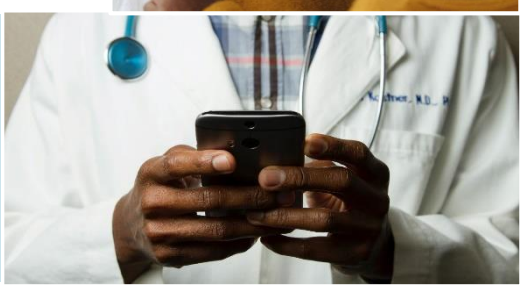
2021-2022 Benefits Enrollment Guide



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The following descriptions of available benefit elections options, are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

Presented by:

ONEDIGITAL HEALTH AND BENEFITS

ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Locate your enrollment/change forms.
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer states otherwise
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change, or you will be considered a late enrollee.

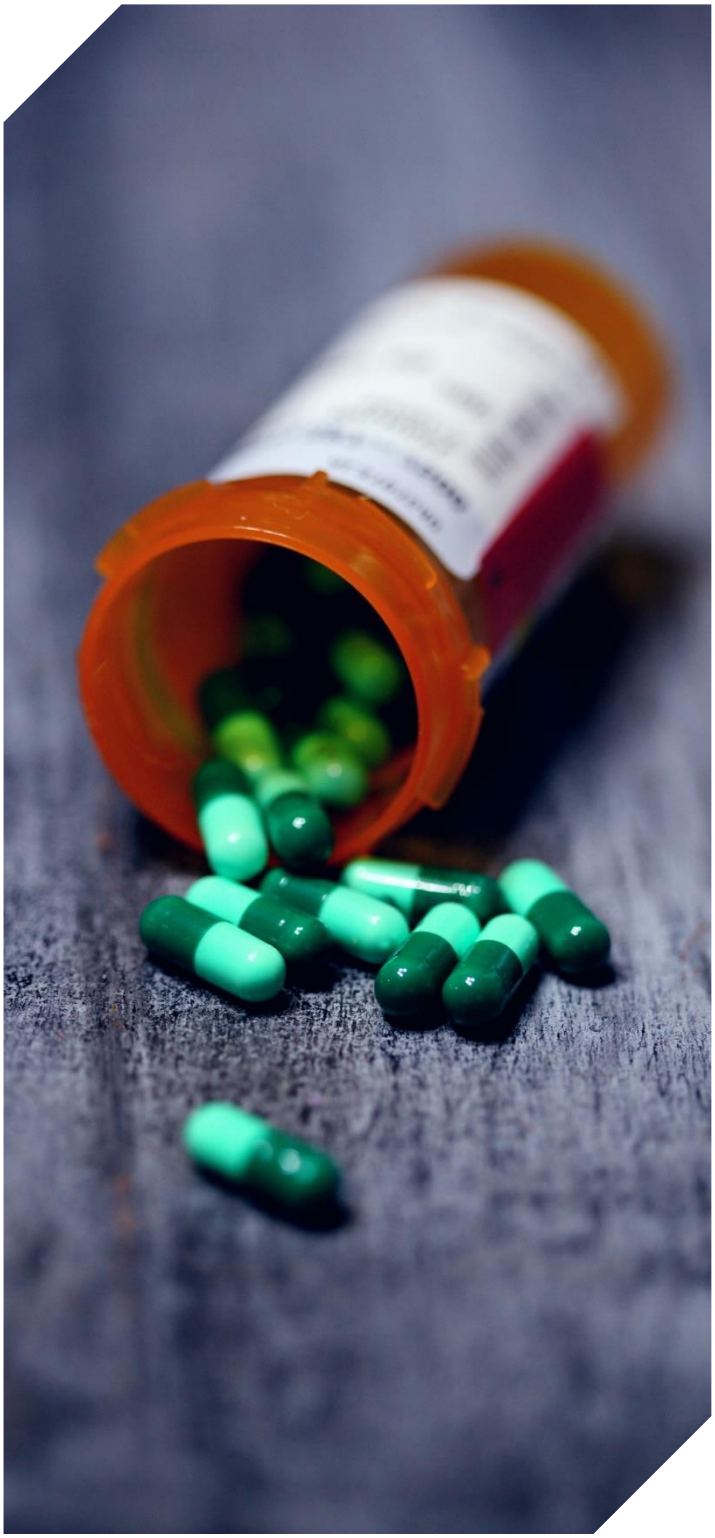
Examples of changes in status:

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

Did you know?

Open Enrollment is the only chance to make changes, unless you experience a "change in status."

ADVANCED RESOLUTION TEAM



Through our **Advanced Resolution Team**, you have access to live representatives who will help you get the most out of your benefits and answer your questions.

The OneDigital Advanced Resolution Team can help educate you about your benefits and teach you how to navigate within the healthcare system.

- Help you with enrollment changes including ID card requests
- Coverage assistance
- Facilitate resolution on billing issues
- Assist you with claims
- Locate in-network providers
- And much, much more

Advanced Resolution Team
We are available by phone or email

Call: (866) 802-6311
Email: art@onedigital.com

Monday through Friday 8am to 5pm (EST)

ONEDIGITAL
HEALTH AND BENEFITS

PACKAGE OVERVIEW

County of Pulaski offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.

Effective July 1, 2021:

- Medical plans with Anthem
- Dental plan through Delta Dental
- Voluntary Vision Plans with EyeMed
- Voluntary Accident, Critical Illness with Cancer and **NEW** Fraud Protection with Aflac
- EAP with Optima
- Flexible Spending Accounts with Flexible Benefit Administrators
- HSA administration with HSA Administrators

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards. In the meantime, you can look up providers for your plans on the internet.

MEDICAL PLANS

For this plan year, you can choose from the following medical options. Refer to the carrier benefits summaries for the exact benefit levels associated with your plan choice.

In Network Benefits	KeyCare PPO $1,400/20% HSA	KeyCare PPO $20/$40
Referrals Required	No	No
Plan Accumulator	Calendar Year	Calendar Year
Annual Deductible	$1,400 individual $2,800 family Non-embedded	No deductible
Coinsurance	20% after deductible	Most services are copays/ 20% coinsurance
Maximum Out-of-Pocket	$4,075 individual $8,150 family	$2,500 individual $5,000 family
Preventive Care	Covered 100%	Covered 100%
Physician's Office Visits	20% coinsurance, after deductible	PCP: $20 copay Specialist: $40 copay
Urgent Care	20% coinsurance, after deductible	$40 copay
Emergency Room	20% coinsurance, after deductible	$250 copay 20% coinsurance ER doctor and other services
Inpatient Facility	20% coinsurance, after deductible	$300 per day; up to 5 days per admission
Outpatient Facility	20% coinsurance, after deductible	$300 copay
Diagnostic Lab & X-Ray Services	20% coinsurance, after deductible	Office: 20% coinsurance Outpatient Hospital: $300 copay
Advanced Diagnostic Imaging Services	20% coinsurance, after deductible	20% coinsurance - Office $300 Co-Pay- Freestanding Radiology Center or Outpatient Hospital
Retail Pharmacy Prescription	$10/$30/$50/$50, after deductible	$10/$30/$50/$50
Mail Order Prescription Drugs	$10/$60/$150 $50 Tier 4 30 day supply after deductible	$10/$60/$150 $50 Tier 4 30 day supply
Routine Eye Exam	$15 copay	$15 copay
Out of Network Benefits	**KeyCare PPO $1,400/20% HSA**	**KeyCare PPO $20/$40**
Annual Deductible	$1,400 individual $2,800 family	$750 individual $1,500 family
Maximum Out-of-Pocket	$10,000 individual $20,000 family	$3,750 individual $7,500 family
Coinsurance	40%	30%

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HEALTH SAVINGS ACCOUNT (HSA)

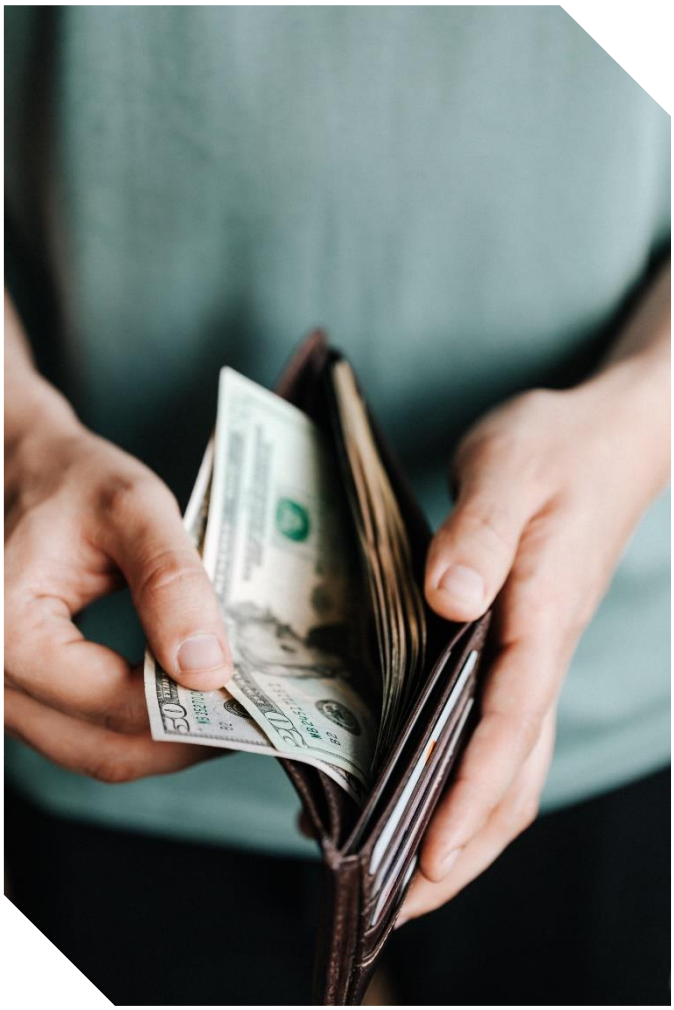
Option for High Deductible Health Plan (HDHP)

For employees who elect the KeyCare $1,400 plan, in order to receive contribution dollars from Pulaski County, you **must** open a Health Savings Account (HSA). This HSA eligible plan provides a way to save money that is available in future years for health care expenses.

For Fiscal Year 2021/2022 the County will contribute:

- $2,508 – Family, Employee Spouse & Employee Child(ren) in January 2022
- $1,260 Employee only in January 2022

- In 2021 individuals can contribute up to $3,600 and families can contribute up to $7,200 to their HSA.
- If you are 55 or older, you can make a $1,000 catch-up contribution.
- Contributions to a HSA can be made on a pre-tax or post-tax basis, and funds within the HSA grow without incurring taxes. Funds are withdrawn tax-free for healthcare related needs without having to file receipts, although you should keep your receipts in case you are ever audited.
- Money deposited in the HSA is the employee's asset and is portable.



Pre-Tax Plan	What is this account and how does it work?	Maximum Contribution Allowed	Can money in accounts be "rolled over"?
Health Savings Account (HSA)	An HSA account can be funded with pre-tax dollars by you, your employer or both to help pay for eligible medical expenses.	Employee only coverage: $3,600 Family coverage: $7,200 Catch up contribution (55 year of age or older): $1,000	Yes, amounts left in your HSA account can be rolled over year to year and is portable if you leave employment of the company

The benefit plan information shown in this guide is illustrative only. This information is not intended to be exhaustive nor should any discussion or opinions be construed as professional advice.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Who is Eligible and When

All Full-Time Employees working at least 30 hours each week. Please check with your HR representative for specific eligibility requirements.

Benefits You Receive

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses and prescriptions not covered by their insurance plan with pretax dollars. There are limits on salary reduction contributions to a health FSA offered under a cafeteria plan and is applicable to both grandfathered and non-grandfathered health FSAs. This limit will be indexed for cost-of-living adjustments. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA

The Dependent Care FSA lets employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Limited Flexible Spending Account – Flexible Benefit Administrators

Who is Eligible and When:

All Full-Time or Part-Time Employees working at least 30 hours each week.

Limited Flexible Spending:

With a Limited Flexible Spending Account, you are able to pay for eligible dental and vision care expenses with pre-tax dollars.

This account can be opened if you have a high deductible health plan.

Contribution Limits:

The maximum for the plan year is $2,750

Some examples of eligible expenses include:

- Orthodontia (braces)
- Crowns
- Fillings
- Checkups
- Eyeglasses
- Prescription Sunglasses
- Routine Eye Exam
- Lasik Eye Surgery
- Contact Lenses

For a more comprehensive list of covered and non-covered services, refer to the benefit summary.

DENTAL PLAN

For this plan year, the following dental option is available. Refer to the carrier benefits summary for the exact benefit level associated with your plan.

In-Network Benefits	PPO plus Premier
Individual Annual Maximum	$1,000
Annual Deductible	$0 per person
Preventive Services (exams, cleaning, x-rays, fluoride, sealants, etc.)	0%
Basic Services (fillings, root canals, periodontics, extractions, etc.)	20%
Major Services (implants, crowns, dentures, bridges, inlays, onlays, etc.)	50%
Orthodontic Services Child Only (up to age 19)	50% to $1,000 Lifetime Max
Out of Network Benefits	**Out of network benefits mirror in network benefits. However, out of network providers may balance bill.**

Did you know?

For a child, one can of soda represents three full days worth of sugar. Sugary sodas are a major risk factor for tooth decay

- American Dental Association (ADA)

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Your Delta Dental Network

To ensure services are covered and that you receive the greatest value for your dental benefits, it is important that your dentist **participates** in the network listed at the top of your ID card.

Delta Dental PPO plus Premier

Group Name:	DELTA DENTAL OF VIRGINIA
Group Number:	0000000000-000000000-0000
Subscriber Name:	[illegible]
ID#:	XXXXXXXXXXXXX
Membership Type:	Subscriber
Effective Date:	01/01/2016

BENEFIT SERVICES: 800-237-6060
DeltaDentalVA.com

Delta Dental PPO℠ plus Premier

With Delta Dental PPO plus Premier, you have the option of visiting any dentist. However, your out-of-pocket costs will be lowest if you see a Delta Dental PPO dentist and highest if you choose an out-of-network dentist. Here are some highlights of the plan:

- Delta Dental Premier is the largest dental network in the nation, with nearly 80% of dentists participating nationally. More than half of all dentists participate nationally in the Delta Dental PPO network.[1]
- The discounts under our PPO network are greater than those provided by the Premier network, so we encourage you to visit a PPO dentist when possible.
- Both Delta Dental PPO and Delta Dental Premier dentists agree to discount their fees, submit claims on your behalf and not balance-bill you.

The payment example below shows how much you can save with a Delta Dental in-network provider.

	Delta Dental PPO℠ Network	Delta Dental Premier® Network	Out-of-Network
Dentist Charge for Covered Procedure	$215	$215	$215
Plan Allowance (The maximum amount Delta Dental will pay)	$126	$169	$113
The percent Delta Dental pays after any deductible	80%	80%	80%
Plan Payment (What we pay)	$100.80	$135.20	$90.40
Patient Payment	**$25.20**	**$33.80**	**$124.60**

NOTE: Payment examples are for illustrative purposes only. Payment structures may vary between plans.

[1]Delta Dental Plans Association, March 2017

STANDARD VISION PLAN – Voluntary

For this plan year, you can choose to enroll in the STANDARD or ENHANCED vision options. Refer to the carrier benefit summary for the exact benefit level associated with your plan.

STANDARD	In-Network	Out of Network Reimbursement
Annual Exam	$10 copay	Up to $40
Lenses Single Bifocal Trifocal	$20 copay	Up to $40 Up to $60 Up to $80
Contact Lenses *in lieu of glasses lenses	$125 allowance	Up to $125
Frames	$130 allowance then 20% off remaining balance	Up to $45
Frequency Exam Lenses Frames	Once every 12 months Once every 12 months Once every 24 months	

Did you know?

Research has linked smoking to an increased risk of developing age-related macular degeneration, cataract, and optic nerve damage.

-National Eye Institute*
https://nei.nih.gov/health/healthyeyes

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ENHANCED VISION PLAN – Voluntary

For this plan year, you can choose to enroll in the STANDARD or ENHANCED vision options. Refer to the carrier benefit summary for the exact benefit level associated with your plan.

ENHANCED	In-Network	Out of Network Reimbursement
Annual Exam	$15 copay	Up to $40
Lenses Single Bifocal Trifocal	$15 copay	Up to $40 Up to $60 Up to $80
Contact Lenses *in lieu of glasses lenses	$150 allowance	Up to $150
Frames	$130 allowance then 20% off remaining balance	Up to $45
Frequency Exam Lenses Frames	Once every 12 months Once every 12 months Once every 24 months	

Did you know?

Your eyes need a rest even while you're awake. Use the 20-20-20 rule to reduce eyestrain. After working for 20 minutes, look away about 20 feet in front of you for about 20 seconds.*

*National Eye Institute **
https://nei.nih.gov/health/healthyeyes

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Employee Assistance Program - Optima

- The Optima Employee Assistance Program (EAP) is a confidential service available to employees and household members – at no cost to you. Trained professionals can easily refer you to the following resources:

- Face to Face Counseling – You and your household member are eligible for up to 3 visits for each personal situation, as needed. Short-term, solutions-focused counseling to address a wide range of personal and professional challenges.

- Legal - one, initial 30-minute office or telephonic consultation per separate legal matter at no cost. Retention of the attorney for the matter may be provided at a 25% discount off normal, hourly fees. (Some limitations apply.)

- Financial – one telephonic consultation per separate financial matter at no cost. Consultation is typically limited to 30-60 minutes.

- Identity Theft – one, 30-minute telephonic consultation with a fraud recovery specialist, who will offer counsel on identity restoration steps.

- To contact Optima EAP, please call us toll-free at 1-800-899-8174. You can also visit www.optimahealth.com. Password: **CountyofPulaski**

- **Note**: VRS Hybrid employees are entitled to additional benefits - 3 additional free counseling sessions and unlimited legal and financial counseling services.

Accident

Here are some sample benefits (per incident) for the Off the Job Accident plans.

Wellness Benefit	**$25 year one; $50 2nd – 4th year; $75 5th year and after**
Accident Hospitalization	$900 once per year, per covered person; then $225 per day of hospital confinement, up to 365 days per covered accident
Intensive Care Unit	$300 per day, up to 30 days
Emergency Room	$125/$175 with X-Ray
Dislocations	Up to $2,000 based on schedule
Fractures	Up to 2,500 based on schedule
Follow-up Physical Therapy	$35 per visit up to 10 visits per covered accident
Ambulance	$300 - Ground Transportation $900 - Air Transportation
Additional Covered Conditions	Burns, paralysis, surgery, coma, concussion, lacerations, diagnostic exams (CT, CAT, EKG, MRI, X-ray)
Dismemberment	$8,750 Single $17,500 Double
Accidental Death	$50,000

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Critical Illness Including Cancer

Wellness Screening Benefit	$50 for Employee $50 for Spouse (must be covered on plan) $50 Child
Coverage Amount Options	Employee: $10,000 or $20,000 Spouse: $5,000 or $10,000 Child: $5,000 *Employee must elect coverage in order to elect coverage for any dependent.
Guarantee Issue amount	Employee: $10,000 Spouse: $10,000; Child: $5,000; coverage at no additional cost with enrolled employee *Employee must elect coverage in order to elect coverage for any dependent.
Included Illness at 100%	Heart attack, Stroke, Cancer, End-stage kidney disease, Major organ transplant, Bone Marrow transplant, Blindness, Coma, paralysis, severe burns
Included Illness at 25%	Coronary artery bypass surgery, non-invasive cancer
Recurrence Benefit	There is 6 month waiting period for the Additional occurrence benefit
Pre-existing Conditions	12/12 months* If you have received care or taken medication in the 12 months prior to the effective date, benefits will not be paid for that condition until the earlier of 12 months treatment free or 12 months of continuous insurance under the plan
*the pre-existing condition clause can be waived if you have coverage under a similar plan. See the Aflac representative for additional information.	

NEW – Fraud Protection

EZShield®
Identity Crime Protection™

Make sure your business stays your business

Stay secure with Fraud Protection, available through Aflac.

It happens everywhere, every day. One in every 16 people in the U.S. were victims of identity theft in 2016. It's no wonder that fraud is among the top concerns for working adults.* No one wants to go through the hassle, expense and time of dealing with fraud.

But you can protect yourself. Your employer and Aflac have teamed up to provide an easy way to reduce your risk of becoming the next victim — at no cost to you.

Fraud Protection is now available to you as part of your employer's benefits package.

FRAUD IS A REAL CONCERN. BUT NOW THERE'S A REAL SOLUTION.

- **Safe, secure** digital storage of personal info
- **Email alerts**
- **Recovery process** for lost/ stolen wallet, fraud or ID theft
- **Live support 24/7**

Aflac.

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Fraud Protection gives you stronger peace of mind.

These services are automatically available to you when your coverage begins.

RESTORE

Certified Resolution Specialist

- Fully managed restoration services
- One-on-one dedicated care

End2End Defense℠ 32-step recovery process

- For lost/stolen wallet, breached data, fraud or ID theft
- Designed to discover, isolate and prevent future fraud

24/7 LIVE SUPPORT

Expert assistance, whenever and wherever you need it

- 24/7 access to expert professionals who can help you if fraud or identity theft occurs

These services require registration and additional information before they're available for use:

SECURE

Online Identity Vault

- Secured digital storage for personal and account information, vital documents, images and other data
- Mobile app for on-the-go access to manage your identity
- Password Manager

Expert Protection Tips and Timely News

- Monthly activity reports via email detailing your account status and protection tips
- Breach alert emails to make you aware of recent breaches and scams

MONITOR

Internet Monitoring

- Fraud exposure report of your personal information on black market websites
- Daily monitoring for your personal information (stored in your Online Identity Vault)

Aflac's Fraud Protection is here for you.

When your coverage begins, call: **866-826-8851** or visit: **aflac.ezshield.com/register.**

Available through Aflac, powered by EZShield.

[1]Identity Theft Hit an All-Time High in 2016, USAToday.com, February 6, 2017

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service providers, and does not own or administer any of the products or services provided by the Value-Added Service providers. Each Value-Added Service provider offers its products and services subject to its own terms, limitations and exclusions. Value-Added Services are not available in Idaho or Minnesota. State availability may vary. Continental American Insurance Company, a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated.

aflacgroupinsurance.com | **1.800.433.3036**

Continental American Insurance Company | Columbia, South Carolina

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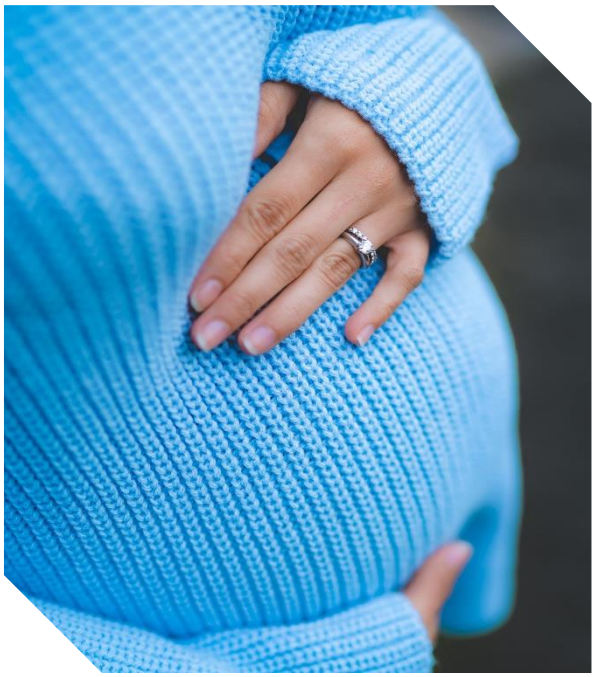
REQUIRED NOTICES

Newborn and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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 newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy , including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.



REQUIRED CHIP NOTICE

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 **1-877KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

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

REQUIRED CHIP NOTICE (CONT)

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

REQUIRED CHIP NOTICE (CONT)

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

REQUIRED CHIP NOTICE (CONT)

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

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

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

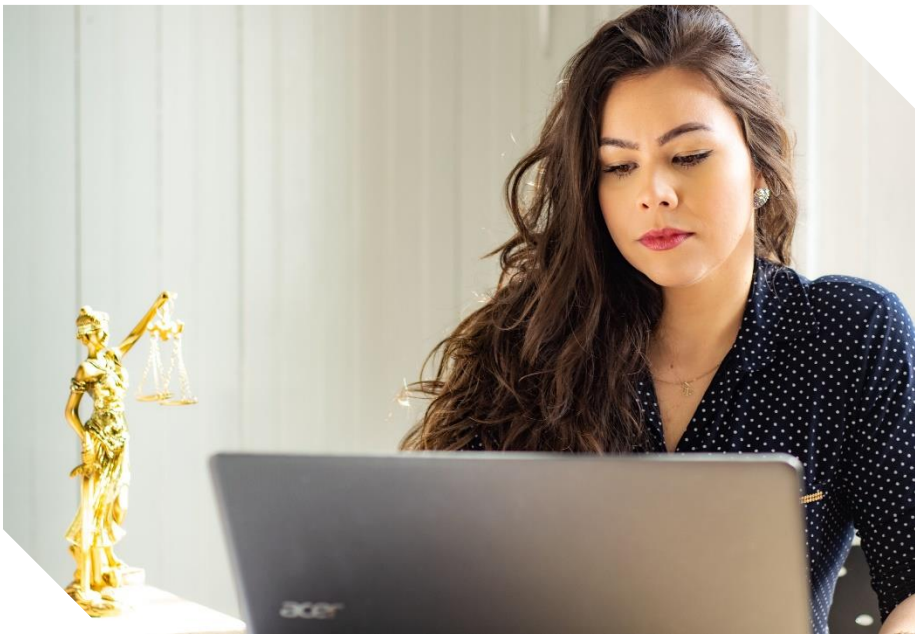
Paperwork Reduction Act Statement

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 1/31/2023)

HIPAA Notice



HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants. All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI. If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

More information can be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

Link to OneDigital's privacy policy: https://www.onedigital.com/privacy-policy/

Model Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within the appropriate time period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

More information can be found at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance

For additional information on your employer's privacy policy, please contact your HR department.

GINA Notice

GENETIC INFORMATION

Title II of the Genetic Information Nondiscrimination Act of 2008 ("GINA") protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. For further information on GINA, please see the poster "Equal Employment Opportunity is The Law," which should be posted in a common area at your employment location.

COBRA – Continuation Coverage

Continuation Coverage Under COBRA Notice

This notice applies to everyone with healthcare coverage under the Plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

You must provide this notice to: Tammy Safewright at 143 Third Street NW, Suite 1, Pulaski, VA 24301

How is COBRA continuation coverage provided?

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

COBRA – Continuation Coverage

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Pulaski County
Tammy Safewright
143 Third Street NW, Suite 1
Pulaski, VA 24301
(540) 994-2512

CONFIDENTIALITY NOTICE

Digital Insurance LLC dba OneDigital Health and Benefits does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

Medicare Part D Notice

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

OMB 0938-0990

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 Pulaski County coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Pulaski County coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Pulaski County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pulaski County changes. You also may request a copy of this notice at any time.

Medicare Part D Notice

Important Notice from Pulaski County About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pulaski County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

1. **Pulaski County has determined that the prescription drug coverage offered by Anthem 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.

Medicare Part D Notice

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 Sate 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 (1-800-433-4227). TTY users should call 1-877-486-2048.

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

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

Date:	April 30, 2021
Entity/Sender:	Pulaski County
Contact--Position/Office:	Tammy Safewright
Address:	143 Third Street NW, Suite 1 Pulaski, VA 24301
Phone Number:	540-980-7705

CMS Form 10182-CC

Updated April 1, 2011

CARRIERS, VENDORS & CONTACTS

Program	Vendor	Contact Information
Medical/Rx Customer Service	Anthem	www.anthem.com
Dental	Delta Dental of Virginia	www.deltadentalva.com
Vision	EyeMed	www.eyemed.com *use the INSIGHT network
Accident, Critical Illness and Cancer	Aflac	www.aflac.com
Flexible Spending Account/Dependent Care/Limited Flexible Spending Account	Flexible Benefit Administrators	www.flex-admin.com
HSA Administration	Health Savings Administrators	www.healthsavings.com
EAP	Optima	www.optimahealth.com
Advanced Resolution Team	One Digital	art@onedigital.com 1-866-802-6311

Know Where to Go!

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