HAMILTON COUNTY SCHOOLS

2024 | Employee Benefits Overview

A Note From the Benefits Department

HCS strives to give you the best and most competitive benefits package, because we know this is an investment in You. The benefits we offer can help safeguard your financial security by providing low premiums, co-pays and deductibles. We also provide free clinics and free generic prescriptions. We care about your health and well being and strive to offer employees access to excellent benefits!

What's Inside

This guide is designed to provide a general overview of your benefits at Hamilton County Schools (hereinafter "HCS"). It is not a contract or an official interpretation of the benefit plans. For more detailed information, please refer to your summary plan descriptions or the legal plan documents.

Should any questions or conflicts arise, the plan documents will be the final authority in determining your benefits. HCS reserves the right to modify or discontinue the plans at any time. This document was prepared exclusively for employees of HCS. Unauthorized reproduction is strictly prohibited.

Please contact the Benefits Department if you have any questions regarding your benefits plan. Benefits end on the end of the month following the separation date. For school-based employees (with 26 checks) who work until the end of their contract date in May, benefits will cease the end of August.

Eligibility

Employees are eligible for benefits upon their date of hire. Employees have 30 days to enroll in benefits. It can take up to 2 weeks to receive ID cards. Dependent children are covered until age 26, must be a legal dependent and show proof of relation. If you cover a spouse on all plans, a marriage certificate is required. If you cover a spouse on the medical plan, a spousal coverage affidavit is required (reference pg. 3 Spousal Carve-out).

Enrollment Changes

Changes to your enrollment may be made annually during open enrollment each year. Other changes may be made for the following qualifying events such as marriage/divorce, birth/adoption, death, change in job status of yourself or your spouse, and/or change in Medicaid/CHIP eligibility. Documentation for life events must be submitted within 30 days.

However, all changes must be made within 30 days (with the exception of Medicaid/CHIP, which gives you up to 60 days) of your qualifying event. You must notify the Benefits Department immediately when you experience a qualifying event. Changes to benefits will be reflected based on pay calendar.

Section 125 Plan Premium Conversion

Section 125 Premium Conversion Plan lets you exclude your Medical, Dental and Vision premiums from your taxable income, meaning your premiums will come out of your pre-tax income. This lowers your taxable income. By default, these premiums will be deducted pre-tax, increasing your take-home pay anywhere from a few hundred dollars to a thousand or more annually.

You may elect to have your premiums deducted after-tax. If you wish to have your premiums deducted after-tax, please contact the Benefits Department.

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 the Annual Notices for more details.

Medical Benefits

BCBST | 1-800-565-9140 | www.bcbst.com | **Cigna** | 1-800-244-6224 | www.cigna.com

HCS's medical benefits are provided through **BlueCross BlueShield of TN** ("BCBST") and **Cigna** .

The BCBST plan offers options in both the S or P Network. With the S Network, all local hospitals (with the exception of Parkridge and Parkridge East) are in Network. The P Network is BCBST's largest network and contains all LOCAL hospitals (including Parkridge).

The Cigna plan offers options in the both Local Plus and Open Access Plus Network. The Local Plus option has a smaller network that includes most providers and hospitals (with the exception of Parkridge and Parkridge East). Cigna's LocalPlus Network is a cost effective solution to help control medical costs. The OAP is Cigna's national network that includes most providers and hospitals (including Parkridge). Cigna plans are in network only.

When selecting a plan, make sure your physicians are in network. To find an in-network provider near you, go to www.bcbst.com for BCBST and www.mycigna.com for Cigna. Click on "Find A Doctor." Please be sure to consult either the online directory or the customer service department to confirm that your provider participates in the network.

26 Pay Periods	BCBS PPO S Network	BCBS PPO P Network	Cigna LCP-IN LP Network	Cigna OAP-IN OAP Network	Cigna HDHP OAP Network
Employee Only	$66	$76	$66	$76	$23
Employee + Spouse	$253	$278	$253	$278	$120
Employee + Child(ren)	$160	$179	$160	$179	$69
Employee + Family	$307	$340	$307	$340	$138

22 Pay Periods*	BCBS PPO S Network	BCBS PPO P Network	Cigna LCP-IN LP Network	Cigna OAP-IN OAP Network	Cigna HDHP OAP Network
Employee Only	$78	$89	$78	$89	$27
Employee + Spouse	$299	$328	$299	$328	$142
Employee + Child(ren)	$189	$212	$189	$212	$82
Employee + Family	$363	$402	$363	$402	$164

*Only certain positions are classified as 22 pays. If you are unsure, please contact your supervisor.

Spousal Carve-out

HCS's Medical Plan includes a provision that benefit eligible employees may only cover a spouse as a dependent if the spouse does not have access to medical coverage through their employer. If your Spouse has a high deductible health plan with a deductible of $1,600 or higher through their employer, you can add them to your plan for a $100 monthly surcharge. Employees will be required to complete Spousal Coverage Affidavit each year at open enrollment.

Medical Benefits Chart

BCBST | 1-800-565-9140 | www.bcbst.com | **Cigna** | 1-800-244-6224 | www.cigna.com

Employee Amounts*		BCBST S and P Network In-Network*	Cigna LCP and OAP In-Network*	Cigna HDHP In-Network*
Deductible	Individual / Family	$450 / $1,200	$0	$2,000 / $4,000
Out-of-Pocket Max	Individual / Family	$1,750 / $4,750	$1,300 / $2,600	$3,000 / $6,000**
Lifetime Maximum		Unlimited	Unlimited	Unlimited
Benefit Overview				
Preventive Care Visits		100%*	100%*	100%*
Primary Care Office Visit		10% After Deductible	$15 Copay	20% After Deductible
Specialist Office Visit		10% After Deductible	$20 Copay	20% After Deductible
Most Diagnostic / Lab Services		10% After Deductible	100%	20% After Deductible
Urgent Care		10% After Deductible	$75 Copay	20% After Deductible
Emergency Room		10% After Deductible	$250 Copay	20% After Deductible
Most Other Services		10% After Deductible	Various Copays	20% After Deductible
Pharmacy - Prescription Drugs				
Generic / Tier 1 $ (Retail)		$20 Copay	$20 Copay	30% After Deductible
Preferred / Tier 2 $$ (Retail)		$45 Copay	$45 Copay	40% After Deductible
Non-Preferred / Tier 3 $$$ (Retail)		$65 Copay	$65 Copay	50% After Deductible
Specialty Drug (Retail)		$65 Copay	$65 Copay	50% After Deductible

*Review plan documents for out-of-network rates, prior authorization requirements, limits on the number of visits per year and service restrictions.
** Individual within a family $4,000

EdHealth & Wellness Clinics

1-423-558-3111 | www.hcsedhealth.com | patientservicesHCS@121.health

HCS offers ALL employees access to our Health and Wellness Clinics! In addition, all employees, dependents, and retirees who are enrolled in our medical plan have access to the Clinic, Telehealth, TextCare, and Pharmacies. Dependent children must be over 2 years of age.

Clinic services are at **NO COST**, and include routine office visits, sick visits, labs, flu shots, COVID testing, health coaching, Telehealth, behavioral health and more!

For more information or to schedule an appointment for any HCS EdHealth and Wellness, contact information is provided above.

Text (423) 558-3111 to schedule an appointment.

Clinic Locations & Hours of Operation

Hickory Valley	**Hixson**	**Riverfront**
3074 Hickory Valley Road, Bldg. 229 Chattanooga, TN 37421 **Hours of Operation*** Monday - Friday: 9am-6pm Saturday: 8am-12pm	4206 North Access Road Hixson, TN 37415 **X-ray available** **Hours of Operation*** Monday-Friday: 7am-4pm	1067 Riverfront Parkway Suite 201 Chattanooga, TN 37402 **Hours of Operation*** Monday-Friday: 8am-5pm

**Hours are subject to change*

Textcare

TextCare offers direct, unlimited access to medical care 24/7 through text message.

TextCare is offered to you for well and sick visits. While our TextCare providers are able to diagnose and treat most health-related concerns, it is possible the provider may feel that you need to be referred to another level of care at an outside facility.

TextCare is available 24/7 by appointment. You may request a TextCare appointment by calling 423-558-3111.

Counseling and Behavioral Health

Behavioral health offers a full range of confidential mental health services via Telehealth provided by One-to-One Health licensed professional counselors and board-certified psychiatric mental health nurse practitioners. Services include individual or group therapy to help individuals improve their life by reducing symptoms of mental illness and by coping with personal challenges.

Wellness Health Coaching

Develop individual health and nutrition goals by focusing on personalized habit changes that will last. Provide nutrition education, so you feel empowered in your ability to make appropriate food choices. Discuss stress management and sleep hygiene tactics, so they become a part of your healthy lifestyle. You and your health coach will work together to create an individualized plan to help meet your health and wellness needs.

Text (423) 558-3111 to schedule an appointment.

Scan the QR code and save the number (423) 558-3111 to your phone.

EdHealth Onsite Pharmacies

Now offering Mail Order! Please call 844-978-2825 to sign up.

HCS EdHealth Pharmacies

Onsite pharmacies are conveniently located inside the Hickory Valley and Hixson clinics.

Employees, retirees, and dependents covered under our medical plan will receive **FREE** generic drugs and **discounts** on Preferred and Non-Preferred medications. (see chart below)

Employees not covered by our medical plan can receive select generic drugs for **$5 copay** (30 day supply or less) and **$10 copay** (over 30 day supply).

	BCBST		Cigna	
	Retail Pharmacy 30 day supply	OnSite RX 30 day supply	Retail Pharmacy 30 day supply	OnSite RX 30 day supply
Generic	$20	FREE	$20	FREE
Preferred	$45	$10	$45	$10
Non-Preferred	$65	$20	$65	$20

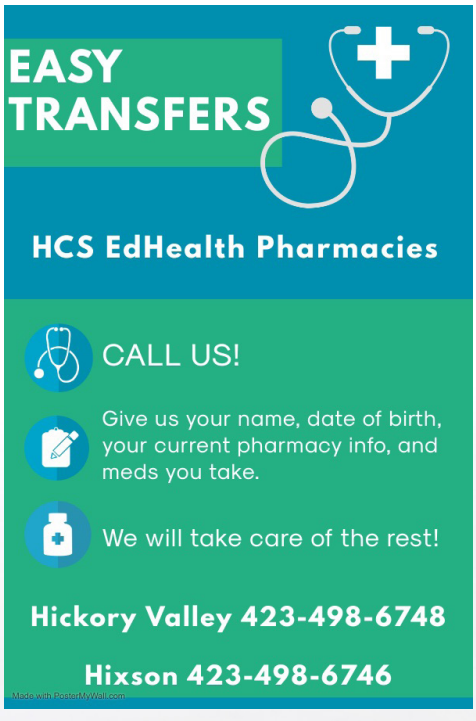
Be sure to check out over the counter medications and other items at the pharmacy at a discounted rate. It's another way for you to save money!

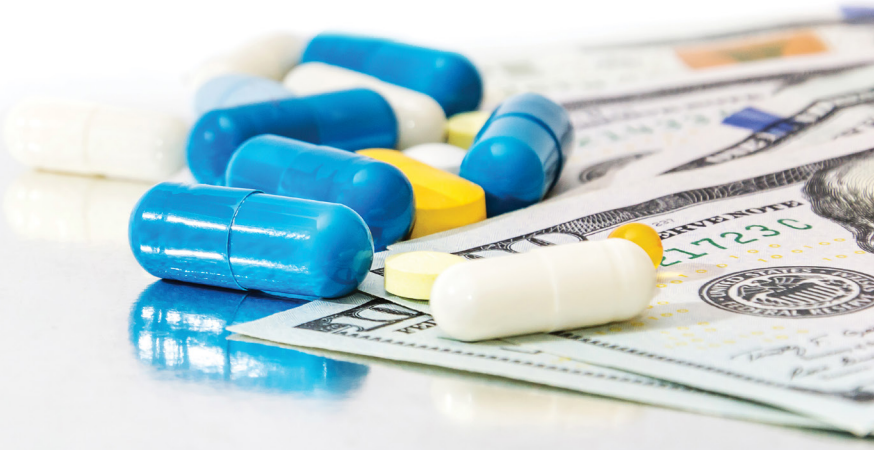
Pharmacy Hours:

Monday – Friday 8:00 am – 6:00pm

Saturday 9:00 am – 1:00 pm

*M-F Closed for lunch 1:30 pm – 2:00pm





Dental Insurance Benefits

Cigna | 1-800-244-6224 | www.cigna.com

Dental PPO

We offer access to dental benefits. Using in-network providers is always the best choice, and offers the greatest discounts and benefits. To find an in-network provider visit www.cigna.com.

This is a standalone product. Whether you choose Cigna or BCBST for medical, you can still have dental coverage.

If you are covered elsewhere on dental, you can still enroll in the HCS Dental Plan. Our dental plan will coordinate with your other dental insurance.

Dental Plan	*Base Plan 26 Pay Periods*	*Base Plan 22 Pay Periods**	*Buy-Up Plan 26 Pay Periods*	*Buy-Up Plan 22 Pay Periods**
Employee Only	$3.88	$4.59	$5.54	$6.55
Employee + Spouse	$7.67	$9.06	$10.94	$12.93
Employee + Child(ren)	$10.26	$12.13	$14.64	$17.30
Employee + Family	$15.16	$17.91	$21.63	$25.56

Dental Benefits	Base Plan	Buy-Up Plan
Deductible: (Aggregate) Individual / Family	$0 / $0	$0 / $0
Benefits Paid by the Plan		
Calendar Year Maximum	$1,000	$1,500
Preventive - Includes exams, cleanings (2 per year), sealants, x-rays	Plan Pays 80%	Plan Pays 85%
Basic - Fillings, periodontic services, oral surgery, Major endodontics,	Plan Pays 50%	Plan Pays 60%
Major - Major Restorative, Prosthodontics, Implants	Plan Pays 50%	Plan Pays 50%
Orthodontia Coinsurance / Lifetime Maximum (per lifetime, per dependent)	50% / $1,000	50% / $1,500

*Only certain positions are classified as 22 pays. If you are unsure, please contact your supervisor.

Vision Benefits

EyeMed | 1-866-299-1358 | www.eyemed.com

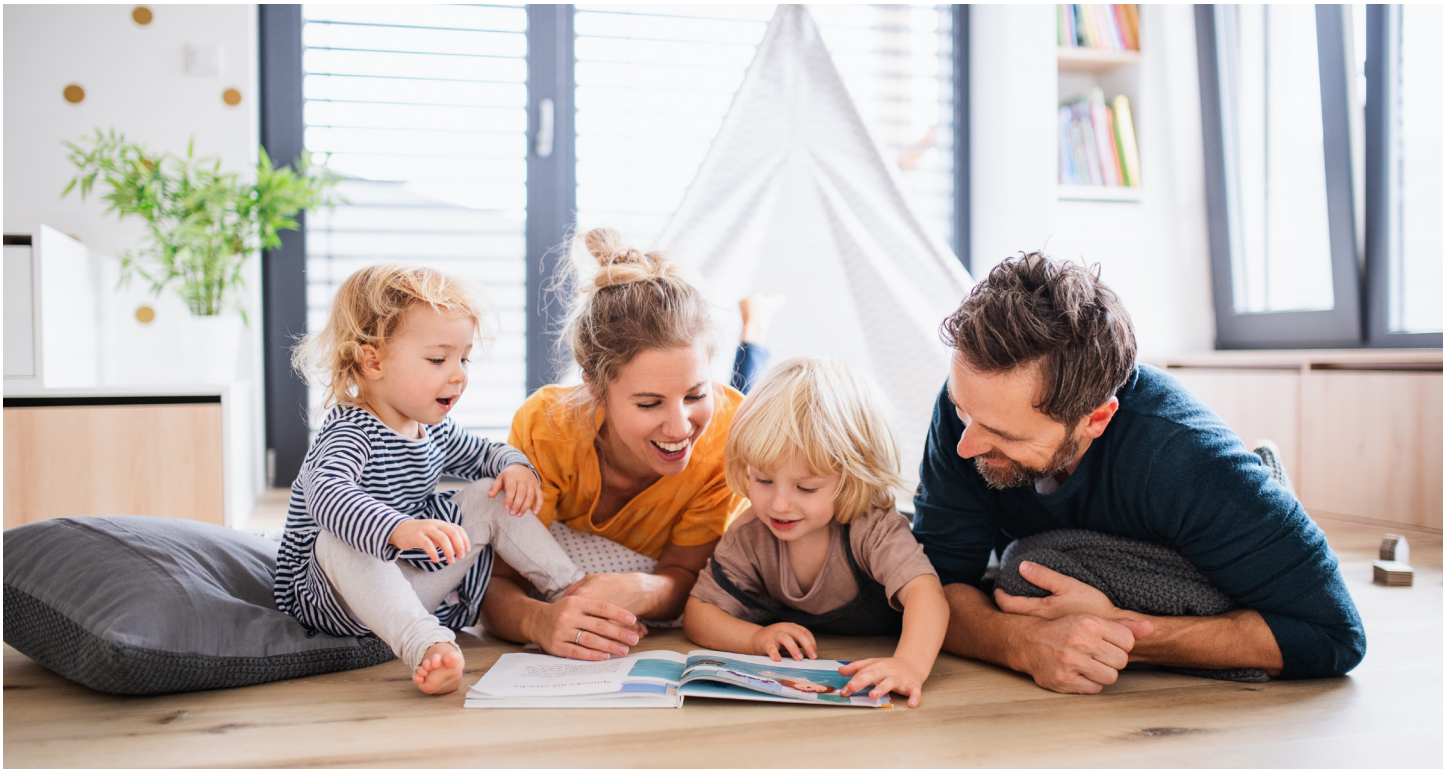
HCS offers access to vision benefits provided by **EyeMed**. When using in-network providers, this PPO plan covers most exams. Discounts are available for upgrades on covered frames and lenses, as well. The carrier partners with several refractive eye surgery centers to offer discounts to its members.

Eye 360 features a $0 eye exam and an additional $50 added to your frame allowance at Premier PLUS providers.

Vision Plan	26 Pay Periods	22 Pay Periods*
Employee Only	$2.53	$2.99
Employee + Spouse	$4.81	$5.68
Employee + Child(ren)	$5.06	$5.98
Employee + Family	$7.44	$8.79

*Only certain positions are classified as 22 pays. If you are unsure, please contact your supervisor.

Vision Benefits	In-Network		Out of Network Reimbursement
	Frequency	Details	
Vision Exam	Once every calendar year	$10 Copay $0 - Premier PLUS Providers	Up to $30
Prescription Glasses			
Frames	Once every 2 years	$170 Premier PLUS Provider $120 Allowance, 20% Off Balance	Up to $60
Lenses	Once every calendar year	$15 Copay	Up to $55
Contact Lenses (instead of glasses)			
Elective	Once every calendar year	$120 Allowance, 15% Off Balance	Up to $96



Employee Assistance Program

Symetra | 1-888-327-9573 | www.guidanceresources.com | Web ID: Symetra

The employee assistance program (EAP) services include counseling for marital/family, depression, addiction, stress/anger, life transitions or any issue for short term counseling for you or an immediate household family member.

- In-person help with short-term issues, up to 5 face-to-face visits
- Connect to a counselor for free support services
- Unlimited telephonic support - Legal service, financial service, work life service
- A discount on in-person consultations with network lawyers
- Financial consultations and referrals
- Work/life services for assistance with child care, finding movers, kennels and pet care, vacation planning, and more
- Toll-free phone and web access 24/7
- All contact is completely confidential

Flexible Spending & Dependent Care Accounts

P&A Administrative Services, Inc. | 1-716-362-5440 | www.padmin.com

HCS offers employees the option to defer money on a pre-tax basis for use on approved medical and dependent care expenses. (This is NOT insurance). This is simply a way for you to save on your medical (FSA) or day-care expenses (DCA) by setting money aside from your pre-tax, gross income for expenses that you anticipate for the plan year.

Medical FSA: With the Medical FSA, the total dollar amount set aside for the plan year is eligible for withdrawal from the account on day one of your first payroll deduction towards the account. The maximum medical FSA annual contribution amount is $3,050. If you are a new hire and enroll in the plan midyear, your rates will be prorated for the annual amount you select. Employees may rollover up to $610 of their balance to the following year.

Dependent Care Account (DCA): You may elect to set money aside to use for your approved childcare services, provided at a day-care facility, in your home, or in someone else's residence through a DCA. Certain requirements must be satisfied for the services to be approved for reimbursement. You may set aside up to $5,000 per plan year if single or married and filing jointly, or $2,500 if married and filing separately.

FSA Type	Maximum Annual Contribution*
Health Care FSA *Savings & spending account for eligible health care related expenses*	$3,050
Limited FSA *Savings & spending account for eligible dental or vision related expenses*	$3,050
Dependent Care Account (DCA) *For eligible dependent care expenses: day care, after-school programs, adult day care & summer camp*	$5,000/household

*Subject to change

By setting aside money pre-tax into either a FSA or DCA, you save on taxes and take home more spendable income! Please contact P & A customer service for a list of eligible medical and dependent care expenses.

Basic and Voluntary Life

Symetra | 1-877-377-6773 | www.symetra.com

Basic Life/AD&D Insurance

At HCS, Basic Life/Accidental Death and Dismemberment (AD&D) Insurance is a provided benefit at no cost to you through **Symetra**. **HCS covers 100% for Employee coverage in the amount of $40,000.**

AD&D insurance pays an additional amount based on a specific list of losses such as loss of life, limb, or sight due to an accident. You can update beneficiary information in ESS under "Personal Information". Amounts are subject to age reductions beginning at age 70.

Voluntary Life and AD&D Insurance

You have the option to purchase Voluntary Term Life and AD&D. You may purchase:

- Employee coverage in increments of $10,000 to a maximum of $300,000. Newly hired employees may purchase up to $300,000 without evidence of good health. If you elect an amount over $300,000, you must complete the Evidence of Insurability form and email it to the benefits department at empbenefits@hcde.org.
- If you elected Voluntary Life Insurance last year, but did not purchase up to the Guarantee Issue, you can increase your coverage by $10,000 each year at open enrollment until you reach the Guarantee Issue Amount of $300,000.
- Spousal coverage in increments of $5,000 up to $50,000, but must not exceed 100% of the employee's purchased amount. Newly hired employees may purchase the first $50,000 without evidence of good health.
- Child(ren) coverage, the full amount is available without evidence of good health. You may purchase $5,000 or $10,000 of coverage on child(ren) age 6 months to 26 years (if a full-time student).

Benefits are subject to age reduction beginning at age 70 and terminate upon retirement.

Disability Coverage

Symetra | 1-877-377-6773 | www.symetra.com

Short-Term Disability Insurance

Short-Term Disability (STD) Insurance can help support you and your family should you become temporarily disabled. Employees must exhaust all accrued paid leave before STD benefits begin. **This base coverage is paid by HCS.** Your employer paid STD benefits begin the 7th day of injury or illness. Your weekly benefit is 60% of your weekly earnings to a maximum of $500.

You can also buy-up your STD Benefit. The buy-up pays 66 2/3% of your pre-disability earnings to a max of $2,000 a week.

Long-Term Disability Insurance

LTD Insurance can protect your income in case of a long-term injury or illness. **This coverage is paid by HCS**.

Your LTD benefits are equal to 66.67% of your basic monthly earnings not to exceed $4,000 per month. This benefit picks up after Short-Term Disability ends and you have been deemed disabled for 180 days. Benefits last up to social security normal retirement age.

Pre-existing condition limitations apply. Contact the Benefits Department for more information.

Voluntary Benefits

Symetra | 877-377-6773 | www.symetra.com

Critical Illness

Provides a cash benefit when a covered person is diagnosed with a covered illness or event. Coverage is available for the employee and spouse in amounts of $10,000, $20,000, or $30,000. Coverage is also available for children in the amounts of $5,000 or $10,000.

Health screening benefit in the amount of $50 annually included.

The following conditions are covered at 100% of the face amount of the policy: Heart Attack, Stroke, Major organ failure, Paralysis, ALS, Advanced Alzheimer's, Parkinson's Disease, Multiple Sclerosis, End Stage Renal Failure, loss of sight, loss of speech, loss of hearing, severe burns, Occupational HIV.

Hospital Indemnity

Provides a cash benefit when a covered individual incurs a hospital stay resulting from a covered injury or illness.

Admissions to a Mental Health Facility, a Substance Abuse Facility, or a Nursing Facility are also covered.

Hospitalization benefit is $1,000 upon admission, then $200 per day (limit 15 days) for regular hospital stay and $400 per day for ICU (limit 15 days).

Accident Insurance

Provides a cash benefit if a covered person suffers an injury, or incurs one of the covered medical treatments from an accident. Coverage is available for the employee, spouse, and child.

Benefit is paid by Symetra according to a specific schedule by injury and treatment type.

Examples of payout:

- Emergency Room- $200
- Hospital Confinement: $1,000 (initial day) $200 per day for 15 days
- Dislocations: $180-$6,000
- Fractures / Broken Bones: $420-$6,000

Other Benefits

Childcare

Hamilton County employees have several school-based daycares available for their use in twelve Hamilton County Schools. Daycare hours follow the school schedule. Daycares are operated by the Chambliss Center for Children and are available at an affordable rate. Visit www.chamblisscenter.org/offsite-programs to learn more. Hamilton County also operates school aged child care where Hamilton County employees are eligible for a discounted rate. Childcare sites are subject to availability. Please reach out to the Chambliss Center or HCS School-Aged Childcare for more information at www.hcde.org/district/department_directory/child_care.

Sick Leave

Full-time regular employees are allowed one (1) sick day for each month worked. Employees are not limited to the number of days they can accumulate. Classified sick leave is accrued. Sick leave is defined as personal illness from natural causes or accident, quarantine, or illness or death of a member of the immediate family, meaning wife or husband, parents, grandparents, children, grandchildren, brothers, sisters, mother-in-law, father-in-law, daughter-in-law, son-in-law, brother-in-law, and sister-in-law. The immediate supervisor may require a physician's certificate.

At the termination of employment, all unused sick leave accumulated will be administered as follows: 1. If the employee retires under any State of Tennessee or Hamilton County approved retirement plans, they may be eligible for a loyalty bonus of unused sick leave (refer to Board Policy 5.302). 2. If the employee resigns, his/her leave will be held in escrow in the event the employee is rehired at a later date. 3. Provided that another Tennessee Public School System and/or entity that accepts sick leave hires the employee, the employee may transfer his/her accumulated sick leave provided that the school director or other appropriate Tennessee official requests the leave to be transferred by HCDE. 4. If an employee is terminated for cause, the employee loses all accumulated sick leave. (refer to Board Policy 5.302)

Personal Leave

All full-time employees are allowed (3) three personal leave days per year. For part-time employees earning benefits, personal leave will be prorated. (refer to Board Policy 5.303)

Bereavement

Regular full-time and regular part-time employees are granted (5) consecutive work days of paid bereavement leave without loss of pay or benefits, and not chargeable to any other type of leave on the death of parent or court appointed legal guardian, spouse, child of the employee, natural and/or adopted siblings, grandparents, and current parents-in-law if the leave is taken within seven (7) calendar days for the funeral or cremation. For more information, please reference Board Policy 5.3022.

Vacation

All eligible twelve month employees shall receive annual vacation according to the following schedule.

Experience Vacation Earned
- 0-9 years 12 days (90 hours)
- 10-14 years 17 days (127.5 hours)
- 15-19 years 18 days (135 hours)
- 20 + years 24 days (180 hours)

(refer to Board Policy 5.310)

Holidays

- Holidays will be granted as follows:
- Christmas and New Years - 4 days (total)
- Thanksgiving - 2 days
- Labor Day - 1 day
- Spring Holiday - 1 day
- Independence Day - 1 day
- M.L. King - 1 day
- Memorial Day - 1 day
- Juneteenth - 1 day

Total - 12 days

Chattanooga Area Schools Federal Credit Union

1-423-624-9094 | www.casfcu.com

Chattanooga Area Schools Federal Credit Union (CASFCU) offers savings accounts, loans, investments and more. All employees and retirees in our Field of Membership:

1. Children of Primary or Secondary Members, Progressive
2. Spouses of Primary or Secondary Members, Progressive
3. Parents of Primary or Secondary Members, No Progression

As a member, you are eligible for Very Competitive Interest Rates on Loans and Savings Accounts. You are also eligible for our Beach Bucks, our Christmas Cash Drawing, and our Dividend Bonuses and Interest Rebates. Call (423) 624-9094 for more details.

Tennessee Consolidated Retirement Plan

1-800-922-7772 | mytcrs.tn.gov

There are two types of retirement plans covering public employees: Defined Benefit Plans and Defined Contribution Plans. These type plans are summarized below:

Defined Benefit Plan

- Annuity at retirement is based on a set formula.
- The employer bears the risk of investment loss.
- Contributions are not available for loans or withdrawal until termination of employment.
- Benefit payments are for an employee's lifetime.
- Examples of defined benefit plans: TCRS and Social Security.

Defined Contribution Plan

- The annuities/distributions at retirement are based on the retiree's account balance.
- The employee chooses the investments and bears the risk of investment losses or gains.
- Contributions may be available for withdrawal or loans, subject to early withdrawal penalties.
- Examples of defined contribution plans: 401(k) and 403(b) plans.

Full time employees of the Hamilton Co. Dept. of Education participate in the Tennessee Consolidated Retirement System, which offers both options to eligible state employees, higher education employees, K-12 public school teachers, and employees of political subdivisions in the state of Tennessee.

The TCRS provides retirement benefits as well as death and disability benefits to plan members and their beneficiaries. Benefits under the defined benefit plan portion are determined by a formula using the member's high five-year average salary and years of service. A reduced retirement benefit is available to vested members with five years of service who become disabled and cannot engage in gainful employment. There is no service requirement for disability that is the result of an accident or injury occurring while the member was in the performance of duty.

Teachers hired before 6/30/2014 are Legacy.
Teachers hired on or after 7/1/2014 are Hybrid.

Classified hired before 9/30/2015 are Legacy.
Classified hired on or after 10/1/2015 are Hybrid.

Annual Notices

SUMMARY OF BENEFIT COVERAGE The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is provided by your Medical carrier. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual open enrollment period, upon plan renewal and upon request at no charge to you.

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).

To see if any other states have added a premium assistance program since **July 31, 2023**, 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

Alabama	855-692-5447
Alaska	866-251-4861
Arkansas	855-692-7447
California	916-445-8322
Colorado	800-221-3943
Florida	877-357-3268
Georgia	678-564-1162
Indiana	877-438-4479
Iowa	888-346-9562
Kansas	800-792-4884
Kentucky	855-459-6328
Louisiana	855-618-5488
Maine	800-442-6003
Massachusetts	800-862-4840
Minnesota	800-657-3739
Missouri	573-751-2005
Montana	800-694-3084
Nebraska	855-632-7633
Nevada	800-992-0900
New Hampshire	603-271-5218
New Jersey	800-701-0710
New York	800-541-2831
North Carolina	919-855-4100
North Dakota	844-854-4825
Oklahoma	888-365-3742
Oregon	800-699-9075
Pennsylvania	800-692-7462
Rhode Island	855-697-4347
South Carolina	888-549-0820
South Dakota	888-828-0059
Texas	800-440-0493
Utah	877-543-7669
Vermont	800-250-8427
Virginia	800-432-5924
Washington	800-562-3022
West Virginia	855-699-8447
Wisconsin	800-362-3002
Wyoming	800-251-1269

For a listing of State websites, visit: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

For states not listed:
877-543-7669
www.insurekidsnow.gov

OMB Control Number 1210-0137
Expires 1/31/2026

NOTICE OF PATIENT PROTECTIONS

Your medical plan may require the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. Until you make this designation, the medical plan may designate one for you. For information on how to select a PCP, and for a list of the participating providers, contact your carrier.

If you must select a PCP for your child(ren), you may designate a pediatrician as such.

You do not need prior authorization from your carrier or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your carrier.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Introduction. The Consolidated Appropriations Act of 2021 was enacted on December 27, 2020, and contains many provisions to help protect consumers from surprise bills, including the No Surprises Act under title I and Transparency under title II.

Your Rights and Protections Against Surprise Medical Bills. When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of- network provider.

You are protected from balance billing for:

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).

Your health plan will pay out-of-network providers and facilities directly.

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

If you believe you've been wrongly billed, you may contact Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

HIPAA– PRIVACY ACT LEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract providers.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

SECTION 111 OF JANUARY 1, 2009 Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including Social Security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine if the Employer plan or Medicare/Medicaid/SCHIP is primary for those employees covered under a government plan and an employer sponsored plan.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 The Newborns' and Mothers' Health Protection Act of 1996 provides that 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). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans 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). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

MICHELLE'S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC), this law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38. The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the USERRA. See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides employees with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans' Preference.

HIPAA SPECIAL ENROLLMENT

SPECIAL ENROLLMENT NOTICE This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage If you are declining coverage 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 toward 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).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage. For More Information or Assistance To request special enrollment or obtain more information, please contact:

Lori Heffington

3074 Hickory Valley Road
Chattanooga, TN 37421

423-498-7086 Ext. 20071

Note: If you or your dependents enroll during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the "Health Information Technology for Economic and Clinical Health (HITECH) Act." The HITECH Act

supports the concept of meaningful use (MU) of electronic health records (EHR), an effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

RESCISSIONS The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

PREVENTIVE CARE Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

HIPAA PRIVACY NOTICE The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law.*** We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, the right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Individual Rights You may obtain a copy of your health claims records and other health information from us typically within a 30 day period from your request. We may charge a reasonable, cost-based fee. You may ask us to correct your health/claims records if you think they are incorrect. We reserve the right to say "no" to your request, but will give you an explanation in writing within a 60 day period. Requesting a specific way to contact you for confidential reasons is permitted (home or office phone for example), specifically if you would be in danger from a certain form of communication.

If you would like us not to use or share certain health information for treatment, payment or our operations, you are permitted to do so. However, we are not required to agree to your request if it would affect your care. At your request, we will provide you with a list of the times we have shared your health information up to six years prior to your request date, who we shared it with, and why. This list will include all disclosures excluding treatment, payment, and health care operations, as well as other certain disclosures (such as any you ask us to make). We provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You can ask for a paper copy of this notice at any time, which we will promptly provide, even if you have agreed to receive the notice electronically. If you have given someone medical power of attorney or if you have a legal guardian, that person can exercise your rights and make choices about your health information. We will make sure they have this authority and can act in your interests before we take any action.

If you feel that we have violated your rights, you may contact us using the information on the back page, or 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 can assure no retaliation from us against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. You have the right and choice to tell us to share information with your family, close friends, or others involved in payment for your care, and 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 and when needed to lessen a serious and imminent threat to health or safety. We never share your information for marketing purposes of sale of your information without your expressed written consent.

Our Uses and Disclosures We typically use or share your information in several different ways. We help manage the healthcare treatment you receive by sharing information with professionals who are treating you. 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). Our organization can use and disclose your health information as we pay for your health services, as well as disclose your health information to your health plan sponsor for plan administration.

Other Uses and Disclosures Typically in the matter of public health and safety issues, we can use and share your information. For instance, preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, as well as preventing or reducing a serious threat to anyone's health or safety, and health research.

We may need to share your information if state or federal law requires it, including the Department of Health and Human Services if it wishes to see that we're complying with federal privacy law. Other organizations and professionals we may share your information with are organ procurement organizations, coroners, medical examiners, and funeral directors. We can share your information in special instances such as for worker's compensation claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share 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.

"We, Our, and Us" is defined as the insurance carrier for fully insured plans or the plan administrator or third party administrator for self insured plans.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

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

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

For more information visit https://www.medicare.gov/medicare-and-you, or https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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

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

Plan contact information

Lori Heffington

3074 Hickory Valley Road
Chattanooga, TN 37421

423-498-7086 Ext. 20071

Trinity Advisors | RUSS BLAKELY & ASSOCIATES, LLC

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Important Notice from Our Company 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 Our Company 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. Our Company has determined that the prescription drug coverage offered by the medical plans 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 employee coverage will not be affected. You can keep this coverage if you elect part D and the Medical Carrier plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Our Company's 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 Our Company 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.

More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date	01/2024
Name of Entity	Hamilton County Schools
Contact	Penny Murray -- Executive Director
Address	3074 Hickory Valley Road Chattanooga, TN 37421
Phone	423-498-7069

HAMILTON
COUNTY
SCHOOLS