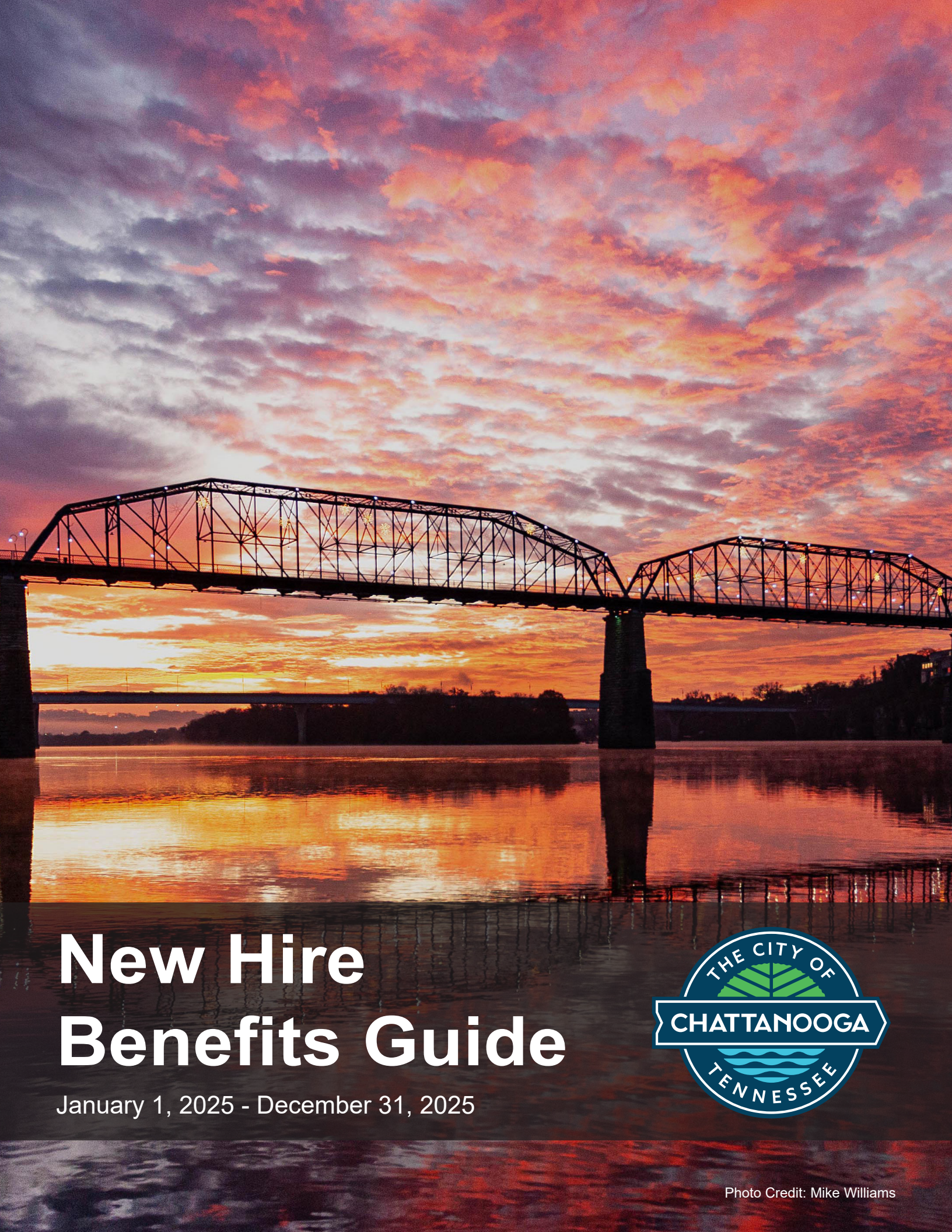


New Hire Benefits Guide

January 1, 2025 - December 31, 2025

THE CITY OF CHATTANOOGA TENNESSEE

Photo Credit: Mike Williams

What's Inside

Please note this guide is designed to provide an overview of the coverages available. Your employer reserves the right to amend or change benefit offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations. If any discrepancy exists between this guide and the official documents, the official documents will prevail. If you would like a printed copy of the materials, please contact your employer.

Please contact Human Resources if you have any questions regarding your benefits plan.

Review your benefit options detailed in this booklet and at mychattanoogabenefits.com. This site is available 24/7 for employees to reference benefit option details. Please contact Human Resources if you have any questions regarding your benefits plan.

Summary of Material Modifications

This document is to serve as a Summary of Material Modifications to the Summary Plan Description (SPD) for the City of Chattanooga Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Annual Notices section for more details.

When Your Coverage Begins

All employees must **enroll or decline coverage within 10 days of their date of hire** to avoid coverage delays and to ensure they receive ID cards prior to the effective date.

ALL employees must enroll or decline in benefits and name a beneficiary for the company-provided life insurance.

Effective Date for Employer-Paid Benefits

- City Basic Life – First day of the month following date of hire.
- Long-Term Disability – First day of the month following 180 days of employment
- Employee Assistance Program – First day of employment

Effective Date for All Other Benefit Plans

Your benefit elections will be effective the first day of the month following date of hire.

Benefit Eligibility - Dependents

- Your legal spouse
- Your or your spouse's: (1) natural child; (2) legally adopted child (including children placed for the purpose of adoption); (3) step-child(ren); or (4) children for whom the employee or employee's spouse is the legal guardian; who are less than 26 years old; or
- Your child or your spouse's child for whom a Qualified Medical Child Support Order has been issued; or
- Your Incapacitated Child or your spouse's Incapacitated Child

Documentation

In order to cover your dependents on The City of Chattanooga benefit plans, you must provide the following documentation before the coverage effective date:

- Marriage Certificate or 1040 for the addition of a spouse.
- Birth certificate for the addition of a child or children.
- Social security cards must be submitted for **all dependents that will be covered under medical, dental and vision benefits**.

Most documents can be uploaded directly into the Oracle Cloud System. For assistance, contact the Benefits Office. Date of birth and the social security number are needed for all dependents who will be covered under the medical, dental and vision benefits.

Mid-Year Life Changes - Qualifying Events

Each year you have the opportunity to make changes to your benefits package during an Annual Open Enrollment. With the exception of certain qualifying events, open enrollment is the only time benefit changes may be made. A qualifying event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of a Qualifying event are listed below as defined by the IRS:

- Change in legal marital status, including marriage, death of a spouse, divorce, legal separation and annulment.
- A change in the number of dependents, including birth, death, adoption, and placement for adoption.
- A change in employment status.
- A dependent ceasing to satisfy eligibility requirements for coverage due to attainment of age 26, change in marital status, or other similar circumstances.

If you are not sure whether your change is a qualifying event, please ask!

It is the employee's responsibility to notify the Benefits Office at (423) 643-7220 or benefits@chattanooga.gov of any life change that results in a gain or loss of dependent eligibility within **31 days** *of the date of the event. The employee may be responsible for any costs associated with misrepresentation.*

Medical Benefits

The City of Chattanooga operates a self-funded medical insurance plan. **BlueCross BlueShield of Tennessee** (**BCBST**) is the administrator of the City's insurance plan.

The Plan has two options – a Preferred Provider Organization Plan (PPO) and a High Deductible Health Plan (HDHP). The PPO plan has copays, a deductible and coinsurance after the deductible has been met. The HDHP has a deductible and coinsurance after the deductible has been met. A Health Savings Account (HSA) is used with the HDHP to set aside savings for future medical expenses.

The plan offers options in the BCBST S and P Networks. You have the flexibility to go to any provider that you choose; however, anytime you select an in-network physician or facility, you will see significant discounts and savings. In Tennessee, both networks include the Vanderbilt and St. Thomas hospital systems. BCBST makes it easy to determine whether your providers are in-network for the network choice you make.

To find an in-network provider near you, go to www.bcbst.com and click on "Find A Doctor." You can sort by Network P or S to see which of your providers participate in each network. You can also consult either the online directory or the BlueCross BlueShield of TN Customer Service department at 1-800-565-9140 to confirm that your provider participates in the network.

Monthly Premiums*	Network S		Network P	
	PPO	HDHP	PPO	HDHP
Employee Only	$110.46	$57.08	$134.80	$72.52
Employee + Child(ren)	$203.90	$104.80	$248.78	$132.56
Employee + Spouse	$237.08	$119.50	$289.70	$152.12
Employee + Family	$337.54	$171.92	$411.78	$220.68

**If either you or your covered spouse use tobacco products, as defined by the policy, we will add an additional $15 per month to your rate. This applies to both Network S and Network P.*

Terms to Remember

Copay (Copayment) – The set fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible – The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Coinsurance – The percentage of total costs that you pay "out-of-pocket" for covered expenses after you meet the deductible.

Out-of-Pocket Maximum (OOPM) – The maximum amount an individual or family will pay (in addition to premiums) for covered services during a plan year. This amount includes all money paid for eligible expenses toward the deductible, coinsurance and copays.

Network – The doctors, pharmacists and/or other health care providers who makeup the plan's preferred providers. When you use in-network providers, you pay less because they have agreed to pre-negotiated pricing. Also called in-network.

Preventive Care Services – Health care services you receive to help you stay healthy (rather than when you are sick or injured). Preventive care services include annual physicals, wellness screenings and well-baby care.

Plan Options	
PPO - P or S Network	**HDHP - P or S Network**
• Higher Premium • Copays for select services • Deductible: $1,000 for single or $2,000 for family. The plan pays after reaching the deductible. • 100% Preventive coverage • Not eligible for HSA	• Lower Premium • HSA Eligible • Deductible: $2,000 for single or $4,000 for family. The plan pays after reaching the deductible. • 100% Preventive coverage

Medical Benefits Chart

Benefit Plan Features	PPO In-Network	High Deductible Health Plan (HDHP) In-Network*
Preventive Care (See full list)	100% Coverage	100% Coverage
Annual Deductible Individual / Family	$1,000 / $2,000	$2,000 / $4,000
Annual Out-of-Pocket Max Individual / Family	$3,200 / $6,400	$4,000 / $8,000
Non-Network Benefits (Non-Network benefits are available, however, your share will increase)	2x In-Network Deductible and Out-of-Pocket Max Coinsurance will increase to 40%	
Covered Services & Copays		
Well Advantage Clinic	$0	$20
Office Visit Primary Care / Specialist	$30 / $40	20% after deductible
Telemedicine - Teladoc Health	$0 Copay	20% after deductible
Urgent Care	$75	20% after deductible
Routine Diagnostic Lab, X-ray (In office)	No additional copay	20% after deductible
Non-Routine Diagnostic Services (Includes MRI, CT scan, PET scan, nuclear medicine and other technologies)	20% after deductible	20% after deductible
Emergency Services (ER)	$300	20% after deductible
Ambulance	20% after deductible	20% after deductible
Provider Administered Specialty Drugs	$100	20% after deductible
Services Received at a Facility (Inpatient, Outpatient, Radiology etc.)	20% after deductible	20% after deductible
Behavioral Health		
Outpatient Behavioral Health	$30 copay	20% after deductible
Inpatient Behavioral Health	20% after deductible	20% after deductible
Pharmacy - Now through Navitus - See page 6 for more details.		
WellAdvantage Pharmacy Generic / Preferred / Non-Preferred	$4 / $27 / $52	20% after deductible
WellAdvantage (90-day Supply)	$10 / $67.50 / $130	20% after deductible
Retail Generic / Preferred / Non-Preferred	$12 / $42 / $67	20% after deductible
Mail Order (90-day Supply) Copay	$30 / $105 / $167.50	20% after deductible

**If more than one person is covered under the High Deductible Health Plan, the full family deductible must be satisfied before benefits will be paid for the employee or any covered family members.*

Pharmacy Benefits

The City of Chattanooga offers pharmacy benefits through **Navitus** (formerly EpiphanyRx). Navitus has the tools to help you and your physician make the best decisions possible for your care. Their network of over 64,000 pharmacies includes all major pharmacy chains.

To find a list of covered drugs and preferred pharmacies near you, visit www.navitus.com. If you need assistance with a prescription, contact Navitus Member Services.

Pharmacy Contacts

Navitus Member Services:
1-855-847-1025

Lumicera Specialty Pharmacy:
1-855-847-3553

Costco Mail Order Pharmacy:
1-800-607-6861

Copay Assistance

Many medications have copay assistance programs where drug manufacturers pay a part of the medication cost to make it more affordable. If you do not currently use a copay assistance program, the Navitus Customer Care team can help you enroll to take advantage of these savings. If you already use copay assistance, your out-of-pocket cost will not change. With copay assistance, only the amount you have paid out-of-pocket will apply to your annual deductible and/or out-of-pocket maximum. Some copay assistance programs require re-enrollment annually.

Lumicera Specialty Pharmacy

If you are taking a specialty medication, Lumicera will be your specialty pharmacy. A Navitus representative will reach out to you to talk about this transition. If you have questions before, please call member services or Lumicera directly.

Mail Order Pharmacy - Costco

For maintenance medications, you can use our preferred mail order pharmacy, Costco Home Delivery. Costco offers convenient delivery options and makes refilling your medications easy with the ability to refill by phone call, text message, or online.

To get started, go to pharmacy.costco.com and click on “Get Started” to create your account.

You do not have to be a Costco member to take advantage of savings offered by this service. If you need assistance, you can call Costco Monday - Friday from 8:00 am - 10:00 pm ET, or Saturday from 12:30 pm - 5:00 pm ET.

Terms to Remember

Formulary – A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list. Drugs are chosen for the formulary depending on their effectiveness, safety and appropriateness.

Drug Tier – Drugs are placed in tiers based on the type of drug: generic, preferred brand, non-preferred brand, and specialty. Drugs in lower tiers will cost less and those in higher tiers will cost more.

Specialty Drug – A medication used to treat complex and rare diseases that is either a self-administered (non-diabetic) injectable medication; a medication that requires special handling, special administration, or monitoring; or, is a high-cost oral medication.

Prior Authorization – Your physician must follow a process to obtain prior approval from your insurance company when administering specific medications, medical devices and medical procedures. Prior authorization must be performed before the insurance company or plan will provide full or partial coverage.

Medication adherence – The degree to which patients take their medications as prescribed (eg, twice daily), as well as whether they continue to take a prescribed medication.

TextCare

Welcome to TextCare!

Ever wish you could just text a doctor whenever you needed it? *Now you can*.

Text (423) 481-9760 for care!

TextCare is available to all employees enrolled in the medical plan and their entire household.

TextCare provides access to One to One Health board-certified providers via text message - 24/7. You'll get a provider response in *under 5 minutes*. You'll be able to discuss primary and urgent care needs, chronic condition management and routine medication needs.

TextCare is accessible via text message and video chat. There's no app to download to use the service! TextCare assists with:

- General care, preventative check-ins, personal wellbeing and urgent care needs (aches, injuries, colds, sickness)
- Pediatric wellbeing (2+ years old)
- Managing a chronic condition (diabetes, hypertension) with provider follow-up
- In-person care coordination (specialists, imaging and prescriptions)
- Ordering labs and reviewing results
- Prescription drug orders or refill

Appointments are not required. Simply send a text to **(423) 481-9760** to initiate care!

Telemedicine

City of Chattanooga is proud to offer **Teladoc** to all employees and dependents enrolled in the medical plan.* Teladoc is 24/7/365 access to a doctor by phone when your primary care physician is not available, and you have a condition when you would consider using urgent care.

All Teladoc doctors are practicing primary care physicians, pediatricians, and family medicine physicians who average 15 years experience and are U.S. board-certified and licensed in your state.

Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for non-emergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

Login to BCBSTN app or visit bcbst.com/Teladoc and choose "Talk with a Doctor Now" or call 1-800-TELADOC.

Prescriptions. Teladoc doctors can prescribe short term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, non therapeutic and/or certain other drugs which may be harmful because of their potential abuse. When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. You will be responsible for the co-pay based on the type of medication and your plan benefits.

Teladoc is most frequently used to treat conditions like:

- Urgent Care 24/7
- Mental Health Care (including psychology/psychiatry)
- Dermatology
- Neck/Back Care
- Nutrition Counseling
- Tobacco Cessation

*Refer to medical benefits chart on page 5 for member cost details.

Health Savings Account

HealthEquity

If you are enrolled in the High Deductible Health Plan (HDHP), you are eligible to participate in a Health Savings Account (HSA) through **HealthEquity**. An HSA is established to pay for future qualified medical, dental and vision expenses.

You can use your account to pay for qualified medical expenses that are incurred by you or your dependents identified on your Federal tax return. These qualified expenses are defined by the IRS in Publication 502. Your contributions to the HSA are made tax-free by payroll deduction. The funds are deposited into a Health Equity custodial account. When a qualified expense is incurred, you pay with your Health Savings Account debit card or request reimbursement for the expense from HealthEquity. The account is yours to keep, even if you leave employment with the City.

2025 Annual Maximum Contributions to your HSA

Employee:	**$4,300**
Family:	**$8,550**
Catch-Up Contribution for those 55+:	**$1,000**

To contribute tax-free to an HSA, you must be enrolled in an HDHP and no other coverage. You cannot contribute tax-free to an HSA if:

1. *You are covered by Medicare A, B or D or Tricare*
2. *Your spouse covers you under a plan that is not an HDHP*
3. *Your spouse has a Health Reimbursement Account (HRA) or an unrestricted Flexible Spending Account*

Qualified Medical Expenses for H.S.A		
Qualified medical expenses are designated by the IRS. They include medical, dental, vision and prescription expenses. Refer to the IRS publication 502 for a list of specific examples. Some Highlights Include:		
Prescription Drugs	Insulin	Dental Procedures
Orthodontics	Eye Exams	Eye Surgery
Prescription Eyeglasses and Contact Lenses	Hearing Aids	Hospital Services
Laboratory Fee and X-Rays	Long-Term Care Premiums	

BCBST BlueAccess Features

BCBSTN App

The BCBSTN app is your mobile BlueAccess. Through this app, you can view the mobile version of your Rewards portal, as well as access many of your subscriber tools like finding a doctor and reviewing your claims (if a BCBST medical subscriber).

Log in to the BCBSTN app using your BlueAccess username and password. iPhone users can also choose fingerprint Touch ID in the app settings. ***Tip:*** you can access your digital ID card on the app!

Healthy Maternity

With a little one on the way, you have a lot on your mind. That's why BCBST created a program that matches you with your very own maternity nurse, who will be there to help however you need.

Once you sign up, you'll get:

- One-on-one support from a maternity nurse
- Weekly emails for each stage of pregnancy and online pregnancy resources
- Immunization help
- Emotional support, during and after your pregnancy
- Help from high-risk maternity nurses or a certified lactation counselor if you need it

Log in or register now at bcbst.com/myhealthymaternity or call 1-800-818-8581.

24/7 Nurseline

Log in or register now at bcbst.com/member

- Choose the "Managing Your Health" tab
- Click on NurseChat

Nurses are here for you every day, around the clock. You can call when you need to talk. Or, if you prefer, chat with a nurse online through NurseChat on BlueAccess.

You can use Nurseline when you have questions about common health concerns - like a rash or a sprained ankle. Or you can talk with a nurse about big health decisions, like having back surgery or other treatments.

Call Nurseline at 1-800-818-8581 or 1-800-848-0298 (TTY).

BlueCross BlueShield | Blue365

As a BlueCross member, you get exclusive discounts on health and wellness products and services, including vision and hearing products, through our members only discount program. They're available from big national chains, and your local favorites. These discounts change often, so you can check back frequently, or opt in to get a weekly email full of new discounts for you.

You can see all available discounts by logging in at www.bcbst.com/memberdiscounts, or through the BCBSTN app.

Onsite Health Center Benefits

WellAdvantage Health Center	WellAdvantage On-Site Pharmacy
(423) 481-9760 Hours of Operation: Monday, Wednesday & Friday: 7:30am - 5:00pm Tuesday & Thursday: 7:30am - 6:00pm Saturday: 8:00am - 12:00pm TextCare - 24/7 access to One to One Health board certified providers via text message.	(423) 266-1586 (423) 266-3314 (fax) Hours of Operation: Monday-Friday: 8:00am - 6:00pm Closed for Lunch Daily 1:30pm - 2:00pm

- No or low office visit copays
- Full service, onsite WellAdvantage Pharmacy offering generic, preferred, non-preferred and over-the-counter medications
- Primary care for annual check-ups and physical exams
- Acute care visits for colds, sore throat, flu or other non-emergent concerns
- Health coaching to help with weight loss, physical activity plans or other chronic health conditions
- Onsite, convenient labs
- ***NEW!*** The WellAdvantage On-Site Pharmacy is going cashless in 2025. You can use your FSA, HSA, Credit/Debit/PrePaid cards for payment.
- ***REMINDER!*** Increased behavioral health services

All personal health information is protected and maintained in a HIPAA compliant manner. Health information will not be shared.

Who is Eligible?

WellAdvantage Health Center and On-Site Pharmacy: City employees, retirees, and their dependents, who are covered by the City's health insurance, may utilize the health center and pharmacy. Dependents using the health center MUST be 2 years or older to be eligible.

WellAdvantage Fitness Center: All full-time employees, elected officials, pension-eligible employees, and retirees, regardless of insurance coverage, may utilize the fitness center. Dependents, who are covered by the City's health insurance, may use the fitness center. Dependents age 13-17 may use the Fitness Center but MUST be accompanied by a parent.

WellAdvantage Fitness Center	How do I join the Fitness Center?
620 E. 11th Street Chattanooga, TN 37403 (423) 643-7970 Hours of Operation: Monday-Friday (Staffed Hours): 8:00am - 6:00pm 24/7 Access with your Key Card	If you are eligible to utilize the Fitness Center, you will need to attend a Fitness Center Orientation. In the orientation, you will review your Fitness Center access card, as well as review the available equipment, guidelines for use and safety regulations. To schedule an appointment or for more information, call (423) 643-7982.

Employee Assistance Program

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

- In-person help with short-term issues
- Unlimited telephonic support - Legal service, financial service, work life service
- Financial consultations and referrals
- Work/life services for assistance with child care, finding movers, kennels and pet care, vacation planning, and more.
- Toll-free phone and web access 24/7

Get Unlimited FREE help at:

www.guidanceresources.com

Web ID: CHATTEAP

Or Call (844) 268-5475

Digital Solutions are available to help with financial wellness and taking care of yourself through a guided program.

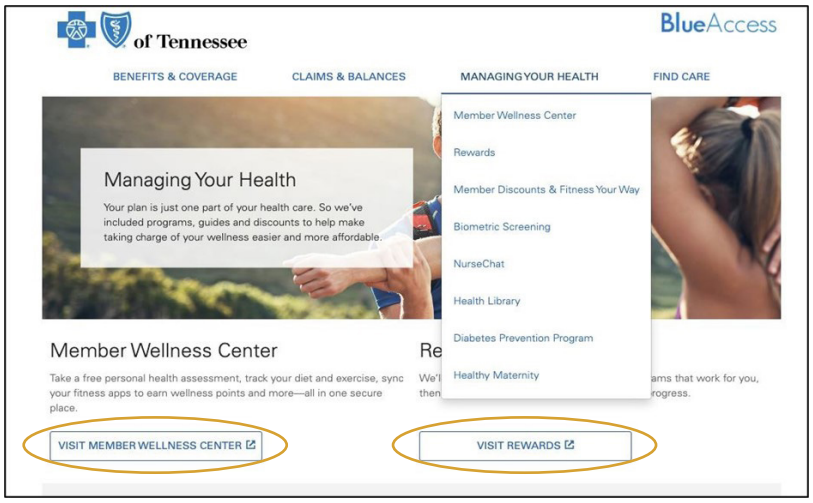
Wellness Rewards Program

The City of Chattanooga is proud to provide each employee with a comprehensive wellness program, administered by BlueCross BlueShield of Tennessee (BCBST), to help you reach your health and wellness goals. The employee must be enrolled in the Medical Insurance to participate in this program.

Our Wellness Rewards program lets you choose from a variety of activities to complete in order to earn up to 150 points. You can then redeem your points in the online Rewards catalog for things like gift cards, event tickets, electronics, and more. Your points expire 36 months from the day they are earned. **IMPORTANT!** Beginning 1/1/2025, the wellness program will be moving to a NEW Rewards structure in which 1 point equals $1. **In anticipation of this new structure, all existing reward points earned prior to 1/1/2025 must be redeemed by 12/31/2024. Point balances will not roll over into 2025.**

Examples of Rewards activities you can earn points for are:

- Annual Wellness Exam **and** Biometric Screening
- Mammogram
- Work with fitness trainer or dietitian
- Wellness Program Engagement at One to One
- Complete Healthy Culture Program
- And more!



The first step on your journey to wellness is to register at www.bcbst.com. From here, you can access your Rewards portal by choosing “Rewards” from the “Managing Your Health” tab, where you’ll find new wellness activities to try and can check your progress along the way. To find out more about your plan’s incentives and rewards or your terms and conditions, call us at 1-844-269-2583 (844-2MYBLUE) or email us at help@bcbstrewards.com.

The official Rewards Program Member Guide containing more details about this program will be sent after the beginning of the plan year.

Dental Benefits

Your dental benefits are provided by **Cigna**. There are three dental plans offered.

Dental 1000 and **Dental 1500-O** are PPO plans. You may visit your provider of choice, however, you will receive the best benefits by using an in-network provider at the Cigna DPPO Advantage level in the Cigna Total DPPO network.

Dental HMO is an HMO plan. **You must choose your dentist before you receive services.** The cost of services is based on the Patient Charge Schedule. Find your dentist in the Cigna Dental Care Access Plus network.

To find a provider in the network, visit www.cigna.com and click on "Find A Doctor, Dentist or Facility."

Monthly Premiums		
Rate Tier	**Dental 1000**	**Dental 1500-O**
Employee Only	$27.00	$31.36
Employee + Child(ren)	$50.84	$59.04
Employee + Spouse	$62.18	$72.22
Employee + Family	$86.14	$100.04

Rate Tier	Dental HMO
Employee Only	$13.50
Employee + 1	$21.88
Employee + 2 or more	$33.32

'Employee +1' means a spouse or one child
'Employee +2 or more' means 2 or more children or family

Plan Features	Dental 1000	Dental 1500-O	Dental HMO
Calendar Year Annual Maximum Applies to all benefits including Preventive, Basic & Major services.	$1,000	$1,500	Unlimited annual maximum, refer to Schedule of Benefits
Calendar Year Deductible Per Individual / Family	$50 / $150	$50 / $150	None
Preventive & Diagnostic (Class I) Includes oral exams, cleanings, sealants, x-rays, fluoride treatment, space maintainers	Plan pays 100%	Plan Pays 100%	Refer to Schedule of Benefits GIV9 Reduced, fixed, pre-set charges apply for all services. Certain limitations apply and you must select and identify your dental provider prior to treatment. Once enrolled, you may access the Schedule of Benefits: www.mycigna.com.
Basic Services (Class II) Fillings, simple extractions, periodontal maintenance, palliative treatment	Plan pays 80%	Plan pays 80%	
Major Services (Class III) Surgical extractions, oral surgery, root canals (endodontics), periodontal therapy and surgery, crowns, dentures, bridges, inlays, onlays	Plan pays 50%	Plan pays 50%	
Orthodontia Coinsurance Lifetime Limit - dependent children and adults	Not covered	$1,500	Refer to Schedule of Benefits

Accessing your digital ID cards is easy!

1. Log in to www.mycigna.com or the myCigna App
2. Click or tap "ID Cards"
3. View your card(s), as well as any dependents' card(s)
4. Email cards directly to doctors
5. Save your digital ID cards in your Apple Wallet

Vision Benefits

The Vision plan is designed to encourage you and your family to visit the optometrist or ophthalmologist regularly to maintain your vision health. This benefit is administered by **EyeMed** and you must use an EyeMed provider.

Monthly Vision Rates	
Employee Only	$5.52
Employee + Child(ren)	$11.32
Employee + Spouse	$10.80
Employee + Family	$16.08

The Vision Plan described below can be purchased with monthly premiums and offers covered benefits for exams, glasses and contacts. For more information and for a list of providers, visit www.bcbst.com/members/chattanooga. **This is an EyeMed Benefit and you must use a Provider that is In-Network with BCBST/EyeMed to receive the full In-Network Benefit.**

Vision Benefits	Frequency	In-Network	Out-of-Network
Vision Exam	Once every 12 months	$10 copay	$35 allowance
Lenses			
Single / Bifocal / Trifocal	Once every 12 months	$25 copay	$30 / $45 / $60 allowance
Progressive, Anti-reflective and Photochromic		$65 additional copay	$45 allowance
Frames	Once every 24 months	$150 allowance	$75 allowance
Contact Lenses			
Medically Necessary	Once every 12 months	Paid-in-full	$200 allowance
Conventional Disposable		$150 allowance	$120 allowance

Disability Plans

Important! Please refer to your Plan Documents for definitions and eligibility rules.

Short-Term Disability (STD) Insurance

Short-Term Disability (STD) Insurance can help support you and your family should you become temporarily disabled. This coverage is provided by **Symetra** and is paid entirely by you.

Please note: You may be asked to answer health questions if adding short-term disability coverage outside of your initial eligibility period.

Short-Term Disability Rates	
Age Last Birthday as of January 1, 2025	**Monthly Rate per $10 of Benefit**
Less than 55	$0.407
55-59	$0.631
60 and up	$1.063

Long-Term Disability (LTD) Insurance

For those in the General Pension Plan Only*

Long-Term Disability (LTD) Insurance can protect your income in case of a long-term injury or illness. This coverage is provided through **Symetra** and paid entirely by the employer.

Contact the HR Benefits Office at (423) 643-7220 with your questions about this benefit.

Disability Details	Short-Term Disability	Long-Term Disability *(General Pension Plan Participants Only)*
Income Replacement	50% or 70% of weekly earnings	60% of monthly earnings*
Maximum Benefit	$2,000/week	Up to $5,000/month
Accident Elimination Period	14 days	180 days
Illness Elimination Period	14 days	
Benefit Duration	Terminate after 24 weeks	Social Security Normal Retirement Age

**Partial disability benefits may be available.*

Basic and Supplemental Life

Basic Life/AD&D Insurance | *Paid for by the Employer*

At the City of Chattanooga, Basic Life/Accidental Death and Dismemberment (AD&D) Insurance is a provided benefit at no cost to you through **Symetra**.

Basic Life/AD&D	
Coverage Amount	Coverage equal to employee's stated annual salary rounded to the next $1,000, but no more than $50,000
Age Reduction	Benefits reduce to 65% at age 70 and to 50% at age 75

Supplemental Life and AD&D Insurance | *Purchased by the Employee*

You have the option to purchase Supplemental Term Life and AD&D through **Symetra**. Newly hired employees may purchase Supplemental Life/ AD&D up to the Guaranteed Issue Amount without answering health related questions. You may purchase:

Supplemental Life/AD&D*			
	Employee	**Spouse**	**Child(ren)**
Coverage Amount	Increments of $10,000 up to 5 times salary, not to exceed $500,000	Increments of $5,000 up to employee's amount, not to exceed $250,000	Increments of $2,000, not to exceed $10,000
Guaranteed Issue Amount	$250,000	$25,000	$10,000
Age Reduction	Benefits reduce to 65% at age 70 and to 50% at age 75	Benefits reduce to 65% at employee's age 70 and to 50% at employee's age 75	Not Applicable

**If an employee and spouse are both City employees, they cannot cover each other.*

Important! Please refer to your Plan Documents for definitions and eligibility rules.

Employee & Spouse Age	Monthly Rate Per $1,000
Under 25	$0.077
25 - 29	$0.088
30 - 34	$0.107
35 - 39	$0.148
40 - 44	$0.212
45 - 49	$0.337
50 - 54	$0.538
55 - 59	$0.832
60 - 64	$1.312
65 - 69	$2.293
70 - 74	$4.095
75 - 79	$7.948
80+	$7.948
Child(ren) Flat Rate (Per $1,000)	$0.20
AD&D per $1,000	$0.04

Worksite Benefits - Hospital Indemnity

IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage

This Policy	Insurance on HealthCare.gov
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorder	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

Worksite Benefits

You do not have to be enrolled in any other benefit to enroll in these plans.

Unum will continue to provide additional voluntary worksite benefits for City employees and their families. You can enroll in these benefits through the Oracle system.

Group Hospital Indemnity

Group Hospital Indemnity Insurance pays a lump sum benefit for qualified hospital admissions and confinement.

- Cash benefits paid directly to you
- A Be Well benefit which pays $50 for specified exams, procedures, and screenings
- Rates will not go up as you age
- Coverage is available for employees, legal spouses, and dependent children

Monthly Payroll Premiums	
Employee Only	$17.46
Employee + Spouse	$35.90
Employee + Child(ren)	$26.60
Employee + Family	$45.04

See the Highlight sheet at mychattanoogabenefits.com and The Landing for more information.

Group Accident Insurance

Accident Insurance pays benefits for covered off-the-job accidents based on the type of accident and the treatments received.

- Cash benefits paid directly to you
- Rates will not go up as you age
- Coverage is available for employees, legal spouses, and dependent children

Monthly Payroll Premiums	
Employee Only	$9.06
Employee + Spouse	$16.62
Employee + Child(ren)	$22.82
Employee + Family	$30.38

See the Highlight sheet at mychattanoogabenefits.com and The Landing for more information.

Group Critical Illness Insurance

Critical Illness Insurance pays a lump-sum payment if you are diagnosed with a covered health condition.

- Cash benefit is paid directly to you.
- Includes a Be Well benefit that pays for specified exams, procedures, and screenings
- Coverage is available for employees, legal spouses, and dependent children
- Rates are age banded and based on the Employee's age.

See the Highlight sheet at mychattanoogabenefits.com and The Landing for more information.

Monthly Payroll Premiums (for $10,000 of Employee coverage and $5,000 of Spouse coverage)*		
Age**	Employee	Employee & Spouse
Under 25	$3.76	$6.48
25 - 29	$4.36	$7.38
30 - 34	$5.16	$8.58
35 - 39	$6.36	$10.38
40 - 44	$8.26	$13.22
45 - 49	$11.36	$17.88
50 - 54	$16.06	$24.92
55 - 59	$21.66	$33.32
60 - 64	$36.66	$55.82
65 - 69	$49.26	$74.72
70 - 74	$50.66	$76.82
75 - 79	$68.76	$103.98
80 - 84	$92.26	$139.22
85 +	$134.46	$202.52

**Premiums for $20,000 and $30,000 are separate rate tables.*
***Age banded rates are based on the Employee's age.*

Scan the QR code for more information on Unum worksite benefits!

General Pension Plan

The City provides various benefits to assist with your future financial security as you plan for retirement or in the event of a disability. If you are a civilian full-time employee of the City, you are automatically a member of the General Pension Plan (Plan).

General Pension Plan

As a participant, you contribute 2% of your pensionable earnings to the Plan and the City contributes additional amounts sufficient to fund the future retirement benefit payments from the Plan. The City's contribution will vary from year to year based on the recommendations of the Plan's actuary and the General Pension Plan Board of Trustees. The Trustees direct the investment strategy and objectives for the growth of the Plan's assets. All combined, the Plan will furnish a lifetime of retirement benefits for its participants.

The Plan is a defined benefit plan, which means that your basic monthly benefit is based on your years of service in the Plan and the average of your three highest calendar year earnings while in the Plan. A participant becomes vested in the Plan after earning 60 pension service credits. The Plan's stated normal retirement age is 62; however, a vested participant can retire as early as age 55 with a reduced benefit. If a vested participant has met the Rule of 80 before age 62, the participant can retire early without reduction in benefits. The basic monthly pension benefit is a single life annuity. The Plan offers other payment options that may help the participant to reach personal retirement goals.

For more information about this valuable benefit and Plan features, please visit the web page: http://www.chattanooga.gov/general-pension-plan.

Contact the HR Benefits Office at (423) 643-7224 with your questions about this benefit.

Deferred Compensation

Deferred Compensation Plan (457b)

Regardless of your participation in a pension plan, if you have income, you can specify an amount to be set aside through payroll deduction in a deferred compensation plan.

The 457b deferred compensation plan is designed for governments and operates in a manner similar to a 401(k). There are four different programs available through the City. You may choose from Empower, Nationwide, Voya, and ICMA to defer a portion of your income before tax to supplement your retirement. Each plan has a booklet that contains all the forms necessary to set up your deferrals and describes the menu of assets available for investment. You select the assets that fit your 'risk profile' to allocate and grow your dollars and increase your retirement nest egg. But even if you only contribute a small amount, with your selection of assets to grow your dollars, the funds can help you to supplement your retirement or provide insurance against unforeseeable future expenses.

- Employee Contributions: Your pre-tax contributions are made through payroll deduction. You may stop deductions or make changes to your contribution percentage by completing a form.
- Elective Deferral Maximum Contribution: You can make elective deferrals up to the maximum allowed by federal regulations. The maximum annual amount is $23,500 for 2025.
- Catch-up Contribution: If you are age 50 or older and make the maximum allowable deferral, you are entitled to make additional 'catch-up' contributions of $7,500 for 2025.
- Rollovers: Employees may transfer balances from other tax-qualified plans, 403(b), 457(b), traditional IRA, 401(k).
- Withdrawals: Withdrawals of money from your account will incur a mandatory 20% tax withholding, and may incur an additional 10% tax penalty, unless it is a hardship withdrawal or a rollover to another plan.

For further information about the City of Chattanooga's deferred compensation plan, contact Lindsay Lacy at (423) 643-7382 or llacy@chattanooga.gov.

Employee Care Center

As a full-time benefit eligible employee of the City, you have access to the **Employee Care Center of The Baldwin Group.**

The Employee Care Center (ECC) is a dedicated team of Advocacy Analysts.

Each Advocacy Analyst is licensed, HIPAA certified, and compassion trained and can assist with benefit related matters such as:

- Benefit Assistance & Education
- Claims Resolution
- Enrollment Guidance
- Healthcare Decision Support
- Prior Authorization Help
- Finding Providers/Finding Care
- Coordinating Care
- ID Card Help
- Settling Billing Challenges

Available Monday through Friday*

8:00 AM to 5:00 PM EST

Contact: 866.784.2242 or mybenefits@baldwin.com

**Available in English and Spanish*

The ECC Team ensures your needs are met accurately and timely during new hire enrollment, open enrollment, and throughout the year.

Benefit Contacts

Benefit Plan	Administrator	Contact Number	Website
Medical	BCBS of Tennessee	1-800-539-0688	www.bcbst.com
Prescription Drugs	Navitus	1-855-847-1025	www.navitus.com
Telemedicine	TextCare	423-481-9760	N/A
	Teladoc	1-800-835-2362	www.bcbst.com/Teladoc
Health Savings Account	HealthEquity	1-866-346-5800	www.healthequity.com
Employee Assistance Program	ComPsych® GuidanceResources®	1-844-268-5475	www.guidanceresources.com App: GuidanceResourcesNow Web ID: CHATTEAP
Wellness Rewards	BCBS of Tennessee	1-844-269-2583	www.bcbst.com
Dental	Cigna	1-800-244-6224	www.mycigna.com
Vision	BCBS of Tennessee	1-877-342-0737	www.bcbst.com
Short-Term Disability	Symetra	1-877-377-6773	www.symetra.com
Long-Term Disability	Symetra	1-800-426-7784	www.symetra.com
Basic Life Insurance	Symetra	1-800-426-7784	www.symetra.com
Supplemental Life Insurance	Symetra	1-800-426-7784	www.symetra.com
Worksite Benefits	Unum	1-800-635-5597	www.unum.com
General Pension Plan	City of Chattanooga	423-643-7224	www.chattanooga.gov/general-pension-plan
Deferred Compensation Plan	City of Chattanooga	423-643-7382	www.chattanooga.gov
Employee Care Center	The Baldwin Group	866-784-2242	mybenefits@baldwin.com

Visit the Chattanooga Employee Benefits Website for more information: www.mychattanoogabenefits.com.

If you have questions, please contact the Benefits Office at (866) 784-2242 or mybenefits@baldwin.com.

Notes

Annual Notices

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

CONSENT TO RECEIVE ELECTRONIC NOTICES

By participating in Open Enrollment, and providing an email address, I understand and consent that:

1. The following documents and/or notices may be provided to me electronically: **Summary Plan Descriptions; Summaries of Material Modifications; Summary Annual Reports; COBRA Notices; Summary of Benefits and Coverage; Notice of Health Insurance Marketplace Coverage Options; and Other ERISA required or Model Benefit Notices.**
2. I may provide notice of a revised e-mail address or revoke my consent at any time without charge by sending an e-mail or calling the Human Resources/Finance Department.
3. I am entitled to request and obtain a paper copy of any electronically furnished document free of charge by contacting the Human Resources/Finance Department contact.
4. In order to access information provided electronically, I must have a computer with Internet access; an e-mail account that allows me to send and receive e-mails; and Microsoft Word or Adobe Acrobat Reader.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

To see if any other states have added a premium assistance program since **March 17, 2025**, or for more information on special enrollment rights, contact either:

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

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

Alabama	855-692-5447
Alaska	866-251-4861
Arkansas	855-692-7447
California	916-445-8322
Colorado	800-221-3943
Florida	877-357-3268
Georgia	678-564-1162
Indiana	800-403-0864
Iowa	888-346-9562
Kansas	800-792-4884
Kentucky	855-459-6328
Louisiana	855-618-5488
Maine	800-442-6003
Massachusetts	800-862-4840
Minnesota	800-657-3672
Missouri	573-751-2005
Montana	800-694-3084
Nebraska	855-632-7633
Nevada	800-992-0900
New Hampshire	603-271-5218
New Jersey	800-356-1561
New York	800-541-2831
North Carolina	919-855-4100
North Dakota	844-854-4825
Oklahoma	888-365-3742
Oregon	800-699-9075
Pennsylvania	800-692-7462
Rhode Island	855-697-4347
South Carolina	888-549-0820
South Dakota	888-828-0059
Texas	800-440-0493
Utah	888-222-2542
Vermont	800-250-8427
Virginia	800-432-5924
Washington	800-562-3022
West Virginia	855-699-8447
Wisconsin	800-362-3002
Wyoming	800-251-1269

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.

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

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

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

NOTICE OF PATIENT PROTECTIONS

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

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

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

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

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

You are protected from balance billing for:

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

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

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

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

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

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

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

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

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

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

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

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

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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 of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

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

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a

cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

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

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

HIPAA SPECIAL ENROLLMENT

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

Loss of Other Coverage If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth, or Adoption If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

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

Starla Benjamin

101 E. 11th Street, Suite #201
Chattanooga, TN 37402

(423) 643-7220

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the "Health Information Technology for Economic and Clinical Health (HITECH) Act." The HITECH Act supports the concept of meaningful use (MU) of electronic health records (EHR), an effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

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

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

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

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

PREVENTIVE CARE Health plans will provide in-network, first-

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

WELLNESS PROGRAM Our company's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including 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). You may also be asked to complete a biometric screening, which may include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

The above Wellness Program notice is only applicable if your plan administrator or medical plan provides a wellness program.

ADA NOTICE REGARDING WELLNESS PROGRAM

****Only applicable if your plan administrator or medical plan provides a wellness program for which individual medical information is obtained (e.g., through completing a health risk assessment or biometric screening."***

The group may provide a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including 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 may be asked to complete a voluntary health risk assessment (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). You may also be asked to complete a biometric screening, which may include a blood test.

You are not required to complete the HRA or to participate in the blood test or any other medical examinations. However, employees who choose to participate in the wellness program may receive an incentive for participation. You are not required to complete the HRA or participate in the biometric screening, but only employees who do so receive an incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard.

You may request a reasonable accommodation or an alternative standard by contacting your plan administrator.

The personally identifiable information from your HRA and the results from your biometric screening will not be shared with your employer in accordance with HIPAA regulations. It may be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, the carrier or wellness vendor will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

If you are participating in a company sponsored or carrier sponsored wellness program, the only individual(s) who will receive your personally identifiable health information is a medical professional, such as a registered nurse, doctor, or a health coach associated with the program to provide services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against because of medical information you provide while a participant in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your plan administrator.

HIPAA NOTICE OF PRIVACY PRACTICES

Starla Benjamin

101 E. 11th Street, Suite #201
Chattanooga, TN 37402

(423) 643-7220

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research & comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

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

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get 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. We 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.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

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

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation or include it within a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: understanding your rights.

Help with public health and safety issues
We can share health information about you for certain situations such 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

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes
- 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

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

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: understanding this notice.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request or in our office.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction. You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

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

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to our company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; 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 [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to the appropriate party.

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

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

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

Disability extension of 18-month period of COBRA continuation coverage. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. ***Second qualifying event extension of 18-month period of continuation coverage.*** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

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

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

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

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

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

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

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

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www.baldwin.com

Important Notice from Our Company About Your Prescription Drug Coverage and Medicare

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

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

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

2. Our Company has determined that the prescription drug coverage offered by the medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current employee coverage will not be affected. You can keep this coverage if you elect part D and the Medical Carrier plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every

month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date	Updated 06/2025
Name of Entity	The City of Chattanooga
Contact	Starla Benjamin
Address	101 E. 11th Street, Suite #201 Chattanooga, TN 37402
Phone	(423) 643-7220

HR Benefits Office

benefits@chattanooga.gov | (423) 643-7220

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