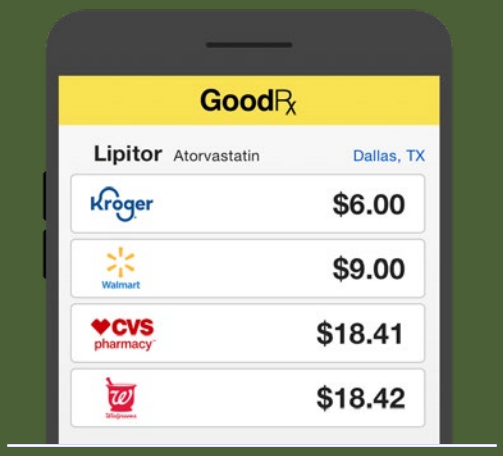
Who cannot contribute to an HSA?

- If you are age 65 or older and enrolled in Medicare.
- If you have health coverage under another medical plan that is not a high deductible plan.
- If you or your spouse has a Full Purpose FSA, you can still enroll in the High Deductible Health Plan, but neither you nor Murray County Government can contribute money into the HSA.

FIND THE LOWEST COST PRESCRIPTIONS

Did you know that drug prices can vary drastically between different pharmacies? Did you know that purchasing a drug through your company medical plan is not always the lowest cost option? A free, independent, third-party solution, GoodRx, is here to help!

- Navigate to **www.GoodRx.com** or download the free mobile app (search "GoodRx" in your app store).
- Type in your prescription name and then adjust your location, dosage, and quantity.
- Review the real-time cost of your prescription at various pharmacies around your zip code.
- Download a free coupon for that pharmacy, or order online when available.
- Please be aware that any prescriptions purchased outside of your medical insurance do not accumulate to your plan deductible and/or out-of-pocket maximum.



MURRAY WELLNESS PROGRAM

Murray County values and appreciates all the hard work that each employee provides. We care about our employees' quality of life and want the best for each individual, including providing a healthy work environment. As such, Murray County invests in providing quality healthcare to improve its employees' overall health by continuing Murray County's proactive Health and Wellness program for the 2024 plan year.

For employees who participate in this free program, you will not only have the benefit of improving your overall health, but you can also lower your health insurance premiums! ($1,200/year for EE/EE+C; $2,400/year for EE+S/FAM) by maintaining compliance with the program. In addition, you may receive monitoring devices and supplies, Nurse Care Manager or Wellness Coach access, and educational materials at no additional cost.

Murray's Wellness Program encourages employees to improve or maintain their health by providing premium credits if they satisfy certain health conditions. The biometric screenings include Total Cholesterol / HDL Ratio, Glucose, Blood Pressure, and Body Mass Index (BMI).

Murray County recognizes that some individuals have health issues beyond their control, which would adversely impact their biometric screening results. If an employee needs assistance with managing their health condition, they may still qualify to receive the premium credit through alternative means through the Wellness Coaching and/or Health Management programs.

To get started, visit www.wellvisor.com to register and create your login credentials. Once you are logged in, you can download the screening form, complete your Biometric screening, review your screening results, and see your program compliance status. Once you have submitted your screening results, please allow five business days for processing before contacting the County for any questions or concerns.

DENTAL | unum

Your dental coverage is offered through Unum for the 2024 plan year. Please review your plan summaries or policy for coverage information and complete plan details.

Your dental plan through UNUM also includes a carryover benefit. During each benefit year, if a member receives at least one cleaning and one regular exam and their total dental claims are below $600, then $300 will automatically roll over to the following year. The carryover benefit maxes out at $1,200 (in addition to your base annual amount).

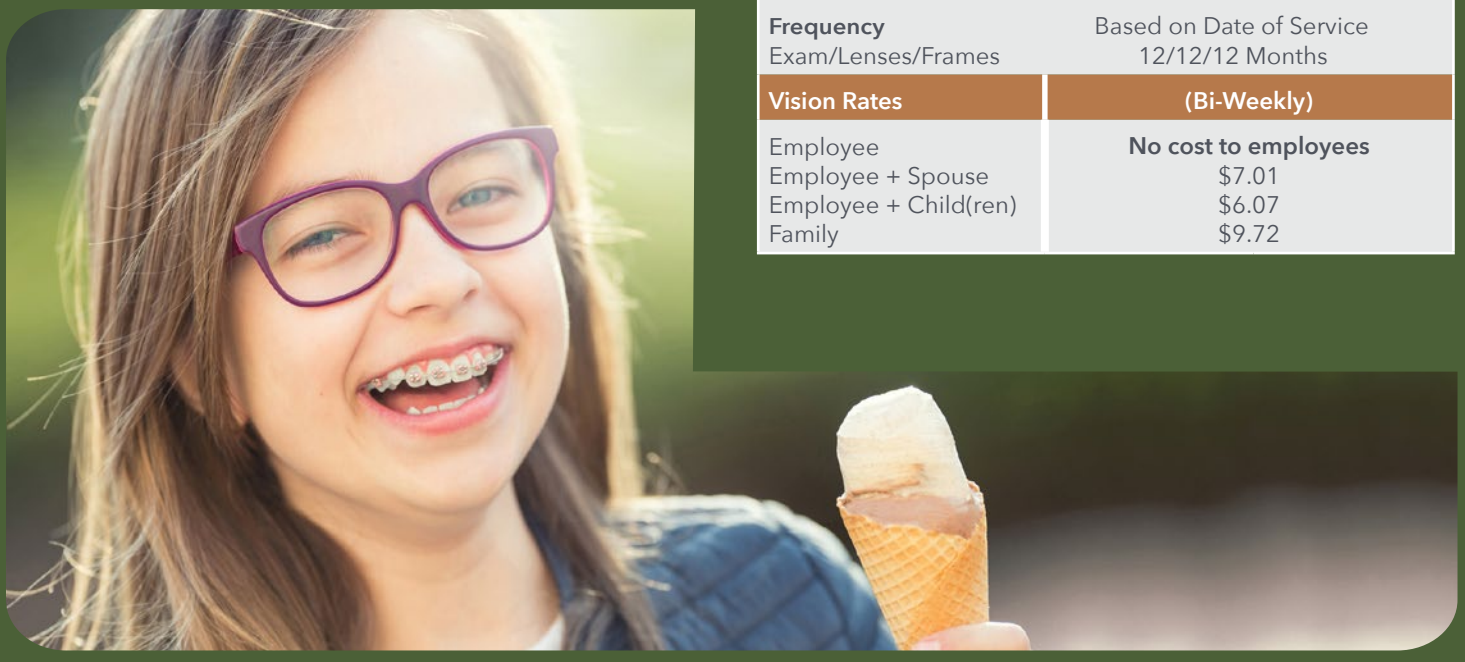
Dental Plan	In-Network
Calendar Year Deductible	
Individual	$50
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontia	50%
Orthodontia Lifetime Maximum	$1,000
Annual Benefit Maximum	$1,200
Out-of-Network	90th UCR
Dental Rates	**(Bi-Weekly)**
Employee	$14.36
Employee + Spouse	$29.84
Employee + Child(ren)	$38.63
Family	$54.06

VISION | unum

Your vision coverage is offered through Unum. This coverage is provided to employees free of charge, however for employees electing dependent coverage, the additional cost will be covered by the employee.

Search for providers and manage your benefits online at www.unumvisioncare.com.

Vision Plan	In-Network	Out-of-Network
Eye Exam	No Copay	$35 Allowance
Lenses		
Single Vision	$20 Copay	$25 Allowance
Bifocals	$20 Copay	$40 Allowance
Trifocals	$20 Copay	$50 Allowance
Frames	$200 Allowance	$50 Allowance
Contacts		
Disposable	$200 Allowance	$100 Allowance
Medically Necessary	$210 Allowance	$210 Allowance
Frequency	Based on Date of Service	
Exam/Lenses/Frames	12/12/12 Months	
Vision Rates	**(Bi-Weekly)**	
Employee	**No cost to employees**	
Employee + Spouse	$7.01	
Employee + Child(ren)	$6.07	
Family	$9.72	



LIFE | unum

Basic Life and Voluntary Life insurance provides financial support in the untimely passing of a covered participant.

Basic Life and AD&D Insurance

- **Benefit amount:** $15,000.
- Please be advised that should you reach age 70, your coverage will reduce by 65%. Should you reach age 75, your coverage will reduce by 50%.
- **100% Employer-paid**

DISABILITY | unum

Short and Long-Term Disability insurance provides partial income replacement in the event of a covered illness or accident that occurs outside of work.

Voluntary Short-Term Disability

- Benefits begin once you have been out of work due to your disability for 7 days.
- Weekly benefit checks will be 60% of your weekly earnings, up to a maximum of $500 per week.
- You can receive these weekly benefit checks up to 26 weeks if you continue to be out of work due to your disability.
- **100% Employee-paid**

Voluntary Long-Term Disability

- Benefits begin once you have been out of work due to your disability for 180 days.
- Monthly benefit checks will be 60% of your monthly earnings, up to a maximum of $5,000 per month.
- You can receive these monthly benefit checks up to Social Security Normal Retirement Age if you continue to be out of work due to your disability.
- **100% Employee-paid**

Voluntary Life and AD&D

- Employees can elect Voluntary Life and AD&D for themselves, their spouse, and their dependent children.
- The cost is based on the amount you purchase and your age at the time of purchase. You can calculate your cost while enrolling in the Murray County Government PlanSource portal.
- **100% Employee-paid**

Employee Coverage	Spouse* Coverage	Child Coverage
Increments of $10,000 up to a maximum of $250,000, not to exceed 5x your earnings **Guaranteed Issue:** $150,000	Increments of $5,000 up to $100,000, or 100% of the employee election **Guaranteed Issue:** $25,000	Increments of $2,000 to maximum of $10,000 **Guaranteed Issue:** $10,000

*If your spouse is also a benefits-eligible employee at Murray County Government, then spousal coverage cannot be purchased on them.

Please be advised that should you reach age 70, your coverage will be reduced by 65%. Should you reach age 75, your coverage will be reduced by 50%.

WORKSITE BENEFITS | unum

ACCIDENT*

The group accident policy provides a cash benefit for out-of-pocket expenses associated with an accidental injury and can help protect hard-earned savings should an on or off-the-job accident occur.

Wellness Benefit: Pays a $50 Wellness Benefit once per calendar year per insured individual if a covered health screening test is performed, which includes but is not limited to, blood tests, stress tests, colonoscopies, and mammograms. The benefit is paid even if medical insurance pays 100% of the cost.

ACCIDENT INSURANCE BI-WEEKLY EMPLOYEE CONTRIBUTIONS	
Employee	$6.67
Employee + Spouse	$11.84
Employee + Child(ren)	$13.49
Family	$18.60

CRITICAL ILLNESS & CANCER*

Unum's Critical Illness policy provides the ability for an insured to receive a lump sum benefit payment upon first and second diagnoses of any qualified Critical Illness. Benefits are paid directly to the insured when they need it most to be used however they see fit. Employees can also cover a spouse and dependent children up to age 26.
Pre-existing Condition: 12/12

New Hires: Health questions are not required for amounts up to the guaranteed issue limit of $30,000 for the employee and $15,000 for the spouse.

Wellness Benefits:
$10,000 - $50
$20,000 - $75
$30,000 - $100

**If your spouse is also a benefits-eligible employee at Murray County Government, then spousal coverage cannot be purchased on them.*

NOTES:

MURRAY COUNTY GOVERNMENT

2024

Important Notice
Comprehensive Notice of Privacy Policy and Procedures

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.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from Murray County Government 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 Murray County Government and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Murray County Government has determined that the prescription drug coverage offered by the Murray County Government Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within good as specific time periods.

Enrolling in Medicare— General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage. For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19 percent higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or web address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Murray County Government Plan due to your employment (or someone else's employment, such as a spouse or parent); your coverage under the Murray County Government Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Murray County Government prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information, or call (229) 312-4346. **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 Murray County Government changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help; Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at

1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	July 1, 2021
Name of Entity/Sender:	Murray County Government
Contact—Position/Office:	Human Resources
Address:	121 N. 4th Ave, #101, Chatsworth, GA 30705
Phone Number:	706-517-1400 x1243

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

Murray County
Government
Important Notice
Comprehensive Notice of Privacy Policy and Procedures

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.

This Notice is provided to you on behalf of:

Murray County Government Comprehensive Employee Welfare Benefit Plan*
Murray County Government Medical Plan

Murray County Government
Dental Plan

Murray County Government
Vision Plan

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Murray County Government that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health Care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization.

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Murray County Government) who sponsor or maintain the Plan for the benefit of employees and dependents.
  However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration, payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
- **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the employer for such purposes as reporting or investigation of unusual incidents.
- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

Privacy Officer Murray
County Government
Telephone: (706-517-1400
x1243

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

Trustmark/Cigna Medical Plan
UNUM Dental Plan
UNUM Vision Plan

Effective Date

The effective date of this Notice is: January 1, 2024

NOTICE OF SPECIAL ENROLLMENT RIGHTS
Murray County Government Employee
Health Care Plan

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 later 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 toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact: Murray County Government

Murray County Government HR

121 N. 4th Ave #101

Chatsworth, GA 30705

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

Continuation Coverage
Rights Under COBRA

This notice has important information about your right to continue your health care coverage in the Murray County Government Health Plan (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov **or call 1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

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."

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;
- 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 of the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

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. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent in accordance with the outlined COBRA continuation procedures of the Plan Document.

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.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

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.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost- sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov. Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

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.

Women's Health and Cancer Rights Act (WHCRA)

Murray County Government Employee Health Care Plan is required by law to provide you with the following notice: The Women's Health and Cancer Rights Act of 1998 ("WHCRA")

provides certain protections 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 lymphedemas.

The Murray County Government Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see the Open Enrollment Guide for a list of deductibles and coinsurance.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator.

The Newborns' and Mothers' Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act (NMHPA) was signed into law on September 26, 1996. This law protects newborns and mothers by requiring that they be allowed to stay in a hospital for a certain length of time. Group healthcare plans 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)

Mental Health Parity & Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity with respect to how annual and lifetime benefits are applied to mental health and substance abuse benefits. In general, the MHPAEA bars Group Healthcare Plans, insurance companies and HMOs offering mental and substance abuse benefits from setting annual or lifetime dollar limits on mental health benefits.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance- buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE-Medicaid	NEW HAMPSHIRE-Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	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

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

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 1210-013

CONTACTS

Contact your Client Advocate to help you get the most from your group insurance plans. Carolyn Vann is ready to answer any of your benefits-related questions with complete confidentiality.

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cvann@onedigital.com

ONEDIGITAL

- Medical | Trustmark/Cigna
  Member Services: 1.866.273.0059
  www.mycigna.com
- Pharmacy Benefit Manager (PBM) | Maxor
  Member Services: 1.800.687.0707
  www.maxorplus.com
- Health Savings Account (HSA) | HealthEquity
  Member Services: 1.866.346.5800
  www.healthequity.com
- Dental, Vision, Life, Disability, & Worksite Benefits | Unum
  Member Services: 1.800.421.0344
  www.unum.com