



Your City of East Point Employee Benefits Plan Notices

Plan Notices

Table of Contents

Health Insurance Portability and Accountability Act (HIPAA) Privacy Notices	1
Notice of Patient Protections	7
Notice of Special Enrollment Rights	7
Employee Rights Under the Family and Medical Leave Act.....	8
General Notice of COBRA Rights	10
Wellness Program Disclosure (GINA)	14
Notice Regarding Wellness Program (ADA).....	14
Newborns’ and Mothers’ Health Protection Act Notice	15
Women’s Health and Cancer Rights Act.....	15
Notice of Creditable Coverage	15
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP).....	18

Plan Notices

Health Insurance Portability and Accountability Act (HIPAA) Privacy Notices

Your Information. Your Rights. Your Plan's Responsibilities to You.

This notice describes (a) how information your medical plan has about you may be used and disclosed and (b) how you can get access to the information. Where you see “the plan,” it refers to your Humana health plan, depending on which plan you elected for coverage. **Please review this section carefully.**

Article I. You Have

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask the plan to limit the information it shares
- Obtain a list of those with whom the City has shared your information
- Receive a paper copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated.

Article II. You Also Have

You have some choices in the way the plan uses and shares information in (a) answering coverage questions from your family and friends, (b) providing disaster relief, (c) marketing its services, and (d) selling your information.

Article III. Plan Data Uses and Disclosures

The plan may use and share your information in:

- Running its internal operations
- Helping manage the health care treatment you receive
- Paying for your health services
- Administering your health plan
- Helping with public health and safety issues

Plan Notices

- Conducting research
- Complying with applicable laws
- Responding to:
 - Organ and tissue donation requests
 - Medical examiners and funeral directors
 - Workers compensation, law enforcement, and other governmental inquiries
 - Lawsuits and other legal actions.

Article IV. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of the plan's responsibilities to help you.

Obtain a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information. Contact your plan to ask how to do this.
- Your plan will provide a copy or a summary of your health and claims records, usually within 30 days of your request. It may charge a reasonable, cost-based fee.

Ask the plan to correct health and claims records

You can ask the plan to correct your health and claims records if you think they are incomplete or incorrect. If the plan refuses your request, they will tell you why, in writing, within 60 days.

Request confidential communications

You can ask the plan to contact you in a specific way (for example, home or office phone) or to send mail to a different address. The plan will consider all reasonable requests and must agree if you tell them you would otherwise be in danger.

Ask the plan to limit what it uses or shares

You can ask the plan not to use or share certain health information for treatment, payment, or our operations. The plan may refuse if doing so would affect your care.

Obtain a list of those with whom the City has shared information

- You can ask for a list (accounting) of the times the plan shared your health information, for six years before to the date you ask, with whom the information was shared, and why.

Plan Notices

- The plan will include all disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you had asked to have made). The plan will provide one accounting each year at no cost, and at a reasonable fee should you request a second within the following 12 months.

Obtain a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. The plan will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information on your behalf.
- The plan will make sure the person has this authority and can act for you before taking any action.

File a complaint if you feel your rights are violated

- You can contact the plan to complain if you feel your rights have been violated.
- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201; by calling **1-877-696-6775**; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Article V. Your Choices

For certain health information, you can tell the plan your choices about what it shares. If you have a clear preference for how information is shared in the situations described below, let the plan know what you would like it to do, and we will follow your instructions accordingly.

In these cases, you have both the choice and right to tell the plan to share information with your family, friends, or others involved in payment for your care, as well as in cases of disaster relief.

If you unable to tell the plan your preferences — for example, if you are unconscious — the plan may share your information if it believes doing so is in your best interest. The plan may also share your information, when needed, to lessen a serious and imminent threat to health or safety.

The plan *never* shares your information for marketing purposes, or for sale, unless you provide explicit written permission to do so.

Plan Notices

Article VI. Our Uses and Disclosures

Section 6.01 How Does the Plan Typically Use or Share Your Health Information?

Help in managing the health care treatment you receive

The plan can use and share health information with the professionals who treat you.

Example: A doctor sends information about your diagnosis and treatment plan so the plan can arrange additional services

Running the company's internal operations

- The plan can use and disclose your information to run its internal operations and contact you when necessary.
- The plan uses health information to develop better services for you.
- The plan is not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Paying for your health services

The plan can use and disclose your health information as it pays for your health services.

Example: The plan may share information about you with your dental plan to coordinate payment for your dental services

Administering your plan

The plan may disclose health information to your plan sponsor to support administration of the plan.

Example: The City contracts with the plan to provide health care services, and the plan provides the City with statistical data to analyze claims and premiums

Section 6.02 How Else Can the Plan Use or Share Your Health Information?

The plan is allowed or required to share your information in other ways — typically for purposes that contribute to the public good, such as public health and research. The plan must meet many legal conditions before it can share your information for these purposes. For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Plan Notices

Help with public health and safety issues

The plan can share health information about you for such purposes as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Conduct research

The plan can use or share your information for health research.

Comply with the law

The plan will share information about you if state or federal laws require it, including with the Department of Health and Human Services in assessing compliance with federal privacy laws.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- The plan can share health information about you with organ procurement organizations.
- The plan can share health information about a participant who dies with such individuals as a coroner, medical examiner, or funeral director.

Address workers' compensation, law enforcement, and other government requests

The plan can use or share health information about you:

- For workers compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions, such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

The plan can share health information about you in response to a court or administrative order, or in response to a subpoena.

Plan Notices

Article VII. Our Responsibilities

- The plan is required by law to maintain the privacy and security of your protected health information.
- The plan will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The plan must follow the duties and privacy practices described in this notice and give you a copy of it.
- The plan will not use or share your information other than as described herein unless you provide other instructions in writing. If you do, you may change your mind at any time by similarly notifying the plan.

For More Information

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Article VIII. Changes in the Terms of this Notice

The plan can change the terms of this notice, and the changes will apply to all information it has about you. The new notice will be available upon request, on the plan web site, and the plan will also mail a copy to you.

Article IX. Other Instructions for Notice

- The Effective Date of this Notice is January 1, 2020.
 - The Privacy Official under this notice is Iris B. Jessie, Director, who can be reached at ibjessie@eastpointcity.org and **404-270-7065**.
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Plan Notices

Notice of Patient Protections

Your health plan may require or allow for the designation of a primary care provider (PCP). If so, you have the right to designate any PCP who (a) participates in the plan's network and (b) is available to accept you or your family members, including a pediatrician, as the primary care provider. Until you make this designation, the health plan may designate a PCP for you.

For information on how to select a PCP, and for a list of participating primary care providers, contact your health plan.

You do not need prior authorization from the plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or in making referrals.

Notice of Special Enrollment Rights

Eligible employees may decline enrolling in a City health plan, for themselves or their dependents (including spouse), due to coverage under another insurance or group health plan.

If such eligibility is subsequently lost, though, or the employer stops contributing toward the coverage, the eligible employee may be able to enroll him/herself and eligible dependents in the City's plan. To do so, the eligible employee must request to join the City plan within 30 days after the qualifying event (the other coverage ends or the employer stops contributions).

Similarly, if an eligible employee acquires a new dependent, as a result of marriage, birth, adoption, or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents. To do so, he or she must request to make any applicable benefit changes within 30 days of the qualifying event (e.g., after the marriage, birth, adoption, or placement for adoption). If the 30-day period ends before the eligible employee completes the change process, he or she may be required to wait until the next upcoming annual enrollment period to do so. The eligible employee may also be subject to limitations on coverage available at that time.

If the eligible employee declines enrollment in the City plan, for him/herself or eligible dependents while covered under Medicaid or a state Children's Health Insurance Program (CHIP), he or she may be able to join the City plan if eligibility for such other coverage is lost. Any applicable Medicaid- or CHIP-paid subsidies for medical coverage may be applied to the City plan. The eligible employee must complete enrollment in a City plan within 60 days after Medicaid or CHIP coverage ends. Otherwise, he or she will have to wait until the next upcoming annual enrollment period to do so, subject to any coverage limitations at that time.

Employee Rights Under the Family and Medical Leave Act

Leave entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Plan Notices

Eligibility requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months; and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

Requesting leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or

will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

General Notice of COBRA Rights

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. It explains COBRA continuation coverage, when it may become available to you and your family, and what you need do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other 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). Its 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 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, which is also called a "qualifying event." Specific qualifying events are listed later in this notice. After such 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;

Plan Notices

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
 - The parent-employee dies;
 - The parent-employee's hours of employment are reduced;
 - The parent-employee's employment ends for any reason other than his or her gross misconduct;
 - The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
 - The parents become divorced or legally separated; or
 - The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (Part A, Part B, or both); or
- In regard to applicable retiree coverage, commencement of a proceeding in bankruptcy with respect to the employer.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Human Resource Director and provide any supporting documentation and information as requested.

How is COBRA continuation coverage provided?

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

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

Plan Notices

There are also ways in which the 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, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA

Plan Notices

continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

For more information visit <https://www.medicare.gov/medicare-and-you>.

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

Contact the Benefits Central Team about any changes in the addresses of family members. They will provide the address change to your Plan Administrator, Ameriflex. You should also keep a copy, for your records, of any notices you send to Benefits Central Team.

Plan contact information

Benefits Central Team, 2110 Newmarket Parkway SE, Suite 200, Marietta, Georgia 30067, **855 827-3033**

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

Plan Notices

Wellness Program Disclosure (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. Please do *not* provide any genetic information when responding to requests for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, results of an individual’s or family member’s genetic tests, the fact that an individual or family member sought or received genetic services, and genetic information of a fetus carried by an individual or family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Notice Regarding Wellness Program (ADA)

The City of East Point sponsors a voluntary wellness program available to all benefit-eligible employees. The program is administered according to federal rules permitting employers to sponsor such initiatives to improve employee health or prevent disease. These rules include such legislation as the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment, or “HRA,” that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). The program is voluntary, and you may choose whether or not to participate.

Those who do choose to participate in the wellness program will be eligible to receive certain incentives. Although you are not required to complete the HRA, only those who do will qualify for any applicable incentives.

You may be eligible for an additional incentive — discounted health care premiums for non-smokers. To see if you qualify, you will need to complete and submit, in electronic form, the Tobacco Use Certification posted on Employee Navigator. The City may also accept an “alternative standard” to accommodate the recommendation of your personal physician. For information about such alternative standards, contact the **Benefits Central Hotline** at **855 827-3033**.

Plan Notices

Newborns' and Mothers' Health Protection Act Notice

Under federal law, health plans and insurance issuers generally cannot restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. If you deliver your baby outside the hospital and you are later admitted to the hospital in connection with childbirth (as determined by the attending provider), the delivery period begins at the time of the hospital admission. A provider is not required to obtain authorization, from the plan or the insurance issuer, for prescribing a stay of up to these applicable lengths. Nevertheless, federal law does not prohibit an attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for the following.

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information on WHCRA benefits, contact your health plan.

Important Notice About Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

This notice applies only if you and/or your dependent(s) are enrolled in a City of East Point medical plan *and* are eligible for Medicare. Otherwise, you may ignore this section of the document.

If you or a dependent is eligible for Medicare, please read this notice carefully and keep it where you can find it. It has information about your prescription coverage with City of East Point and your options under Medicare prescription drug coverage. It can help you decide whether to join a Medicare drug plan for the upcoming calendar year. If you want to consider doing so, you should compare your current employer benefit — including which drugs are covered and at what cost — with the coverage and cost of

Plan Notices

plans offering Medicare prescription drug coverage in your area. Information about where to get help in making decisions about your prescription drug coverage is shown at the end of this notice.

There are two important things you need to know about your employer 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. City of East Point has determined that prescription coverage under City plans, on average for all participants, is expected to pay out as much as standard Medicare prescription drug coverage and is therefore considered Creditable Coverage. For this reason, you can keep City coverage and not pay a higher premium (a penalty) if you decide to join a Medicare drug plan later.

When Can You Join a Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare — and each year thereafter, between October 15 and December 7. However, if you lose your current “Creditable” prescription drug coverage, through no fault of your own, you will also be eligible for a two-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?

Your City of East Point medical plan pays for health expenses in addition to prescription drugs. If you also enroll in a Medicare drug plan, you and your eligible dependents will be eligible to receive all your current health and prescription drug benefits. If you decide to join a Medicare drug plan and *drop your current coverage*, be aware that you and your dependents will *not* be eligible to receive health and prescription drug benefits in the future.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

If you drop or lose your current coverage with City of East Point and fail to join a Medicare drug plan within 63 continuous days after your current coverage ends, you may have to pay a higher premium (a penalty) to join a Medicare drug plan later.

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

Plan Notices

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

Contact the address below for further information. NOTE: You will continue to receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

City of East Point
Human Resources
2757 East Point Street
East Point, GA 30344
404-270-7064

For More Information About Your Options Under Medicare Prescription Drug Coverage

You can find details on Medicare plans that offer prescription drug coverage in the *Medicare & You* handbook, which you will receive from Medicare, by mail, each year. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage, you can:

- 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, you may be eligible for help in paying for Medicare prescription drug coverage. To learn about this financial assistance, visit Social Security at www.socialsecurity.gov or call them at **1-800-772-1213** (TTY 1-800-325-0778).

Remember: Hold on to this Creditable Coverage notice. If you decide to join a Medicare drug plan, you may be required to provide a copy of this notice to show whether you have maintained Creditable Coverage, which determines whether you can avoid paying a higher premium (penalty).

Plan Notices

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

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (CHIP) and are *also* eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. If you or your children are *not* eligible for Medicaid or CHIP, you will also be ineligible for such premium assistance programs — but you may be able to purchase 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, contact your State Medicaid or CHIP office to see if premium assistance is available in your state of residence. The contact information in Georgia is <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp> online, and, by phone, **678-564-1162 ext. 2131**.

If you or your dependents are *not* currently enrolled in Medicaid or CHIP, and you think you or your dependents might be eligible for either program, contact your State Medicaid or CHIP office, dial **877-KIDS NOW**, or visit www.insurekidsnow.gov to learn how to apply. If you qualify, ask if your state has a program that can help you pay premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, *and* eligible under your employer plan, your employer must allow you to enroll in its medical plan. If you are *not* currently signed up for employer coverage, you have up to 60 days after becoming eligible for premium assistance to enroll in your employer's plan. After the 60-day period lapses, though, you will be unable to join the plan until the employer's next scheduled annual enrollment period, subject to whatever coverage limitations are in effect at that time. For more information about enrolling in your employer's plan, visit the Department of Labor, at www.askebsa.dol.gov, or call **866 444-3272**.

Employee Navigator includes materials with detailed information about your benefits at Enroll.EmployeeNavigator.com.

You can also contact HR for other plan-related notices and documents.