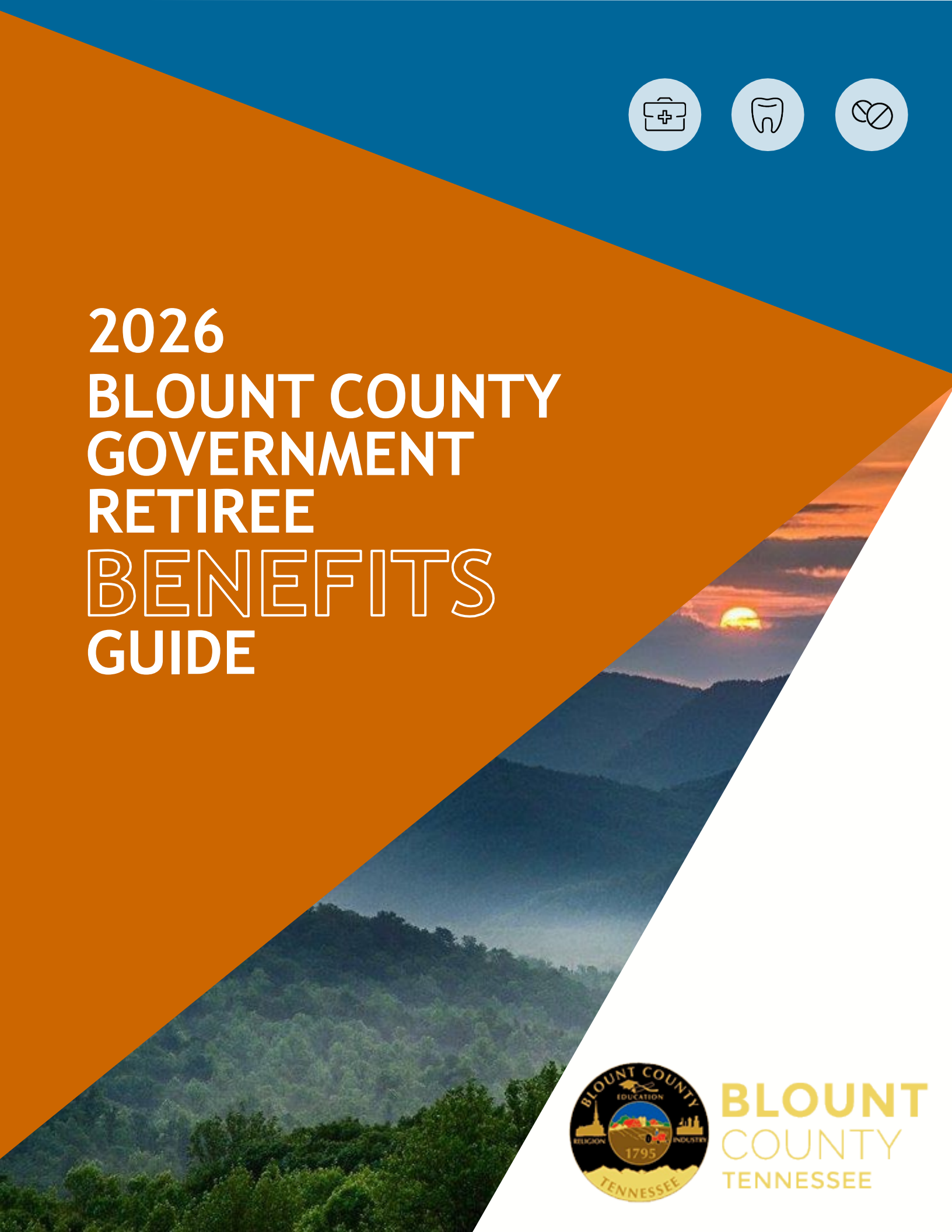
# 2026 BLOUNT COUNTY GOVERNMENT RETIREE BENEFITS GUIDE



BLOUNT COUNTY TENNESSEE

# Welcome to the 2026 Retiree Benefits Guide

Blount County Government recognizes the importance of benefits within the overall compensation package provided to all of our eligible retirees. Please review the following pages for a summary of our benefit offerings.

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# CONTACT INFORMATION

If you have any questions regarding your benefits, please contact your Care Coordinators at Quantum Health or your Human Resources Department.

**Your Human Resources Department**
865.273.5780
www.blounttn.org
hr@blounttn.org

**Care Coordinators**
Quantum Health
www.blountcountybenefits.com
1.866.952.0340

**Medical**
Allegiance
www.askallegiance.com/blount
1.855.999.1051
Group Number: 2003090
Hours: Monday -- Friday 6 am -- 6 pm MST

**2nd Opinion Medical Consultation**
2nd.MD
www.2nd.MD/blountcounty
1.866.841.2575

**Prescription**
CVS Caremark
www.caremark.com
1.800.552.8159

Select Drugs and
Products Program
(Specialty Drugs)
www.paydhealth.com
1.877.422.1776

Blount Discount Pharmacy
865.681.0520

**Dental**
Delta Dental of Tennessee
www.deltadentaltn.com
1.800.223.3104
Group Number: 4207

**CBIZ Service Center**
865.251.5140
9648 Kingston Pike, Ste 8
Knoxville, TN 37922

**Vision**
Superior Vision
www.superiorvision.com
1.800.507.3800
Group Number: 29382

**Basic Life and AD&D**
USAble Life
https://group.usablelife.com/tn/blount-county-government/
1.800.370.5856

**Employee Clinic**
Blount Memorial Physicians Group-Care Today Clinic
266 Joule St. Alcoa, TN 37701
865.983.0093
Operating Hours:
Monday - Friday: 7AM - 10PM
Saturday, Sunday & Holidays: 8am - 8pm
Closed Thanksgiving and Christmas Day

The plan year runs
**January 1, 2026 - December 31, 2026**

Eligible Retirees may enroll themselves in benefits as well as their eligible dependents. Retirees may select any of the tiers below as long as Blount County Government Retiree criteria is met.

See key terms below for coverage selection:

**Employee only:** Retirees, up to age 65, may select this tier if they wish only to enroll themselves on the plan.

**Employee + Spouse:** Retirees may select this tier if they wish to enroll themselves and their legal spouse on the plan, both up to age 65.

**Employee + Child(ren):** Retirees may select this tier if they wish to enroll themselves and one or more children on the plan, up to age 26.

**Family:** Retirees may select this tier if they wish to enroll themselves, their legal spouse, and one or more children on the plan.

## 2026 AT A GLANCE

- This year we will continue to offer three medical plans through Allegiance to better provide for the needs of each of our retirees and their families.
- CVS Caremark will remain the vendor for our prescription coverage.

**DISCLAIMER**

This guide is designed to provide a general overview of your benefits at Blount County Government. 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. Copies of the Plan Documents and notices for all benefits are available at www.blounttn.org. Should any questions or conflicts arise, the plan documents will be the final authority in determining your benefits. Blount County Government reserves the right to modify or discontinue the plans at any time.

# WHEN YOU DON'T KNOW WHERE TO BEGIN, START WITH US.

## IF THERE'S A BETTER WAY FOR YOU TO EXPERIENCE HEALTHCARE,

# WE'LL FIND IT.

From replacing ID cards to more complicated matters like claim resolutions, no request is too big or small for your MyQHealth Care Coordinators. We're your one resource to contact whenever you need help with your medical, dental, vision or pharmacy benefits.

Think of us as your personal team of nurses, benefit experts and claims specialists who will do all we can to support your unique healthcare needs. Each time you contact us, you'll talk to a real person who knows you, your benefits and your health history.

**Empowered and resourceful, MyQHealth Care Coordinators do things like:**

- Verify coverage
- Provide health-education resources
- Advocate for your care
- Help manage chronic conditions
- Find in-network providers
- Contact providers to discuss treatment
- Answer claims, billing and benefits questions
- Create health-improvement plans
- Help reduce unnecessary, out-of-pocket costs

**We also help confirm precertification for services to make sure you're always covered.**

- Home Health and Hospice
- Skilled Nursing Facility admissions
- Transplants
- MRI, MRA and PET scans
- Durable Medical Equipment over $1500
- Oncology therapy
- Dialysis
- Mental Health/ Substance Abuse: Partial Hospitalization
- Genetic Testing

MYQHEALTH CARE COORDINATORS
ARE JUST A TAP, CLICK OR CALL AWAY

2nd.MD
Specializing in Medical Certainty

# WE SPECIALIZE IN MEDICAL CERTAINTY

Through Blount County, you have an exclusive membership to 2nd.MD, a virtual expert medical consultation and navigation service. We connect you with a board-certified, elite specialist for a virtual expert medical consultation via phone or video from the comfort of home.

**2nd.MD specializes in medical certainty by providing access to elite specialists for questions about:**

- Disease, cancer or chronic condition
- Surgery or procedure
- Medications and treatment plans

## WHO IS ELIGIBLE?

2nd.MD is confidential, fast and no cost to employees and eligible dependents enrolled in a Blount County medical plan.

## GET STARTED TODAY

**Call at 1.866.841.2575**
**Visit www.2nd.MD/blountcounty**
**or download our 2nd.MD app**

Download on the App Store | GET IT ON Google Play

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## HOW IT WORKS: *3 Simple Steps*

1. **ACTIVATE YOUR ACCOUNT AND REQUEST A CONSULT**

   Visit www.2nd.MD/blountcounty, download our app or call us at 1.866.841.2575

2. **SPEAK WITH A NURSE**

   Just explain your medical issues and an experienced nurse will handle the rest, including collecting medical records and connecting you with a leading specialist who is an expert in your condition.

3. **CONSULT WITH A LEADING SPECIALIST**

   Get information about your diagnosis, treatment plan and next steps in care from a nationally recognized specialist. Consult via video or phone at a time that works best for you, including evenings and weekends!

## AFTER YOUR CONSULTATION

You'll receive a written summary of your consultation so you're prepared for a conversation with your treating doctor or we can refer you to another in-network doctor in your area.

**98%** of users would recommend 2nd.MD to family or friends*

**85%** of consults result in improved treatment plans*

**35%** of consults lead to an alternate diagnosis*

*2nd.MD's Book of Business Statistics 2019

# MEDICAL INSURANCE

## HOW TO GET STARTED

### SELECT YOUR MEDICAL PLAN

- ☐ **OPTION 1: Gold Plan**
- ☐ **OPTION 2: Silver Plan**
- ☐ **OPTION 3: Bronze Plan**

**TIP:** Get the most out of your insurance by using in-network providers.

As a retiree of Blount County Government, you have the choice between three medical plan options: two PPO plans and a Qualified High-Deductible Health Plan (QHDHP).

Regardless of the plan you select, your deductible will run from January 1–December 31.

To locate an in-network provider, go to www.blountcountybenefits.com.

After you register as a user, you can click "Find Provider."

**Healthcare BlueBook:** Healthcare Bluebook™

You may also visit Healthcare Bluebook to take advantage of significant savings on the most common medical procedures.

All members enrolling onto the health plan will have access to this price transparency tool. Prices of healthcare procedures often vary from 300% - 500%, within the same provider network and same region.

Healthcare Bluebook provides detailed cost information on procedures at different facilities to give you the information you need to be an informed consumer. Healthcare Bluebook also provides a tool that measures the quality of healthcare provided by both hospitals and doctors.

Color-coded results are displayed for members to see, so you can compare price and quality ranking:

- **Green** (less than or equal to the Fair Price; highest quality)
- **Yellow** (slightly above the Fair Price; average quality)
- **Red** (most expensive; worst quality)

### FREQUENTLY ASKED QUESTIONS

**? Will I receive a new Medical ID card?**

You will receive a new ID card if you are enrolled in the Bronze plan, or if you are enrolling for the first time or changing your medical election.

**? Does the deductible run on a calendar year or policy year basis?**

A calendar year basis.

**? How long can I cover my dependent children?**

Dependent children are eligible until the end of the month in which they turn age 26.

## MONTHLY PREMIUMS

| Gold Plan | Full Monthly Premium | Employer Contribution | Retiree Monthly Cost |
|---|---|---|---|
| Employee Only | $761.00 | $596.00 | $165.00 |
| Employee + Spouse | $1,745.00 | $1,368.00 | $377.00 |
| Employee + Child(ren) | $1,716.00 | $1,346.00 | $370.00 |
| Family | $1,773.00 | $1,391.00 | $382.00 |
| **Silver Plan** | **Full Monthly Premium** | **Employer Contribution** | **Retiree Monthly Cost** |
| Employee Only | $701.00 | $596.00 | $105.00 |
| Employee + Spouse | $1,609.00 | $1,368.00 | $241.00 |
| Employee + Child(ren) | $1,583.00 | $1,346.00 | $237.00 |
| Family | $1,635.00 | $1,391.00 | $244.00 |
| **Bronze Plan** | **Full Monthly Premium** | **Employer Contribution** | **Retiree Monthly Cost** |
| Employee Only | $633.00 | $596.00 | $67.00 |
| Employee + Spouse | $1,522.00 | $1,368.00 | $154.00 |
| Employee + Child(ren) | $1,496.00 | $1,346.00 | $150.00 |
| Family | $1,549.00 | $1,391.00 | $158.00 |

## COORDINATION WITH MEDICARE

You will have medical and dental coverage until your 65th birthday, which at that time will automatically terminate at midnight. If you carry your spouse on medical and/or dental coverage, the insurance will continue until their 65th birthday or dependents until their 26th birthday, as long as premiums are paid monthly.

If you or your dependent qualify for Medicare prior to age 65 (Example: due to a disability or End Stage Renal Disease), the Blount County Government Medical plan will coordinate as follows:

Medicare Part A and Part B will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits. This means that this Plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare. Also, failure to enroll in Medicare Part B when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B.

**For Covered Persons who are Disabled**

This Plan is secondary, and Medicare will be primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

**For Covered Persons with End Stage Renal Disease**

Except as stated below*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be Primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above, the Covered Person has no dialysis for a period of twelve (12) consecutive months and:

A. Then resumes dialysis, at which time this Plan will again become primary for a period of thirty (30) months; or

B. The Covered Person undergoes a kidney transplant, at which time this Plan will again become primary for a period of thirty (30) months.

*If a covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary, and this Plan will be secondary. **If you are on Medicare due to a disability, you MUST enroll in Part B or risk having significant out of pocket costs.**

# MEDICAL PLAN OPTIONS

Allegiance® a Cigna Company

| IN-NETWORK BENEFITS | | | |
|---|---|---|---|
| | **Gold Plan** | **Silver Plan** | **Bronze Plan** |
| **Calendar Year Deductible**<br>Individual / Family | $750 / $1,500 | $1,500 / $3,000 | $3,400 / $6,800 |
| | Deductibles incurred in the last quarter of the calendar year (October 1 thru December 31) will carry over to next year's calendar year deductible | | |
| **Supplemental Accident** | First $300 paid at 100% | | |
| **Percentage Payable**<br>(unless otherwise stated) | 85% after deductible | 85% after deductible | 100% after deductible |
| **Out-of-Pocket Maximum**<br>Individual / Family | $3,000 per covered person | $4,500 / $9,000 | $3,400 / $6,800 |
| The out-of-pocket maximum includes deductibles and medical copayments, but excludes cost containment penalties, amounts paid for non-covered services, or reductions in allowed amounts as a result of seeking service from an out-of-network provider. | | | |
| **PREVENTIVE CARE** | | | |
| **Preventive Care** | 100%, no deductible | 100%, no deductible | 100%, no deductible |
| **Preventive/Routine Lab and X-Ray** | 100%, no deductible | 100%, no deductible | 100%, no deductible |
| **Pap Smear and Mammogram** | 100%, no deductible | 100%, no deductible | 100%, no deductible |
| **Prostate Screening** | 100%, no deductible | 100%, no deductible | 100%, no deductible |
| **Adult / Child Immunizations** | 100%, no deductible | 100%, no deductible | 100%, no deductible |
| **Colonoscopies** | 100%, no deductible | 100%, no deductible | 100%, no deductible |
| **PHYSICIAN SERVICES** | | | |
| **Office Visits** | 85% after deductible | $25 copay - Primary Care<br>$45 copay - Specialist | 100% after deductible |
| **Diagnostic X-ray and Lab** | 85% after deductible | 100% covered after Office Visit Copay<br>**Please contact Quantum if you are invoiced separately for lab work performed due to an office visit. They can assist in reprocessing the claim.* | 100% after deductible |
| **Office Surgery** | 85%, no deductible | 100% covered after Office Visit Copay | 100% after deductible |
| **Allergy Injections** | 85% after deductible | 100% covered | 100% after deductible |
| **Inpatient / Outpatient Services** | 85% after deductible | 85% after deductible | 100% after deductible |
| **FACILITY SERVICES** | | | |
| **Inpatient / Outpatient Services** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Outpatient Surgery** | 85%, no deductible | 85% after deductible | 100% after deductible |
| **Outpatient Advanced Imaging**<br>(PET, MRI, MRA, CAT, SPECT) In a hospital, freestanding facility or clinic | 85% after deductible | 85% after deductible | 100% after deductible |
| **Emergency Room/Services** | 85% after deductible, then $150 copay (copay waived if admitted) | 85% after deductible, then $150 copay (copay waived if admitted) | 100% after deductible |

# MEDICAL PLAN OPTIONS

Allegiance® a Cigna Company

| | IN-NETWORK BENEFITS | | |
|---|---|---|---|
| | **Gold Plan** | **Silver Plan** | **Bronze Plan** |
| **OTHER SERVICES** | | | |
| **Skilled Nursing Facility** (limited to 100 days per calendar year) | 85% after deductible | 85% after deductible | 100% after deductible |
| **Hospice Care** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Home Health Care** (limited to 80 visits per calendar year) | 85% after deductible | 85% after deductible | 100% after deductible |
| **Chiropractic Care*** (limited to 25 visits per calendar year) *Only the in-network deductible applies. X-rays are covered for the initial visit only. | 85% after deductible | $45 Specialist copay | 100% after deductible |
| **Physical, Occupational, Speech, Audiology, and Cognitive Therapy** (visits in excess of 20 per type of therapy per calendar year require prior authorization) | 85% after deductible | Office Visit: $45 Specialist copay<br>Evaluation/Therapy Session: 85% after deductible | 100% after deductible |
| **Urgent Care** | 85% after deductible | $45 Specialist copay | 100% after deductible |
| **Durable Medical Equipment** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Prosthesis** (requires prior authorization) | 85% after deductible | 85% after deductible | 100% after deductible |
| **Ambulance** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Maternity** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Non-Surgical TMJ** (limited to $1,500 per calendar year) | 85% after deductible | 85% after deductible | 100% after deductible |
| **Transplant Services** (requires prior authorization) | 85% after deductible | 85% after deductible | 100% after deductible |
| **MENTAL HEALTH, CHEMICAL, AND ALCOHOL DEPENDENCY SERVICES** | | | |
| Inpatient services require pre-admission certification | | | |
| **Inpatient Facility** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Inpatient Physician** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Outpatient Facility** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Outpatient Physician** | 85% after deductible | 85% after deductible | 100% after deductible |
| **Office Visit** | 85% after deductible | $25 PCP copay | 100% after deductible |

Please Note: While all three plans give you the option of using out-of-network providers, you can save money by using in-network providers because Allegiance has negotiated significant discounts with them. The benefit percentage will be the same for in-network providers both inside and outside of Blount County. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and the Allegiance UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.



Medical Plan Summary



Deductible / Copay / Coinsurance / Out-of-Pocket



HDHP vs. PPO

# PRESCRIPTION BENEFITS (INCLUDED WITH MEDICAL)

Retirees enrolled in the Blount County Government health plan have prescription drug coverage included as part of the health plan benefits. Prescription benefits are administered by the health plan's prescription benefit manager (PBM), which is CVS Caremark. Benefit information for your prescription drug coverage is included on your medical ID card from Allegiance - a separate ID card is not needed.



As part of the CVS Caremark family, you have access to a wide range of cost-effective medications and thousands of network pharmacy choices for you and your family.

As a way to save time and money, members can choose to fill a 90-day supply of medications for chronic conditions either through CVS Caremark's mail order service or at a participating pharmacy location. Regardless of your choice, you may experience a lower out of pocket cost!

You can visit the CVS Caremark website at CVS Caremark to obtain more information about both of these convenient options.

## Medical - Gold and Silver Plans

| Prescription Drugs | Retail - 30-day supply | Mail Order - 90-day supply |
|---|---|---|
| **Out-of-Pocket Maximum** | $2,000 per person (separate from medical plan) | |
| **Generic** | $10 copay | $20 copay |
| **Preferred Brand** | 30% coinsurance, up to a maximum copay of $60 | 30% coinsurance, up to a maximum copay of $120 |
| **Non-Preferred Brand** | 40% coinsurance, up to a maximum copay of $100 | 40% coinsurance, up to a maximum copay of $200 |
| **Specialty** | 50% coinsurance, up to a maximum copay of $200 | Not available |

## Medical - Bronze Plan

| Prescription Drugs | Retail - 30 day supply | Mail Order - 90-day supply |
|---|---|---|
| **Out-of-Pocket Maximum** | Included with the Medical Plan Out-of-Pocket Maximum of $3,400 / $6,800 | |
| **Generic** | Covered at 100% after deductible | Covered at 100% after deductible |
| **Preferred Brand** | Covered at 100% after deductible | Covered at 100% after deductible |
| **Non-Preferred Brand** | Covered at 100% after deductible | Covered at 100% after deductible |
| **Specialty** | Covered at 100% after deductible | Not available |

# Select Drugs and Products℠ Program

The Plan's Select Drugs and Products℠ Program allows you to take an active role in helping the Plan reduce your costs, while allowing the Plan to continue to offer generous healthcare benefits to all Participants. The Plan is sponsoring this program at no cost to you. If you are prescribed a prescription drug, product, or service included on the Plan's Select Drugs and Products℠ List, you must enroll in the Program to comply with your Plan's benefit requirements.

## Plan Members Taking Specialty Drugs – 1 – 2 – 3

1

The Plan's specialty contact center will initiate outreach to you by text message or phone call.

2

Complete the digital enrollment application which will allow the Plan's specialty contact center to match you to financial assistance programs that may help you reduce your out-of-pocket costs.

Note: you may be asked to provide household size and income information.

3

Your Plan Case Coordinator will coordinate with you and your pharmacy to ensure you are able to get your medication in a timely manner.

A Plan Case Coordinator is available (8:00 am to 8:00 pm CST) to guide you through the enrollment process and the program. Please respond to calls from your Case Coordinator in a timely manner.

This program will not share your information with any 3rd party solicitors without your consent. If you would like to complete your application over the phone or speak with a Plan Case Coordinator, please call (877) 422-1776 Common questions and answers about your Plan's Select Drugs and Products℠ Program can be found on the next page.

### There are two reasons why you are receiving this important message:

Your Plan has added an important program that includes the Plan's Select Drugs and Products℠ List*.

Your Plan is continuing to offer generous specialty drug benefits while attempting to reduce costs to you and the Plan.

*The Plan's Select Drugs and Products℠ List includes drugs, products, or services typically prescribed by a specialist for chronic health conditions and other complex conditions that may result in financial hardship that makes these therapies unaffordable for you and your family.

# How It Works

## What is the Select Drugs and Product℠ Program?

The Plan's Select Drugs and Products℠ Program provides advocacy services to assist you by identifying and facilitating your enrollment in publicly available financial assistance programs that may reduce or eliminate your out-of-pocket costs for certain prescription drugs, products, and services. A Plan's Case Coordinator will contact you to guide you through the program. The Plan continues to offer generous healthcare benefits but needs your help to continue to meet this goal.

Your active role in helping the Plan reduce your costs is important. The Plan is sponsoring this program at no cost to you. However, you may be required to pay a portion of the cost to acquire your specialty drug, product or service depending on specific situations.

## What is the Enrollment Requirement for the Select Drugs and Products℠ Program?

The Plan requires you to enroll in its Select Drugs and Products Program by following the three-step process outlined above, which starts with a response to texts, calls or other outreach efforts from the Plan's Case Coordinator in a timely manner.

## What happens after I enroll in the Select Drugs and Products℠ Program?

After enrolling in the Plan's Select Drugs and Products Program, you will be asked to complete certain documentation related to the financial assistance program(s) identified by your Plan's Case Coordinator. This will include providing required documents and information to the assistance funding program and may require your prescriber's participation as well. Your timely responses will help you avoid any delays in processing your documentation.

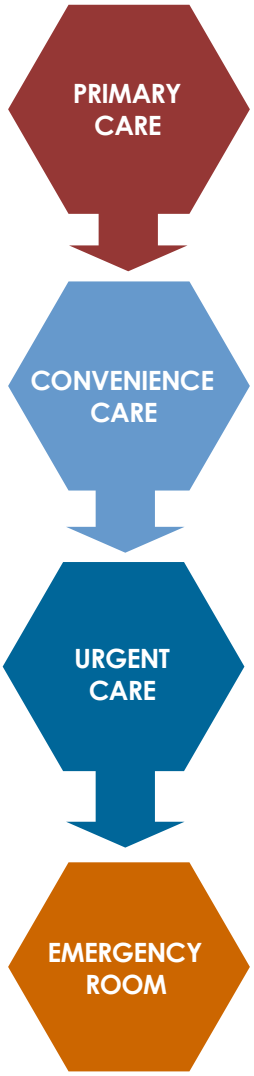
Your Plan Case Coordinator will help you obtain your prescription drugs, products, or services and reduce your out-of-pocket costs by coordinating funding of your out-of-pocket costs. After your acceptance into a financial assistance program, your Plan Case Coordinator will contact you before and after each refill or episode of care to ensure there is no disruption in your treatment.

Call toll-free at (877) 422-1776 to speak to a Plan Case Coordinator, M-F, 8AM to 8PM CT.

# QUICK TIPS ON CARE OPTIONS

Primary Care vs Urgent Care vs ER

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the healthcare provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.blountcountybenefits.com.




- Routine, primary/ preventive care
- Non-urgent treatment
- Vaccinations
- Screenings

- Common infections (ear infections, pink eye, strep throat)
- Flu shots
- Pregnancy tests

- Sprains
- Small cuts
- Strains
- Sore throats
- Minor infections

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 9-1-1

## PRIMARY CARE

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. 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.

## CONVENIENCE CARE

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency.

They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

## URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary.

During office hours, you may be able to go to your doctor's office. Outside regular office hours—or if you can't be seen by your doctor immediately—you may consider going to an Urgent Care Center, where you can generally be treated for many minor medical problems faster than at an emergency room.

## EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in serious injury or is life threatening.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

# DENTAL INSURANCE

**HOW TO FIND A DENTIST**
To find a Delta Dental provider in your area, visit
www.deltadentaltn.com

- Scroll down to "Find a Dentist"
- Select a specialty and "Delta Dental PPO"
- Enter your zip code and click "Find a Dentist"
- You can apply additional filters to narrow your search or leave them blank for a complete directory

As a retiree of Blount County Government, your dental benefits are provided through Delta Dental of Tennessee under a PPO Plan. The benefit levels are the same in-network and out-of-network. If services are provided by an in-network provider, your provider agrees to a negotiated charge, and you will not be responsible for balance billing. Additionally, the provider's office will file a claim for you so there is no paperwork for you to complete.

Dental services are divided into four coverages. Preventive procedures include exams, x-rays and preventive care and is paid entirely by the plan. Basic procedures include basic restorative treatment, endodontics, oral surgery, and periodontics. Major procedures include complex restorative surgeries and prosthodontics. Orthodontia refers to orthodontic procedures.

As a member of Delta Dental of TN, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier. With 3 out of 4 dentists participating, these two networks provide great access to care as well as the privilege of reduced rates through Delta Dental's agreed upon fees with dentists. When seeing a dentist in either the PPO or Premier networks, you cannot be balance billed - giving you added savings. You are also free to visit non-network dentists, but you may be balance billed. If services are provided by a non-network provider, charges in excess of the 80th percentile of usual and customary charges will be your responsibility.

Please be sure to consult either the online directory or call Delta Dental Customer Service (800.223.3104) to confirm that your dentist is in the network.

Dental Plan Summary

What is Dental Insurance?

| Delta Dental | Full Monthly Premium | Employer Monthly Contributions | Retiree Monthly Cost |
|---|---|---|---|
| Employee Only | $29.43 | $23.54 | $5.89 |
| Family (Employee + Dependents) | $92.65 | $23.54 | $69.11 |
| | **In-Network** | | |
| **Plan Year Annual Deductible** Individual / Family | $50 / $150 | | |
| **Plan Year Annual Maximum Benefit** | $1,200 per covered person | | |
| **Orthodontia Lifetime Maximum** (12 month waiting period) | $1,000 | | |
| **Preventive Services** | 100% , deductible does not apply | | |
| **Basic Services** | 80% after deductible | | |
| **Major Services** | 50% after deductible | | |
| **Orthodontia Services** (children only, to age 19) | 50%, deductible does not apply | | |

# VOLUNTARY VISION INSURANCE

SuperiorVision™

**HOW TO FIND A PROVIDER**
To find a provider in your area, visit **superiorvision.com**

- Click on "Find an eye care professional" at the top of the page
- Enter your location, coverage type, Superior National Network, and click search.

The Blount County vision plan covers routine eye care, including eye exams and eyeglasses (lenses and frames) or contacts. When you choose an in-network provider for your eye exam and materials, you are responsible for the copay only. If you choose a provider that is not in network, Superior Vision will reimburse you according to the plan's non-network benefit schedule (listed below under "Out-of-Network Provider").

Superior Vision has contracted with providers who specialize in the highly publicized elective procedures of Radial Keratotomy (RK), Photo Refractive Keratotomy (PRK), and LASIK to provide a 20% discount off their usual customary surgical fee for members.

Go to **www.superiorvision.com** to find an in-network provider near you, and to order and print I.D. cards.


Vision Plan Summary


What is Vision Insurance?

| | Full Monthly Premium | Employer Monthly Contribution | Employee Monthly Deduction |
|---|---|---|---|
| Employee | $8.54 | N/A | $8.54 |
| Employee & Spouse | $16.86 | N/A | $16.86 |
| Employee & Child(ren) | $16.52 | N/A | $16.52 |
| Employee & Family | $25.14 | N/A | $25.14 |

| | In-Network | Out-of-Network |
|---|---|---|
| **Vision Exam**<br>Covered every 12 months<br>Ophthalmologist (M.D.)<br>Optometrist (O.D.) | Covered in full after $10 copay | <br><br>Plan pays up to $34<br>Plan pays up to $26 |
| **Frames**<br>Covered every 24 months | Plan pays up to $125 after $10 copay | Plan pays up to $65 |
| **Lenses**<br>Covered every 12 months<br>Single<br>Bifocal<br>Trifocal<br>Lenticular<br>Progressive | Covered in full after $10 copay | <br><br>Plan pays up to $32<br>Plan pays up to $46<br>Plan pays up to $57<br>Plan pays up to $90<br>Plan pays up to $46 |
| **Contact Lenses**<br>Covered every 12 months - in lieu of glasses<br>Medically necessary<br>Cosmetic (Elective)<br>Standard Contact Lens Fitting Exam Fee*<br>Specialty Contact Lens Fitting Exam Fee | <br><br>Covered in full<br>Plan pays up to $120<br>$25 copay<br>$50 allowance | <br><br>Plan pays up to $210<br>Plan pays up to $100<br>Not covered<br>Not covered |

**Standard contact lens fitting fee applied to an existing contact lens user who wears disposable, daily wear, or extended lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multi-focal lenses. For the specialty fit, the member is responsible for any charges over $50.*

# LIFE INSURANCE AND AD&D

What is Term Life Insurance?

## BASIC LIFE / AD&D

Basic Life/AD&D Insurance is a County provided benefit offered at no cost to you through USAble Life Insurance Company. The coverage amount is a maximum of $10,000. AD&D Insurance pays an additional percentage of the amount of your life insurance benefit based on a specific list of losses such as loss of life, limb, or sight due to an accident.

You are eligible for this benefit until age 65. If you have questions or need to update your beneficiaries, please contact Human Resources.

# ADDITIONAL AVAILABLE SERVICES

## CARE TODAY CLINIC @ ETMG

Blount County Government offers access to the Blount Memorial Physicians Group CareToday Clinic for full-time employees, retirees, spouses and children to age 26 (services are covered at 100% for those enrolled in the **Gold, Silver, or Bronze plan options**).

Examples of services provided include acute onset illnesses such as colds, flu and ear infections; injuries such as sprains, strains, cuts, minor burns; and routine treatments such as blood pressure checks and cholesterol screenings (excludes certain diagnostic testing such as CT scans, MRIs, etc).

### Blount Memorial Physicians Group

### CareToday Clinic

266 Joule St., Alcoa, TN 37701

(865) 983-0093

### Operating Hours

Monday - Friday: 7am - 10pm

Saturday, Sunday & Holidays: 8am - 8pm

Closed Thanksgiving and Christmas Day

# BLOUNT DISCOUNT PHARMACY


Blount Discount Pharmacy has also partnered with Blount County Government to provide retirees access to three programs! Read about each program and eligibility below.

## Diabetes Education Program

This program is only for full-time employees + their dependents and retirees who are actively enrolled in a Blount County Government medical plan.

- ***Do you have Blount County benefits?***
- ***Would you like help controlling your blood sugar?***
- ***Would you like to potentially be on less medications?***
- ***Would you like to have 3 hours with a diet specialist?***

**Then you would benefit from Diabetes Education at *no cost* to you!**

- Providing diabetes education since 2014.
- Proven Results. Of our > 200 graduates:
  - A1C decrease was ***2%***
  - Weight loss of ***12.4 pounds*** or ***5.5% body weight***

ADCES Association of Diabetes Care & Education Specialists

## BC + Program

Blount Discount Pharmacy has partnered with Blount County Government to provide all employees and their dependents access to a Prescription Savings Program at no charge. This program provides you access to many commonly used generic medications at a discounted rate for a 90-day supply.

For additional information on any of these programs, please contact Blount Discount Pharmacy at (865) 681-0520.

# ADDITIONAL AVAILABLE SERVICES

## EMERGICARE

*****Blount County Employee Special Savings*****

American Medical Response is pleased to offer you an Emergicare (AMR ground ambulance transport) membership at a discounted rate of $55 annually

- Emergicare is a program designed to help limit a patient's out of pocket expense for a medically necessary AMR ground ambulance transport for covered services within Blount and Knox counties.
- AMR agrees to accept payment from any primary insurance or third-party payor for medically necessary transports
- Subscription covers ALL persons residing in subscriber's household
- Payroll deduction of **$27.50** each on the 1st and 2nd paycheck in January.

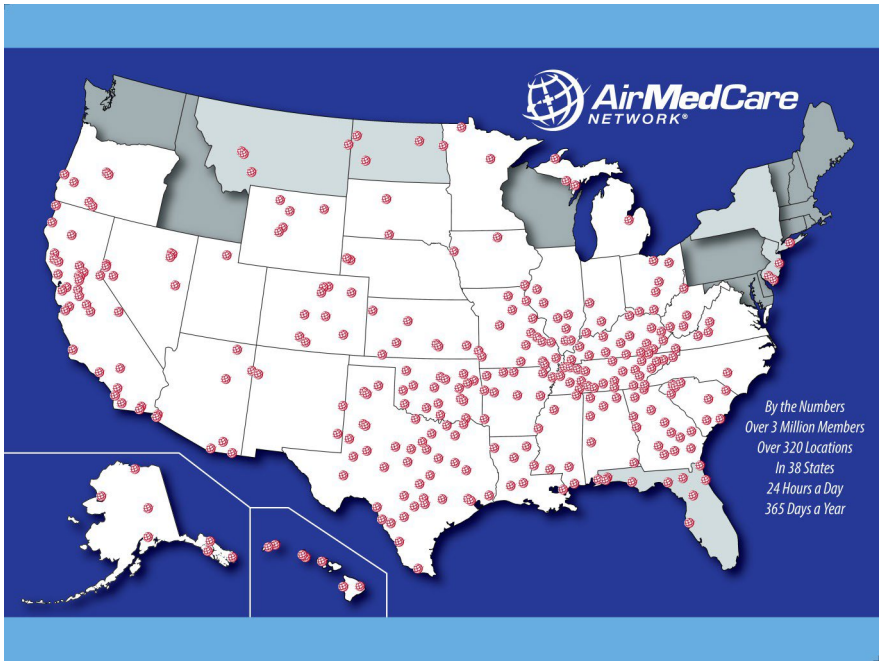
## AIRMEDCARE

Blount County offers the opportunity to purchase an AirMedCare membership as a voluntary benefit to you. This is only available during your open enrollment period. AirMedCare Network is one of America's largest air ambulance membership networks with coverage across a combined 38 state service area.

**1 year membership. = $60.00 annual cost deducted from the 1st and 2nd paycheck in January. You MUST re-enroll annually.**

Coverage Includes:

- No out-of-pocket expenses associated with the flight when flown by participating AMCN providers, even if the claim is denied by insurance.
- Household plan provides membership benefits for any person who resides under one residential roof. Full-time undergraduate college students can be covered under their parents' membership if their primary residence is still with the parents.
- No limit to the number of transports a member may require each year.



# GLOSSARY OF MEDICAL TERMS

**Coinsurance**—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

**Copays**—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

**Deductible**—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

**Emergency Room**—Services you receive from a hospital for any serious condition requiring immediate care.

**Lifetime Benefit Maximum**—All plans are required to have an unlimited lifetime maximum.

**Medically Necessary**—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

**Network Provider**—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

**Out-of-pocket Maximum**—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

**Preauthorization**—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

**Prescription Drugs**—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

**Preventive Services**—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

**UCR (Usual, Customary and Reasonable)**—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

**Urgent Care**—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

# VIDEO LINKS

Medical Summary

HDHP vs PPO

Deductible / Copay / Coinsurance / Out-of-Pocket

CCP

Primary Care vs Urgent Care

FSA

HSA

Dental Summary

Dental Insurance

Vision

Vision Summary

Term Life

Cancer Care

Critical Care

Accident Recovery

Hospital Care

Disability Insurance

# IMPORTANT NOTICE FROM BLOUNT COUNTY GOVERNMENT ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

***This notice only applies if you or your dependents are currently enrolled in our group health insurance plan and are eligible or enrolled in Medicare. You may disregard this notice if this does not pertain to you.***

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Blount County Government 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. Blount County Government has determined that the prescription drug coverage offered by the Allegiance Life & Health Plan 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 Blount County Government coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. Your current drug plan with Blount County Government is as follows: **Plans 1 and 2** - Generic - $10 copay, Preferred Brand – 30% coinsurance to a max $60 copay, Non-Preferred - 40% coinsurance to a max copay of $100, Specialty – 50% coinsurance to a max copay of $200. The prescription out-of-pocket maximum is $2,000 per covered person. **Plan 3** - prescription drug costs are subject to the annual deductible/out-of-pocket maximum of $3,300 individual / $6,600 family. You may retain your existing coverage and choose not to enroll in Part D plan; or you may enroll in a Part D plan in lieu of your other coverage.

If you do decide to join a Medicare drug plan and drop your current Blount County Government coverage, be aware that you and your dependents will only be allowed to obtain the group coverage again during the annual open enrollment period each calendar year; or if you have a life qualifying event, such as marriage, birth, adoption, divorce, or loss of other coverage..

**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 Blount County Government 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…**

**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).**

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 Blount County Government 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'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).

| | |
|---|---|
| **Date:** | **January 1, 2026** |
| **Name of Entity / Sender:** | **Blount County Government** |
| **Contact – Position/Office:** | **Misty Guge** |
| **Address:** | **397 Court Street**<br>**Maryville, TN 37804** |
| **Phone Number:** | **865-273-5780** |

**SPECIAL ENROLLMENT NOTICE**

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact Human Resources.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

**WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular copays, deductibles and co-insurance. Contact Allegiance at the phone number on the back of your ID card for additional benefit information.

**NEWBORNS ACT DISCLOSURE—FEDERAL**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length 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 18 hours (or 96 hours as applicable). In any case, plan s and issuers may not, under Federal law, require that a provider obtain authorization form 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**

Blount County Government is subject to the HIPAA privacy rules, In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

## FORM 1095 INFORMATION

**Form 1095** is a federal information return related to health insurance coverage under the Affordable Care Act (ACA).

There are two primary versions of this form:

**Form 1095-C (Employer-Provided Health Insurance Offer and Coverage):** Issued by large employers, it shows whether coverage was offered, the cost of the lowest-cost plan option for self-only coverage, and the months you and any dependents were covered.

**Form 1095-B (Health Coverage):** Issued by insurance carriers or smaller self-insured employers, it confirms the months you and your dependents were enrolled in minimum essential coverage.

### Important Note

Form 1095 is an **informational document**. It is not required to be attached to your federal tax return, but you can request and keep it with your tax records.

For assistance interpreting your form, please refer to the official IRS instructions:

Form 1095-C Instructions
Form 1095-B Instructions

### Accessing Your Form 1095

When available each year, employees can request their Form 1095 by following the instructions on the secure website at: www.formservices.net.

In accordance with the Paperwork Reduction Act, Form 1095 is available to recipients upon request. Employers are required to provide the form within **30 days** of receiving a request. Forms may be distributed electronically with the recipient's consent. If a request is made prior to **February 2**, employers must ensure delivery no later than **March 3**, in compliance with federal distribution deadlines.

### Form Distribution

**Preferred Method (Electronic):** Email is the most efficient method for form delivery. By providing a valid email address, you are granting consent to receive your Form 1095 electronically.

**Alternative Method (Paper):** If you prefer to receive your form by mail, please indicate this in your request and confirm your current mailing address

**BLOUNT COUNTY GOVERNMENT**

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY**

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice of Privacy Practices also explains your Group Health Plan's legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created and received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices has been drafted to be consistent with the HIPAA Privacy Rule. Any terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule. If you have any questions about this Notice or the policies and procedures described herein, please contact:
Misty Guge, Human Resources Specialist, 397 Court Street Maryville, TN 37804 865-273-5780

## THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of your PHI. The Plan is obligated to: provide you with a copy of this Notice of the Plan's legal duties and of its privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. The Plan reserves the right to change the provisions of its Notice and make the new provisions effective for all PHI that the Plan maintains. If the Plan makes a material change to this Notice, the Plan will make the revised Notice available to you by means of a legally compliant delivery method.

### Permissible Uses and Disclosures of PHI

The following is a description of how the Plan is most likely to use and/or disclose your PHI.

***Payment and Health Care Operations***

The Plan has the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 CFR § 164.501 (this provision is a part of the HIPAA Privacy Rule). Not all of the activities listed in this Notice are included within these definitions. Please refer to 45 CFR § 164.501 for a complete list. In order to administer your health benefits, the Plan may use or disclose your health information in various ways without your authorization, including:

- *Payment*
  The Plan will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill its responsibilities for coverage and providing benefits. For example, the Plan may disclose your PHI when a provider requests information regarding your eligibility for coverage under the Plan, or the Plan may use your information to determine if a treatment that you received was medically necessary.

- *Health Care Operations*
  The Plan will use or disclose your PHI to support its business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, the Plan may use or disclose your PHI: (i) to provide you with information about a disease management program; to respond to a customer service inquiry from you; or (ii) in connection with fraud and abuse detection and compliance

programs. The PHI used or disclosed for these operational activities is limited to the minimum amount that is reasonably necessary to complete these tasks.

**Other Permissible Uses and Disclosures of PHI**

The following describes other possible ways in which the Plan may (and is permitted to) use and/or disclose your PHI.

- ***Required by Law***
  The Plan may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose your PHI when required by national security laws or public health disclosure laws.

- ***Public Health Activities***
  The Plan may use or disclose your PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for purpose of preventing or controlling disease, injury or disability, or the Plan may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- ***Health Oversight Activities***
  The Plan may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits: investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; other government regulatory programs; and (iv) compliance with civil rights laws.

- ***Abuse or Neglect***
  The Plan may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity authorized to receive such information, your PHI, if the Plan believes that you have been a victim of abuse, neglect, or domestic violence.

- ***Legal Proceedings***
  The Plan may disclose your PHI: (i) in the course of any judicial or administrative proceeding: (ii) in response to an order of a court or an administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once all administrative requirements of the HIPAA Privacy Rule have been met. For example, the Plan may disclose your PHI in response to a subpoena for such information but only after certain conditions of the HIPAA Privacy Rule are complied with.

- ***Law Enforcement***
  Under certain conditions, the Plan may also disclose your PHI to law enforcement officials. Some of the reasons for such a disclosure, for example, may include, but not be limited to: (i) it is required by law; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on the Plan's premises.

- ***Coroners, Medical Examiners, Funeral Directors, Organ Donation Organizations***
  The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- ***Research***

The Plan may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

- ***To Prevent a Serious Threat to Health or Safety***
  Consistent with applicable federal and state laws, the Plan may disclose your PHI if the Plan believes that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan may also disclose PHI if it is necessary for law enforcement to identify or apprehend an individual.

- ***Military Activity and National Security, Protective Services***
  Under certain conditions, the Plan may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, the Plan may disclose, in certain circumstances, your information to the foreign military authority.

- ***Inmates***
  If you are an inmate of a correctional institution, the Plan may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

- ***Workers' Compensation***
  The Plan may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- ***Emergency Situations***
  The Plan may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. The Plan will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, the Plan will disclose only the PHI that is directly relevant to the person's involvement in your case.

- ***Fundraising Activities***
  The Plan may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan contacts you for fundraising activities, the Plan will give you the opportunity to opt-out or stop receiving such communications in the future.

- ***Group Health Plan Disclosures***
  The Plan may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. The Plan can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

- ***Underwriting Purposes***
  The Plan may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose your PHI for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

- ***Others Involved in Your Health Care***
  Using its best judgment, the Plan may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. The Plan may release information to parents or guardians if allowed by law.

  If you are not present or able to agree to these disclosures of your PHI the Plan, using its professional judgment, may determine whether the disclosure is in your best interest.

**Uses and Disclosures of Your PHI that Require Your Authorization**

***Sale of PHI***
The Plan will request your written authorization before it makes any disclosure that is deemed a sale of your PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

***Marketing***
The Plan will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when the Plan has face-to–face marketing communications with you or when the Plan provides promotional gifts of nominal value.

***Psychotherapy Notes***
The Plan will request your written authorization to use or disclose any of your psychotherapy notes that the Plan may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide the Plan with such an authorization, you may revoke the authorization in writing and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information the Plan has already used or disclosed, relying on the authorization.

**Required Disclosures of Your PHI**

The following describes disclosures that the Plan is required by law to make.

- ***Disclosures to the Secretary of the U.S. Department of Health and Human Services***
  The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

- ***Disclosures to You***
  The Plan is required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records as well as other records that are used to make decisions about your health care benefits. The Plan also is required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

  The Plan will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with applicable state law. However, before the Plan will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

*Even if you designate a personal representative*, the HIPAA Privacy Rule permits the Plan to elect not to treat the person as your personal representative if the Plan has a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) the Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

- ***Business Associates***
  The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Business Associates will receive, create, maintain, use or disclose PHI, but only after the Business Associate agrees in writing to contract terms designed to appropriately safeguard your information. For example, the Plan may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management.

- ***Other Covered Entities***
  The Plan may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and it may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share your PHI with insurance carriers in order to coordinate benefits if you or your family members have coverage through another carrier.

- ***Plan Sponsor***
  The Plan may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

  **Additional Protections for Certain Categories of PHI** – Certain types of Protected Health Information (PHI) may be subject to enhanced privacy protections under federal and/or state laws. These additional protections may apply to:
  - Psychotherapy notes
  - PHI related to reproductive health care
  - PHI concerning alcohol and drug abuse prevention, treatment, and referral
  - PHI involving HIV/AIDS testing, diagnosis, or treatment
  - PHI related to venereal and other communicable diseases
  - PHI associated with genetic testing

  **Additional Privacy for Substance Use Disorder (SUD) Treatment** – The Plan may receive information from a substance use disorder treatment program ("SUD Program"), about your treatment. The Plan will not disclose this information so that it can be used in a civil, criminal, administrative, or legislative proceeding against you unless (i) we have your written consent, or (ii) a court order accompanied by a subpoena or other legal requirement compelling disclosure issued after we and you were given notice and an opportunity to be heard.

  **Redisclosure** – Understand that once your PHI is disclosed it may be no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) and may be subject to re-disclosure.

**Potential Impact of State Law**

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

**YOUR RIGHTS**

- **Right to Request Restrictions**
  You have the right to request a restriction on the PHI the Plan uses or discloses about you for payment or health care operations. The Plan is *not* required to agree to any restriction that you may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide you with emergency treatment. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact to initiate processing your request. Requests sent to persons or offices other than the designated contact could delay processing the request.

The Plan needs to receive this information in writing and will instruct you where to send your request when you call. In your request please provide: (1) the information whose disclosure you want to limit; and (2) how you want to limit the use and/or disclosure of the information.

- ***Right to Request Confidential Communications***
  If you believe that a disclosure of all or part of your PHI may endanger you, you may request that the Plan communicate with you regarding your information in an alternative form or at an alternative location. For example, you may ask that the Plan only contact you at your work address or through your work e-mail.

  You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct you request for confidential communications to the designated contact so that the Plan can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

  The Plan needs to receive this information in writing and will instruct you where to send your request when you call. In your request please explain: (1) that you want the Plan to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

  The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will include, when appropriate, making alternate arrangements regarding payment.

  Accordingly, as a condition of granting your request, you will be required to provide the Plan information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the plan participant (e.g., an Explanation of Benefits or "EOB"). Unless you have made other payment arrangements, the EOB (in which your PHI might be included) may be released to the plan participant.

  Once the Plan receives all of the information for such a request (along with instructions for handling future communications) the request will be processed as soon as practicable. Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice as soon as you determine that you need to restrict disclosures of your PHI.

  If you terminate your request for confidential communications, the restriction will be removed for all of your PHI the Plan holds including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- ***Right to Inspect and Copy***
  You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

  To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that the Plan can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing, or other supplies associated with your request. The requested information will be provided within thirty (30) days if the information is maintained on site or within sixty (60) days if the information is maintained offsite. A single thirty (30) day extension is allowed if the Plan is unable to comply with this deadline.

  The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the

designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, the denial will not be reviewable. If this event occurs, the Plan will inform you of this fact.

- ***Right to Amend***
  If you believe the PHI The Plan has for you is inaccurate or incomplete, you may request that it be amended. You may request in writing that the Plan amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact to initiate processing your request. Requests sent to persons or offices, other than the designated contact, might delay processing the request. The Plan has sixty (60) days after the request is made to act on the request. A single thirty (30) day extension is allowed if the Plan is unable to comply with this deadline.

  In certain cases, the Plan may deny your request for an amendment. For example, the Plan may deny your request if the information you want to amend is not maintained by the Plan, but by another entity or if the Plan determines that your information is accurate and complete. If the Plan denies your request you have the right to file a statement of disagreement with the Plan. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- ***Right to Accounting***
  You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

  An accounting will include the dates of the disclosure, to whom the disclosure was made, a brief description of the information disclosed, and the purpose for the disclosure.

  You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that the Plan can begin to process the request. Requests sent to persons or offices other than the designated contact might delay processing the request. If the accounting cannot be provided within sixty (60) days, an additional thirty (30) days is allowed if a written statement explaining the reasons for the delay is provided. Your request may be for disclosures made up to six (6) years before the date of your request but not for disclosures made before April 14, 2003. If you request more than one accounting within a twelve (12) month period, the Plan will charge you the reasonable costs of providing the accounting. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

- **Confidential Communications**
  You may ask that the Plan communicate with you in an alternate way or at an alternate location to protect the confidentiality of your PHI. Your request must state an alternate method or location you would like the Plan to use to communicate your PHI to you.

- ***Right to a Copy of This Notice***
  You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on the Plan's Website or by electronic mail, you are entitled to request a paper copy of this Notice.

## CHANGES TO THIS NOTICE

The Plan reserves the right to change this Notice and make any revised Notice effective for health information already on file for you, as well as any health information the Plan receives in the future. The most recent Notice will be posted in a prominent location to which you have access.

**COMPLAINTS**

You may complain to the Plan if you believe it has violated your privacy rights. You may file a complaint with the Plan by calling the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity you are complaining about; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

The Plan will not penalize or retaliate against you in any way for filing a complaint.

**EFFECTIVE DATE**

This Notice of Privacy Practices is effective as of April 14, 2003, with updates effective February 16, 2026.

## 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).**

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

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI):<br>https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |

| GEORGIA – Medicaid | INDIANA – Medicaid |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website:<br>https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/health-care-coverage/<br>Phone: 1-800-657-3672 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |

| MONTANA – Medicaid | NEBRASKA – Medicaid |
|---|---|
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |

| TEXAS – Medicaid | UTAH – Medicaid and CHIP |
|---|---|
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP)<br>Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website:<br>https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website:<br>https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

## Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

**USERRA UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was signed on October 13, 1994. The Act applies to persons who perform duty, voluntarily or involuntarily, in the "uniformed services," which include the Army, Navy, Marine Corps, Air Force, Coast Guard, and Public Health Service commissioned corps, as well as the reserve components of each of these services. Federal training or service in the Army National Guard and Air national Guard also gives rise to rights under USERRA. In addition, under the Public Health Security and Bioterrorism Response Act of 2002, certain disaster response work (and authorized training for such work) is considered "service in the uniformed services" as well.

Uniformed service includes active duty, active duty for training, inactive duty training (such as drills), initial active duty training, and funeral honors duty performed by National Guard and reserve members, as well as the period for which a person is absent from a position of employment for the purpose of an examination to determine fitness to perform any such duty. USERRA covers nearly all employees, including part-time and probationary employees. USERRA applies to virtually all U.S. employers, regardless of size.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) are authorized to investigate and resolve complaints of USERRA violations.

- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at www.dol.gov/vets.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, depending on the employer, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.
- The rights listed here may vary depending on the circumstances. The USRRA notice can be viewed on the internet at https://www.dol.gov/vets/programs/userra/USERRA_Private.pdf
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.
- Under the terms of USERRA, if the military leave is 31 or fewer days, the employer may not charge a higher premium than would be charged to active employees with similar coverage. If the leave exceeds 31 days, the employer may charge up to 102 percent of the applicable premium.

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

## PART A: General Information

Form Approved
OMB No. 1210-0149

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

### What is the Health Insurance Marketplace?

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

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

**Misty Guge, Human Resources Specialist / 865-273-5780**

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

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

# PART B: Information About Health Coverage Offered by Your Employer

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

| | | | |
|---|---|---|---|
| 3. Employer name<br>Blount County Government | | 4. Employer Identification Number (EIN) | |
| 5. Employer address<br>397 Court Street | | 6. Employer phone number<br>865-273-5780 | |
| 7. City<br>Maryville | 8. State<br>TN | 9. ZIP code<br>37804 | |
| 10. Who can we contact about employee health coverage at this job?<br>Misty Guge | | | |
| 11. Phone number (if different from above) | 12. Email address<br>mguge@blounttn.org | | |

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to: Full-time employees, working a minimum of 30 hours per week on a regular basis and retirees.

With respect to dependents:

We do offer coverage. Eligible dependents are: legal spouse, child(ren) up to age 26, and any dependent children who are totally disabled.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

# NOTES

BLOUNT COUNTY
TENNESSEE

CBIZ



The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.