REQUIRED HEALTH PLAN ANNUAL NOTICES

Women's Health and Cancer Rights Act Enrollment Notice

The Woman's Health and Cancer Rights Act of 1998 (WHCRA) is a Federal law that provides rights regarding mastectomy and other breast cancer related services. For individuals receiving mastectomy-related benefits, coverage will be provided for certain services and supplies that relate to:

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

The benefits provided are subject to the health plan deductibles and coinsurance. Please review you contract and Summary of Benefits and Coverage for further details regarding these benefits, cost and coverage.

Statement of Rights Under the Newborn and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable.

Under Federal law, plans and issuers may not require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, for access to certain providers or facilities or to reduce costs, you may be required to obtain pre-authorization by contacting your plan administrator.

Statement of HIPAA Portability Rights

Preexisting condition exclusions.

For plan years beginning on or after January 1, 2014, insurers will be prohibited from imposing pre-existing condition exclusions under the Affordable Care Act (the prohibition on preexisting condition exclusions is already in effect for children under 19 years of age). This prohibition will make certificates of creditable coverage unnecessary. Accordingly, the Departments of Health and Human Services, Labor, and the Treasury have issued final rules **eliminating the requirement to provide certificates of creditable coverage beginning December 31, 2014**.

Right to get special enrollment in another plan

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.
Additionally, if an employee, spouse, or dependent loses or gains eligibility for assistance under CHIP, Medicare or Medicaid coverage, the cafeteria plan may permit the employee to make a prospective election to commence or increase coverage of that employee, spouse, or dependent under the accident or health plan. This is called a "special enrollment" opportunity and the request for coverage must be made within 60 days of the change in eligibility status.

Prohibition against discrimination based on a health factor

Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Additional Information

Please contact the Human Resources Department if you have further questions. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa.

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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**

Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432- 5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**

Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

HIPAA Notice of Privacy Practices

This notice of privacy practices describes how medical information about you may be used and disclosed by the health plan administrator. Please review this notice carefully and share with all members of your family who are covered by the health plan.

The Health Plan administrator (Plan) is required to maintain the privacy of Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"). PHI is any information that may identify you and that relates to your past, present, or future physical or mental health condition and any related health care services and payment for those health care services. This information may be in written, electronic, or oral form. This notice describes how the Plan may use and disclose PHI to carry out treatment, payment, or health care operations, or for other specified purposes permitted or required by law. The notice also provides you with information about your rights to access, to amend, and control the disclosure of your PHI.

Examples of how PHI may be used or disclosed by the health plan:

The following categories describe different ways that the Plan may use or disclose your PHI in compliance with HIPAA. The examples of permitted uses and disclosures listed below are not provided as an all-inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

Treatment, Payment, and Health Care Operations

HIPAA allows the Plan to use and disclose PHI for purposes of treatment, payment, and health care operations, without your consent or authorization. Examples of uses and disclosures for treatment, payment and health care operations are listed below:

- **Treatment**. Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, and includes the referral of a patient for health care from one health care provider to another. The Plan does not provide treatment directly. However, the Plan may use or disclose PHI in arranging or approving treatment by a particular health care provider.
- **Payment.** Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan or to obtain or provide reimbursement for the provision of health care. Examples of payment activities which may involve use and disclosure of PHI include reviewing PHI to determine your eligibility for a benefit payment under the Plan (including sharing PHI for purposes of coordination of benefits); reviewing your PHI for purposes of determining medical necessity; and reviewing PHI in connection with utilization review, including precertification or preauthorization of services.

- **Health Care Operations.** Health Care Operations refers to Plan management, planning and development, and other administrative functions necessary to operate the Plan. Examples of health care operations that may involve use or disclosure of PHI include reviewing PHI for purposes of underwriting, premium rating, drug formulary administration, case management, and care coordination activities.

Other Uses and Disclosures

HIPAA also requires or permits the Plan to use or disclose your PHI for the purposes described below without authorization from you. Please note, the Plan will likely never have reason to make some of these disclosures. However, federal law requires that we inform you of the ways that the Plan is required or permitted to use PHI without your authorization, as provided by HIPAA:

- **Required by Law** - The Plan may use or disclose your PHI to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health** – The Plan may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. The Plan may also disclose your PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Health Oversight** – The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information may include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

- **Disclosures to You** - The Plan may use and disclose your PHI to you. For example, the Plan may disclose PHI for purposes of telling you about or recommending possible treatment options or alternatives that may be of interest to you.

- **Disclosures to a Personal Representative** – The Plan may disclose PHI to a personal representative designated by you or a personal representative designated by law such as the parent or legal guardian of a child or the surviving family members or personal representative of the estate of a deceased or incompetent individual.

- **HIPAA Compliance Review** – The Plan may disclose PHI to the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine the Plan's compliance with the HIPAA Privacy Rules.

- **Business Associates** – The Plan may disclose PHI to a Plan "Business Associate" (as defined by HIPAA) in connection with the Business Associate's performance of services for the Plan. Business Associates are required to appropriately safeguard your PHI.

- **Workers' Compensation** – Your PHI may be disclosed by the Plan as authorized to comply with workers' compensation laws and other similar programs established by law.

- **Abuse or Neglect** – The Plan may disclose your PHI to a public health authority or other appropriate government authority that is authorized by law to receive reports of child abuse or neglect. In addition, the Plan may disclose your PHI if it believes you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. Such disclosures will be made consistent with the requirements of applicable federal and state laws.

- **Food and Drug Administration (FDA)** – The Plan may disclose your PHI to a person or company as directed or required by the FDA: (1) to collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations; (2) to track FDA-regulated products; (3) to enable product recalls, repairs, replacement, or lookback (including locating and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of lookback), or (4) to conduct post-marketing surveillance.

- **Legal Proceedings** – The Plan may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal to the extent such disclosure is expressly authorized by such order. The Plan may also disclose PHI, in response to a subpoena, discovery request, or other lawful process under certain conditions.

- **Law Enforcement** – The Plan may disclose PHI for law enforcement purposes to a law enforcement official, subject to certain conditions specified under HIPAA. This includes: (1) disclosures to a law enforcement official that are required by law; (2) disclosures required by a court ordered warrant, subpoena, or summons issued by a judicial officer or by a grand jury subpoena; (3) disclosures in response to a law enforcement official's request for information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; (4) disclosures in response to a law enforcement official's request for information

about an individual who is or is suspected to be the victim of a crime; (5) disclosures to a law enforcement official concerning the PHI of a deceased person if the person's death may have resulted from criminal conduct; (6) disclosures to a law enforcement official of PHI which may constitute evidence of criminal conduct that occurred on the Plan's premises.

- **Communicable Diseases** – The Plan may disclose your PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition, if the Plan or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation.

- **Coroners, Funeral Directors, and Organ Donation** – The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining cause of death, as necessary to permit the coroner or medical examiner to perform their duties as authorized by law. The Plan may also disclose PHI to a funeral director, consistent with applicable law, as necessary in order to permit the funeral director to carry out applicable duties. For the purpose of facilitating requested organ, eye, or tissue donation and transplantation, the Plan may use or disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissues.

- **Research** – The Plan may disclose PHI to researchers, subject to conditions specified under HIPAA and provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of PHI.

- **Correctional Institutions** – The Plan may disclose to a correctional institution or to a law enforcement official having lawful custody of an inmate PHI about the inmate if the institution or official represents that the PHI is necessary for purposes of providing health care to the inmate or for certain other purposes specified under HIPAA.

- **Military Activity and National Security** – Subject to conditions specified under HIPAA, the Plan may: (1) use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; or (2) disclose PHI to authorized federal officials for purposes of conducting national security and intelligence activities, including the provision of protective services to the President or others as legally authorized.

Authorization for Use or Disclosure of PHI
The Plan will obtain your written authorization for use or disclosure of PHI if such authorization is required by HIPAA. As noted above, written authorization is *not* required for use or disclosure of PHI for purposes of payment, treatment, or healthcare operations. Written authorization is also not required for certain other uses or disclosures of PHI, as described above. Some specific instances where your authorization is required before the Plan may use or disclose your PHI include, without limitation:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of PHI.

If written authorization for use or disclosure of PHI *is* required under HIPAA, the Plan will obtain your written authorization before using or disclosing your PHI. You may revoke such authorization at any time by providing written notice that you wish to revoke your authorization to the Privacy Contact for the Plan. Upon receipt of a valid written revocation, the Plan will stop using or disclosing your PHI, except to the extent that action has already been taken in reliance on the prior authorization.

Your rights with respect to your protected health information

Right to Request Restrictions on Certain Uses and Disclosures
You have the right to request that the Plan limit its uses and disclosures of your PHI or restrict the use or disclosure of your PHI to family members or personal representatives. Any request must be made in writing to the Privacy Contact listed at the end of this notice and must state the specific restriction requested and to whom that restriction would apply. The Plan cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer the Plan.

Right to Receive Confidential Communications
You have the right to request that Plan communications involving PHI be provided to you at an alternative location or by an alternative means of communication. The Plan is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Contact listed at the end of this notice.

Right to Access to Your Protected Health Information
In most cases, you have the right to inspect and copy your PHI that is maintained in a designated record set. Federal law does prohibit you from having access to the following: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. To inspect or copy your PHI, you must send a written request to the Privacy Contact listed at the end of this notice. The

Plan may charge you a fee for the cost of copying, mailing, and supplies that are necessary to fulfill your request.

Right to Amend Your Protected Health Information

If you feel that your PHI is incomplete or incorrect, you have the right to request that the Plan amend it as long as the Plan maintains the PHI. The Plan may deny your request for amendment if it determines that the PHI was not created by the Plan, is not part of a designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the Plan has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be made in writing to the Privacy Contact listed at the end of this Notice.

Right to Receive List of Disclosures

You have the right to receive a listing of all the disclosures of your PHI that the Plan has made, if any, for reasons *other than* disclosures for treatment, payment, health care operations, as described above, and disclosures made to or authorized by you or your personal representative. Your right to an accounting of disclosures applies only to PHI created or maintained by the Plan after HIPAA's effective date (April 14, 2003) and cannot exceed a period of six (6) years prior to the date of your request. A request for a list of disclosures of your PHI should be made in writing to the Privacy Contact listed at the end of this notice and must specify the time period of the PHI requested.

Right to Receive Copy of Notice of Privacy Practices

You have the right to receive a paper copy of this notice upon request. This right applies even if you have previously received a copy of the notice or if you have previously agreed to accept this notice electronically. Requests for a paper copy of this notice should be made to Human Recourse Department.

Breach Notification Requirements

The Plan is required to notify you if unsecured PHI is acquired, accessed, used and/or disclosed by an unauthorized party. This notification must occur without unreasonable delay and in no case later than 60 days of the event.

For More Information Or To Report a Problem

If you have questions or would like additional information about the Plan's privacy practices, you may contact the Human Resource Department. If you believe your privacy rights have been violated, you may file a complaint with the Plan's Privacy Contact, or you may file a complaint with the Secretary of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. There will be no retaliation for filing a complaint.

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Pickens County coverage will be affected. You can keep this coverage if you elect part D and this plan will coordinate with part D coverage.

If you do decide to join a Medicare drug plan and drop your current Plan of coverage, be advised that you and your dependents will 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 Pickens County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the individual listed below for further information. **NOTE:** You will get this notice each year or if this coverage through Pickens County changes. You also may request a copy of this notice at any time.

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

- Visit www.medicare.gov
- Call 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: **01/01/2017 or upon eligibility for Pickens County Group Health Plan.**

Name of Sender: **Pickens County Group Health Plan**

Contact: **Pickens County Human Resources Department**

Address: **1266 E. Church St. Suite 150, Jasper, GA 30143**

Phone: **706-253-8820**

Continuation Coverage Rights Under COBRA

PICKENS COUNTY HEALTH PLAN

Introduction

You are receiving this notice because you have recently become eligible for the Pickens County health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

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

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice **in writing** to: **Pickens County, 1266 E. Church St. Suite 150, Jasper, GA 30143.**

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a

dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at

www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Information about the plan and COBRA continuation coverage can be obtained on request from:

Pickens County

1266 E. Church St. Suite 150

Jasper, GA 30143

Tel: 706-253-8820

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.
What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.
Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.
How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact .
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more

information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

<table>
<tr><td colspan="2">3. Employer Name: Pickens County</td><td colspan="2">4. Employer Identification Number (EIN): 58-6003047</td></tr>
<tr><td colspan="2">5. Employer Address: 1266 E. Church St Suite 150</td><td colspan="2">6. Employer Phone Number: 706-253-8820</td></tr>
<tr><td>7. City: Jasper</td><td colspan="2">8. State: GA</td><td>9. ZIP Code: 30143</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job? Paula Peace</td></tr>
<tr><td colspan="2">11. Phone Number (if different from above):</td><td colspan="2">12. Email Address: ppeace@pickenscountga.gov</td></tr>
</table>

Here is some basic information about health coverage offered by this employer:
•As your employer, we offer a health plan to:

Some employees. Eligible employees are: Full time (30+ hours). Part time (<30 hours) and seasonal (less than 6 month) are not eligible.

•With respect to dependents:

We do offer coverage. Eligible dependents are: Spouses and Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian

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

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

employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

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