HELPING YOU UNDERSTAND
Your Benefit Choices

Open Enrollment Benefits Guide 2023 - 2024

This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your employer's benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

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 "Notices" Section in the back of this benefits booklet.

**This guide may or may not be applicable to union employees.*

CONTENTS

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

Deductible – The amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Care – that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits (EOB) — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Out-of-Network – The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with United Healthcare to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – To have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – To have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any insured dependents.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

WELCOME LETTER

EMPLOYEE BENEFITS

We welcome you to Catoosa County BOC! You are Catoosa County Government's most important asset, and the Board of Commissioners remains committed to making your health and wellness an important part of our benefit offerings. We are pleased to present you with an enhanced benefits program through United Healthcare, Ameritas, and the Hartford.

Please review our 2023-2024 benefits in the enclosed benefits guide. The county believes you will see great value in the opportunities to help you and your family sustain a healthy lifestyle.

We know a great benefits package is vital to recruit and keep skilled employees like yourself. Our Human Resources team is ready to help you understand your choices and answer any questions that you may have. And if you haven't already, please take advantage of the services available to you and your family at Catoosa County Employee Health Clinic.

Thank you for your dedication to serving our neighbors! We appreciate your hard work and wish you the very best in health and happiness.

Catoosa County Board of Commissioners

BOARD OF COMMISSIONERS

Larry Black
Chairman

Jeff Long
District 1

Chuck Harris
District 2

Vanita Hullander
District 3

Charlie Stephens
District 4

The Catoosa County Board of Commissioners meet the first and third Tuesday of every month at 6:00 pm. Meetings are open to the public and held in the Administration Building, 800 Lafayette Street, Ringgold.

The Board of Commissioners is composed of five members elected by the voters for staggered four-year terms. Four Commissioners are elected by specific districts and the Chairman is elected at-large. The Board, as the county's governing authority, is responsible for establishing policy for county operations, enacting ordinances and resolutions to promote the county's health, safety, and welfare, and approving the annual budget which funds the operations of the constitutional officers as well as the departments under the Board's jurisdiction.

The Board appoints the County Manager, County Attorney, and County Clerk.

WELCOME

BENEFITS MENU | ENROLLMENT

BENEFITS OFFERED

MY HEALTH

Medical | **United Healthcare**
Dental | **Ameritas**
Vision | **Ameritas (VSP or EyeMed)**

MY LIFE

Life and AD&D | **Hartford**
Disability | **Hartford**

MY EXTRAS

EAP | **Espyr**
FSA | **United Healthcare**

BSWIFT ENROLLMENT INSTRUCTIONS:

1. Go to www.catoosa.bswift.com
2. Enter your Username: **Last Name + Last 4 of your SSN** e.g.John Smith = Smith4567
3. Enter your Password: **Last 4 of your SSN**
4. Follow instructions and enroll in your benefits
5. Make sure to complete your enrollment and email yourself a confirmation statement.

Open Enrollment Period

May 30th, 2023 – June 2nd, 2023

ENROLLMENT INSTRUCTIONS

1. Review the information in this guide and benefit plan summaries and attend a benefits enrollment meeting.
2. Please go online (bswift) or meet with an NFP Benefit Counselor to elect or decline coverage by June 2, 2023.
3. Please contact NFP at (800) 994-7429 to speak with a Benefit Counselor if you need assistance with your enrollment.
4. You will not be allowed to make changes after the enrollment window closes unless you experience a qualifying life event.

NOTE: All employees are encouraged to log into the bswift enrollment portal to confirm their demographic information, dependent information, student status information, and beneficiary information. For reporting purposes, Social Security numbers and date of birth information must be provided and accurate. During the annual open enrollment, you MUST enroll or waive the FSA/Section 125 plans online.

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Did any of your covered children reach their *26th birthday this year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria. Please contact HR or NFP if you need help determining eligibility.
3. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.

ELIGIBILITY

RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are a full-time, year-round employee. Your coverage will be effective on the 1st day of the month following 30 days of employment.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant; or
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains which dependents are eligible for coverage under each benefit plan type:

Line of Coverage	Dependents Eligible for Coverage
Medical, Dental, Vision, Life Insurance, and EAP	**Married Spouse and Dependent Children** (until the last day of the month the child turns age 26**)**
Short-Term & Long-Term Disability	**Dependents not eligible**

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify the Human Resources Department and complete your election changes **within 30 days** following the event. You must provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

Please contact HR at (706) 965-2500 or NFP at (800) 994-7429 to speak with a benefits counselor regarding enrollment.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to the Benefits Department within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section on page 23.

HEALTH

MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all In-Network services at 100% until the end of the plan year.

PPO (Preferred Provider Organization)

In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

How do I find an In-Network Provider?

In-Network providers can be found on your provider's website (www.myuhc.com) under "Find a Doctor".

Did You Know?

- ✓ **Preventive Services** are c**overed at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

Your Care Options and When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely to be familiar with, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

MEDICAL

HEALTH | PLAN COMPARISON

UnitedHealthcare

UHC CHOICE PLUS

DEDUCTIBLE	In-Network	Out-of-Network
Single Deductible	$500	$1,000
Two Person/Family Deductible	$1,000	$2,000
COINSURANCE *(applies after deductible is met)*		
Member Cost Share %	100%	70%
MEMBER COPAYMENT(S)		
Primary Care (PCP) - Office Visit	$30 copay	70%*
Preventative Care Office Visit	$0 copay	Not Covered
Virtual Visit	$10 copay	Not Covered
Specialist - Office Visit	$40 copay	70%*
Urgent Care Facility	$75 copay	70%*
Outpatient Emergency Room Visit	$150 copay	
OUT-OF-POCKET (OOP) MAXIMUM	***After the Annual Medical Deductible has been met.**	
Single Maximum	$2,000	$4,000
Two Person/Family Maximum	$4,000	$8,000
PRESCRIPTIONS *(deductible does not apply)*	***Mail order available for 2x retail**	
Tier 1 (Generic)	$10	$10
Tier 2 (Preferred Brand)	$35	$35
Tier 3 (Non-Preferred Brand)	$60	$60

PER PAY PERIOD MEDICAL PLAN DEDUCTIONS
(26 Pay Periods Per Year)

Coverage Tier	Medical Plan
Employee Only	$17.21
Employee + Spouse	$108.40
Employee + Child(ren)	$95.49
Employee + Family	$149.69

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year **(July 1st through June 30th)**. The only time you can change your election is during the enrollment period or if you experience a change-in-status event.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at **www.irs.gov.**
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at **www.fsastore.com.**

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | $3,050

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general-purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school full-time.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **$5,000** annually in pre-tax dollars, or **$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

HEALTH CARE FSA ROLLOVER

Health Care FSAs have a **$610 roll over** feature which allows any amount of $610 or less remaining in your account at the end of the plan year to roll over into the new plan year.

MULTIPLE METHODS FOR ACCOUNT MANAGEMENT

UHC Online: http://www.myuhc.com/

UHC FSA Member Services:
(877) 311-7849

***ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:**

1. **'Care'** for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. **'Care'** for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. **'Care'** for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

'Care' is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

HERE'S HOW IT WORKS

An employee earning $30,000 elects to place $3,050 into a Health Care FSA. The payroll deduction is $117.30 based on a 26-pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $713.

	Without FSA	With FSA
Gross Income	$30,000	$30,000
FSA Contributions	$0	-$3,050
TAXABLE INCOME	**$30,000**	**$26,950**
Estimated Taxes		
Federal	$3,090*	$2,776*
State	$1,104**	$991.76**
FICA	$2,295	$2,008
AFTER TAX EARNINGS	**$23,511**	**$21,174**
Eligible Out-Of-Pocket Expenses	$3,050	$0
AVAILABLE/SPENDABLE INCOME	**$20,461**	**$21,174**

That's a savings of $713 for the year!

This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

**Varies, assumes 10.30%;*
***Varies, assumes 3.68%*

OVER-THE-COUNTER (OTC) MEDICATION REMINDER

Effective for purchases on or after January 1, 2020, thousands of items, including pain relievers, cold and flu medications, antacids, acne remedies, and allergy medicines are now reimbursable from an FSA, Section 213 HRA, or HSA without a prescription.

In addition to eliminating the prescription requirement on OTC drugs and medicine, the new CARES Act has added hundreds of menstrual products to the list of approved expenses, including tampons, pads, liners, cups, sponges and similar items. As was the case prior to the passage of the ACA, vitamins and supplements will continue to require a physician's "prescription" indicating that they are being taken to treat a diagnosed medical condition (e.g., anemia) rather than for general health and wellness.

ELIGIBLE HEALTH FSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Artificial teeth/dentures
- Blood pressure monitors
- Braces
- Braille-books & magazines
- Breast pumps & lactation supplies
- Chiropractors
- Co-insurance, co-pay & deductibles
- Cost of operations & related treatments
- Crutches
- Diabetic supplies
- Drug addiction treatment
- Eye exams, eyeglasses, contacts
- Hearing devices & batteries
- Hospital services
- Operations
- Pregnancy tests
- Radial keratotomy & lasik eye surgery
- Smoking cessation programs
- Speech therapy
- Surgical fees
- Vaccines
- Walkers & wheelchairs
- X-rays and more

A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

IMPORTANT: PAYING FOR ELIGIBLE SERVICES & EXPENSES

Visit the FSA Store at **www.FSAstore.com,** where you can purchase FSA-eligible products without a prescription online.

Although you do not need to file for reimbursement when using your FSA debit card, you may be required to submit documentation, so be sure to save your receipts.

If you use a personal form of payment to pay for eligible expenses* out-of-pocket, *you can submit an FSA claim form along with your original receipts for reimbursement.

DENTAL
COVERAGE OVERVIEW

PRE-TREATMENT ESTIMATE
If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you estimate your out-of-pocket costs.

BENEFITS
Members enrolled in the dental plan are eligible for replacements of crowns, inlays, onlays, partial and complete dentures, veneers, implants, and bridges once every five years. All dental participants are eligible for prophylaxis (cleanings) twice every calendar year.

PREVENTION FIRST
Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

How do I find an In-Network Provider?
This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on **www.ameritas.com** under "Find a Dental Provider".

Enter your zip code and select the Classic PPO network. Enter your search criteria and click on the SUBMIT button.

For additional assistance contact: (800) 755-8844

Maintaining our dental health is a large component in our overall health. While brushing and flossing daily is important, routine dental exams and cleanings are necessary to remove bacteria, plaque, and tartar and detect early signs of gum disease. In addition, regular dental visits may reveal other health issues.

Catoosa County offers dental coverage as summarized below.

Ameritas

PLAN FEATURES	
DEDUCTIBLE	
Single	**$50**
Family	**$150**
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive or Orthodontia services)
COVERED SERVICES	
Preventive Services *Periodic oral evaluation; Prophylaxis (cleanings), Bitewing X-rays; Topical fluoride application; Sealants*	**Covered at 100%**
Basic Services *Filling, amalgam, e.g., silver-colored, two surfaces; Extractions, Endodontics, Periodontics*	**Covered at 80%**
Major Services *Crowns, implants, dentures, fixed bridges*	**Covered at 60%**
Orthodontia **(Children only up to age 19)**	**Covered at 60%; up to a lifetime maximum benefit of $1,000**
ANNUAL MAXIMUM	
Maximum Benefit *Allowed per Benefit Period*	**$2,500 per covered individual**

PER PAY PERIOD DENTAL PLAN DEDUCTIONS
(26 Pay Periods Per Year)

Coverage Tier	Dental Plan
Employee Only	$2.78
Employee + Spouse	$9.72
Employee + Child(ren)	$9.24
Employee + Family	$14.58

VISION
COVERAGE OVERVIEW

Good visual health can play an important role in our overall health. For those of us with eye care needs, having a Vision plan available from Catoosa County can ultimately help offset some of those associated costs in preserving our eye health and ongoing wellness. Becoming a member of the vision plan that is available through the county will enable you to take advantage of substantial savings on your eye care and eyewear needs. You will now have two different vision plans to choose from, allowing you to see different In-Network providers at the same low cost!

	Ameritas VSP Plan - Focus	EyeMed Plan - View Pointe
PLAN FEATURES		
Vision Exam	**$10** copay	**$10** copay
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	**$25** copay	**$25** copay
Bifocals	**$25** copay	**$25** copay
Trifocals	**$25** copay	**$25** copay
Frames	**$130** allowance	**$130** allowance
COVERED SERVICES		
Contact Lenses - Elective	**$130** allowance	**$130** allowance
Contact Lens – Medically Necessary	**Covered in full**	**Covered in full**
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 12 Months	Once every 12 Months
Contacts *(contacts in lieu of frames/lenses)*	Once every 12 Months	Once every 12 Months

PER PAY PERIOD VISION PLAN DEDUCTIONS
(26 Pay Periods Per Year)

Coverage Tier	Deduction
Employee Only	$2.74
Employee + Spouse	$5.29
Employee + Child(ren)	$4.47
Employee + Family	$7.00

Need to locate a participating In-Network provider?

For a complete list of providers near you use our Provider Locator on **www.ameritas.com** and select "Find a Vision Provider" or call (800) 755-8844.

BASIC LIFE
COVERAGE OVERVIEW

BENEFICIARY(IES)

It is very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent (Secondary) Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

BASIC LIFE INSURANCE

Basic Term Life and Accidental Death & Dismemberment (AD&D) insurance provides valuable financial protection for your family.

Catoosa County is pleased to provide **$20,000** of Basic Life & AD&D insurance to all full-time employees **at no cost to you**.

BASIC LIFE COVERAGE – THE HARTFORD	
Coverage Amount	Flat **$20,000** Benefit
Accidental Death and Dismemberment (AD&D)	Amount equal to your Life benefit
Benefit Reduction Schedule	Coverage will reduce at age 65 to 65% of the original amount and at age 70 to 50% of the original amount.

ADDITIONAL PLAN PROVISIONS	
Conversion	If your employment ends or you retire, you can convert to an individual permanent life policy without evidence of insurability.
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance.

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit ($20,000) would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

VOLUNTARY LIFE
COVERAGE OPTIONS FOR YOU & THE FAMILY

VOLUNTARY LIFE INSURANCE

Employees have the opportunity to enroll in additional life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. You must elect coverage for yourself in order to enroll in coverage for your spouse and/or child(ren).

PLAN OPTIONS			
Cost of Coverage	Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.		
Coverage Options	**Employee Coverage** Choose in $10,000 increments up to the lesser of 5x your annual salary or $500,000	**Spouse Coverage** Choose in $5,000 increments up to $50,000 (not to exceed 50% of the employee's election)	**Dependent Coverage** Choose in $1,000 increments up to $10,000 (not to exceed 50% of the employee's election)
Do I have to take a health exam to get coverage?	If you and your dependents enroll in coverage at your initial eligibility date (newly hired), you may apply for up to the Guaranteed Issue amounts without medical questions. All other employees adding or increasing coverage will be subject to medical questions.		
Guaranteed Issue	**Employee** $200,000 up to 5x your annual salary	**Spouse** $50,000 (not to exceed 50% of the employee's election)	**Dependent** $10,000 (not to exceed 50% of the employee's election)

PLAN PROVISIONS	
Cost Calculation	Age Rated Benefit (Spouse Life based on employee's age)
Benefit Reduction Schedule	Coverage will reduce at age 65 to 65% of the original amount and at age 70 to 50% of the original amount.
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance.
Conversion	If your employment ends or you retire, you may be eligible to convert to an individual permanent life policy.

***Guaranteed Issue (GI) and Evidence of Insurability (EOI)**

When you are first eligible (at hire) for Voluntary Life, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI).

Any amount elected over the GI will require EOI. If you elect voluntary life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form) or provide to your HR/NFP. In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

VOLUNTARY LIFE RATES

COVERAGE OPTIONS FOR YOU & THE FAMILY

EMPLOYEE LIFE OPTIONS — **BI-WEEKLY DEDUCTIONS (26)**

AGE	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-99
$10,000	$0.20	$0.25	$0.36	$0.66	$0.91	$1.68	$2.64	$3.86	$6.55
$20,000	$0.41	$0.51	$0.71	$1.32	$1.83	$3.35	$5.28	$7.72	$13.10
$30,000	$0.61	$0.76	$1.07	$1.98	$2.74	$5.03	$7.92	$11.58	$19.65
$40,000	$0.81	$1.02	$1.42	$2.64	$3.66	$6.70	$10.56	$15.43	$26.20
$50,000	$1.02	$1.27	$1.78	$3.30	$4.57	$8.38	$13.20	$19.29	$32.75
$60,000	$1.22	$1.52	$2.13	$3.96	$5.48	$10.05	$15.84	$23.15	$39.30
$70,000	$1.42	$1.78	$2.49	$4.62	$6.40	$11.73	$18.48	$27.01	$45.84
$80,000	$1.62	$2.03	$2.84	$5.28	$7.31	$13.40	$21.12	$30.87	$52.39
$90,000	$1.83	$2.28	$3.20	$5.94	$8.22	$15.08	$23.76	$34.73	$58.94
$100,000	$2.03	$2.54	$3.55	$6.60	$9.14	$16.75	$26.40	$38.58	$65.49
$110,000	$2.23	$2.79	$3.91	$7.26	$10.05	$18.43	$29.04	$42.44	$72.04
$120,000	$2.44	$3.05	$4.26	$7.92	$10.97	$20.10	$31.68	$46.30	$78.59
$130,000	$2.64	$3.30	$4.62	$8.58	$11.88	$21.78	$34.32	$50.16	$85.14
$140,000	$2.84	$3.55	$4.98	$9.24	$12.79	$23.46	$36.96	$54.02	$91.69
$150,000	$3.05	$3.81	$5.33	$9.90	$13.71	$25.13	$39.60	$57.88	$98.24
$200,000	$4.06	$5.08	$7.11	$13.20	$18.28	$33.51	$52.80	$77.17	$130.98
$250,000	$5.08	$6.35	$8.88	$16.50	$22.85	$41.88	$66.00	$96.46	$163.73
$500,000	$10.15	$12.69	$17.77	$33.00	$45.69	$83.77	$132.00	$192.92	$327.46

SPOUSE LIFE OPTIONS — **BI-WEEKLY DEDUCTIONS (26)**

AGE	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$5,000	$0.10	$0.13	$0.18	$0.33	$0.46	$0.84	$1.32	$1.93	$3.27
$10,000	$0.20	$0.25	$0.36	$0.66	$0.91	$1.68	$2.64	$3.86	$6.55
$15,000	$0.30	$0.38	$0.53	$0.99	$1.37	$2.51	$3.96	$5.79	$9.82
$20,000	$0.41	$0.51	$0.71	$1.32	$1.83	$3.35	$5.28	$7.72	$13.10
$25,000	$0.51	$0.63	$0.89	$1.65	$2.28	$4.19	$6.60	$9.65	$16.37
$30,000	$0.61	$0.76	$1.07	$1.98	$2.74	$5.03	$7.92	$11.58	$19.65
$35,000	$0.71	$0.89	$1.24	$2.31	$3.20	$5.86	$9.24	$13.50	$22.92
$40,000	$0.81	$1.02	$1.42	$2.64	$3.66	$6.70	$10.56	$15.43	$26.20
$45,000	$0.91	$1.14	$1.60	$2.97	$4.11	$7.54	$11.88	$17.36	$29.47
$50,000	$1.02	$1.27	$1.78	$3.30	$4.57	$8.38	$13.20	$19.29	$32.75

DEPENDENT LIFE OPTIONS — **BI-WEEKLY DEDUCTIONS (26)**

$10,000 for $1.00

DISABILITY

SHORT-TERM | LONG-TERM

SHORT-TERM DISABILITY (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs.

Short-Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

LONG-TERM DISABILITY (LTD)

Serious illnesses or accidents can come out of nowhere. They can interrupt your life and your ability to work for months – even years.

Long-Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

PLAN FEATURES	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Cost of Coverage	**Voluntary Benefit** Employee is responsible for 100% of the cost	**Voluntary Benefit** Employee is responsible for 100% of the cost
Elimination Period *This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.*	Your elimination period is **14 days**	Your elimination period is **180 days** (if elected, this will be the benefit duration of Short-Term Disability)
Benefit Duration *The maximum number of weeks you can receive benefits while you are sick or disabled.*	**Payments may last up to 24 weeks** You must be sick or disabled for the duration of the waiting period before you can receive a benefit payment.	**Payments will last for as long as you are disabled or until you reach Normal Social Security Retirement Age, whichever is sooner** You must be sick or disabled for the duration of the elimination period before you can receive a benefit payment.
Coverage Amount	Covers **60% of your weekly income,** up to a maximum benefit of **$1,000 per week.**	Covers **60% of your monthly income,** up to a maximum benefit of **$5,000 per month.**
What's covered?	**A variety of conditions and injuries.** Typical claims would include: pregnancy, injuries, joint, back, and digestive disorders.	**A variety of conditions and injuries.** Typical claims would include: cancer, back disorders, injuries and poison, cardiovascular, and joint disorders.
Definition of Earnings	**Base Salary** *(excludes commissions and bonuses)*	**Base Salary** *(excludes commissions and bonuses)*
ADDITIONAL PLAN PROVISIONS		
Benefit Payment Frequency	**Weekly benefit** may be reduced or offset by other sources of income.	**Monthly benefit** may be reduced or offset by other sources of income.
Cost Calculation	Composite Rate per $10 of coverage Benefit Payroll deductions are based on salary and age. Note: Rates are age banded and will change at policy anniversary if you move into a new age band.	Composite Rate per $100 of monthly payroll Benefit Payroll deductions are based on salary and age. Note: Rates are age banded and will change at policy anniversary if you move into a new age band.
Waiver of Premium	None	If you're disabled and receiving benefit payments, your cost may be eligible to be waived until you return to work.
Pre-Existing Condition Limitation	None	Pre-Existing Conditions are those conditions which you received medical treatment, care or consultation, including diagnostic measures or took prescribed drugs or medications during the 3 months preceding the effective date of this policy. Pre-Existing Conditions are not covered during the first 12 months of coverage.

Certain exclusions and any pre-existing condition limitations may apply.
Please refer to the Provider's detailed benefit summary for details.

EAP

EMPLOYEE ASSISTANCE PROGRAM

Catoosa County BOC
Employee Assistance Program (EAP)
Free | Confidential | 24/7

Counseling Support for stress, marital and family problems, job-related concerns, life transitions, work-life challenges, emotional issues, and other concerns.

- TalkNow® provides immediate access to counselors for in- the-moment support and guidance.
- Up to 6 EAP sessions for assessment, short-term counseling, and referral.
- Telephonic, video, and in-person options available.

Tess Chatbot is a supportive AI chatbot that is available 24/7, for unlimited conversations to help manage stress, increase self-awareness, build resilience, and discover helpful resources.

Legal assistance for issues such as divorce, family law, wills, adoption, and more. Identity Theft Recovery and mediation services are also available. Get a free 30-minute consultation and 25% discount off the mediator or attorney fees for services rendered beyond the EAP.

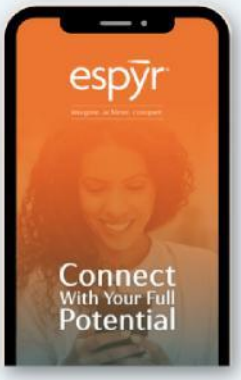
Financial consultation regarding debt matters, investment options, money management, taxes, and retirement planning. Financial personnel services are discounted at 25% as are CPA tax preparation fees.

Work-Life specialists provide consultation, information, resources, and verified referrals for most personal and family needs such as:

Childcare & Eldercare	Relocation
Adoption	Concierge
Academic	Pet Care
Health & Wellness	And More

Catoosa County has partnered with Espyr® to provide you and your eligible family members with immediate support to help improve your well-being. Get help with a variety of personal and work-life matters today.

App: Download the Espyr Connect mobile app from the Apple Store or Google Play Store.



Access digital resources including activities, assessments, videos, quizzes, articles, motivational tips, and more.

Organization ID: catoosacares

Online: care.espyr.com

Call: (800) 869-0276

Tess: Chat with Tess by texting "hi" to (442) 245-8065 or via the Espyr Connect app.

HEALTH CLINIC

ONE TO ONE HEALTH

Catoosa County Government Employee Health Clinic

Hours of Operation

DAY	TIME
Monday	8 am—3:30 pm
Tuesday	1 pm—6 pm
Wednesday	8 am—3:30 pm
Thursday	1 pm—6 pm
Friday	8 am—3:30 pm
Saturday	Closed
Sunday	Closed

Employees & their covered dependents may make appointments by calling: 423-402-8176

Walk-in Appointments available Monday, Wednesday, and Friday from 8 - 10am Tuesday and Thursday from 1 -2 pm

Clinic is located at: 313 Boynton Drive, Ringgold, Georgia 30736

NOTICES

Important Notice from Catoosa County 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 Catoosa County 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. Catoosa County has determined that the prescription drug coverage offered by the State Health Benefit plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing 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 Catoosa County coverage will not be affected.
If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the **Catoosa County** benefit plan during an open enrollment period under the Catoosa County benefit plan.

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 Catoosa County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Catoosa County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:
Visit www.medicare.gov
Call 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).

From: July 1, 2023 to June 30, 2024
Name of Entity/Sender: Catoosa County BOC
Contact Person: Jennifer Hayden
Phone: 706-965-0554
Email: jennifer.hayden@catoosa.com

NOTICES

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

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

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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

NOTICES

IOWA – Medicaid and CHIP (Hawki)	MONTANA – 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://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	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
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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

NOTICES

Unless otherwise noted, a paper copy is available, free of charge, by calling NFP at 800-994-7429.

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contribution toward the other coverage). 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 or your dependents; however, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION 125 PRE-TAX BENEFIT AUTHORIZATION NOTICE:
Before-tax deductions will lower the amount of income reported to the federal government. This may result in slightly reduced Social Security benefits. If you do not enroll eligible dependents at this time, you may not enroll them until the next open enrollment period. You may not drop the coverage you elected until the next open enrollment period. You may only make a change or drop coverage elections before the next open enrollment period under the following circumstances:
A change in marital status, or
A change in the number of dependents due to birth, adoption, placement for adoption or death of a dependent, or
A change in employment status for yourself or your spouse, or
Open enrollment elections for your spouse, or
A change in dependents eligibility, or
A change in residence or worksite.
Any change being made must be appropriate and consistent with the event and must be made within 30 days of when the event occurred. All changes are subject to approval by your Employer/Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE:
The Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breast, prostheses, and complications resulting from a mastectomy, including lymph edema.

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

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION: This Notice describes how the Plan(s) may use and disclose your protected health information ("PHI") and how you can get access to your information. The privacy of your protected health information that is created, received, used or disclosed by the Plan(s) is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice is available on the web at: **www.catoosa.bswift.com**. A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS*:* On April 7, 1986, a federal law was enacted (Public Law 99272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. If you or your eligible dependents enroll in the group health benefits available through your employer, you may have access to COBRA continuation coverage under certain circumstances. Therefore, your plan makes available to you and your dependents the General Notice Of COBRA Continuation Coverage Rights. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The full Notice is available on the web at: **www.catoosa.bswift.com**. A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their spouse/dependents covered under the group health plan.

SUMMARY OF BENEFITS AND COVERAGE (SBC): As an employee, the group health (medical) benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC) which summarizes important information about any health coverage option in a standard format to help you compare across options. The SBC is available on the web at **www.catoosa.bswift.com**. A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan.

HEALTH INSURANCE MARKETPLACE NOTICE (a.k.a. Exchange Notice): When key parts of the health care law took effect in 2014, a new way to buy health insurance became available through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, the Marketplace notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer. This notice is available on the web at **www.catoosa.bswift.com**. A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan.

BRC

BENEFIT RESOURCE CENTER

ONLINE BENEFIT RESOURCE WEB PAGE

Catoosa County offers a Benefit Resource Center. The site was developed to create an interactive, centralized resource for you to visit both during open enrollment and throughout the year.

The Benefit Resource Center will serve as your go-to resource for benefits related questions. You'll be able to access enrollment information, important benefit documents, links to resources, and a link to enrollment sites.

Catoosa County Benefit Resource Center site:

- ✓ **Enrollment Materials**
  - Enrollment Guide, Open Enrollment Memo, link to enrollment sites
- ✓ **Full Benefit Summaries**
  - More details about your coverage
- ✓ **Educational Videos**
  - Learn about your benefits and how they work
- ✓ **Carrier Links and Member Resources**
  - Easily find in-network providers and additional resources specific to your benefit plan
- ✓ **Contact Information**
  - Web address, email, and phone numbers to all vendors

View the Benefit Resource Center at **www.shawhankinsbenefits.net/catoosacounty**.

Why Would I Contact the NFP Service Center?

Order ID Cards: We can contact the insurance carrier directly and have your replacement card to you in ten to fifteen business days.

Claim Resolution and Research: We can help you understand your Explanation of Benefits (EOB) as well as contact the insurance carriers on your behalf. We can assist in appealing a denied claim or help you request a Prior Authorization (PA) from your physician as may be required by your medical carrier. We can also help you file out-of-network claims and assist with reimbursement if you require medical assistance while traveling outside of the United States.

Locate In-Network Providers: Staying in network saves everyone money. Our Service Center can help you locate In-Network Providers for medical, dental and vision coverage whether you are at home or away.

Request Copies of Any Necessary Forms: Medical claim forms, out-of-network claim forms, evidence of insurability forms, short and long-term disability claim forms and any other applicable forms are always available if the need should arise.

Understanding Your Benefits: We can assist you with questions regarding deductibles, copayments and coinsurance. We can explain waiting periods, elimination periods, and eligibility rules.

Explain Qualifying Events: Most benefit plans require that you have a Qualifying Event (like marriage, birth of a child or other life event) to make a change in your election anytime other than during open enrollment. We work with your employer to ensure that your change follows the rules of the plan, that your request is allowed within the appropriate timeframes, and that you give proper documentation of the event.

Annual Enrollment Information: We can provide details about when open enrollment begins and ends and if your plan designs or payroll deductions are changing.

Enrollment Assistance: The Service Center representative can walk you through every step of the enrollment process. Whether it's an online enrollment or paper enrollment form, your Service Center representative is available to help.

Confirmation Statements: We can provide copies of your online enrollment confirmation statement or a copy of your paper enrollment form at any time.

The Service Center is available from 8:30 a.m. to 5:00 p.m. Monday through Friday to assist you. We have an after-hours voice mailbox and your call will be returned the next business day.

(800) 994-7429
NFPsecustomerservice@nfp.com

IMPORTANT CONTACT INFORMATION

PROVIDER	CONTACT INFORMATION
Human Resources	Jennifer Hayden (706) 965-0554 jennifer.hayden@catoosa.com
Human Resources	Lora Ogden (706) 965-0561 human.resources@catoosa.com
Benefit Enrollment Questions	NFP (800) 994-7429 nfpSEcustomerservice@nfp.com
Medical	United Healthcare (866) 314-0335 www.myuhc.com
Dental	Ameritas (800) 755-8844 www.ameritas.com
Vision	Ameritas (800) 487-5553 www.ameritas.com
Basic Life & AD&D **Voluntary Life & AD&D**	Hartford (800) 523-2233 www.thehartford.com
Short Term Disability **Long Term Disability**	Hartford (800) 523-2233 www.thehartford.com
Flexible Spending Accounts (FSA) **(Healthcare FSA & Dependent Care FSA)**	United Healthcare (877) 311-7849 www.myuhc.com
Employee Assistance Program	Espyr (800) 869-0276 https://care.espyr.com/
Employee Health Clinic	One to One Health (423) 402-8176 Catoosa County Health Clinic Patient Portal Login Page

This Benefit Enrollment Guide Is Provided By:

NFP