



2020



City of Hannibal and Board of Public Works Employee Benefits Guide

Your Benefits, Your Choice

BENEFIT HIGHLIGHTS

- Eligibility & Enrollment
- Employee Contributions
- Medical Insurance
- Utilization Requirements
- In-Network vs. Out-of-Network
- Telemedicine
- Be Well at Work
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- Dental Insurance
- Vision Insurance
- Basic Life Insurance
- Benefit Terms
- Annual Required Notices

WELCOME TO YOUR EMPLOYEE BENEFITS!

We understand that your life extends beyond the workplace. That is why we offer a variety of benefit plans to help you and your family. Within this guide, you will find the highlights of the benefits offered by the City of Hannibal and Board of Public Works.

Current Employees

If you take no action during your open enrollment period, your current benefit elections will roll over. Once open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

New Employees

This is your chance to elect benefits and enroll yourself and your eligible dependents. If you take no action now, you will have no benefits and you will not have another chance to elect them until next year’s open enrollment—unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

When to Enroll

Open enrollment begins on **May 1st** and runs through **May 31st**. The benefits you choose during open enrollment will become effective on **July 1st**.

CONTACTS

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE/EMAIL
Medical Insurance	RightChoice	(800) 365-9036	www.RCTPA.com
Prescription Drug	EnvisionRx	(833) 684-7258	Envisionrx.com
Dental Insurance	RightChoice	(800) 365-9036	www.RCTPA.com
Vision Insurance	Anthem	(866) 723-0515	Anthem.com
Life Insurance	Anthem	(800) 551-7625	Anthem.com
Be Well at Work	Hannibal Clinic Blessing Health System	(217) 214-6300	Blessinghealth.org
Personal Advisor Services	HooPayz	(866) 981-4991	Hoopayz.com

THE CITY OF HANNIBAL/BOARD OF PUBLIC WORKS BENEFITS CONTACT		
City of Hannibal – Angel Zerbonia	(573) 221-0111 x 209	AZerbonia@hannibal-mo.gov
City of Hannibal – Candy Golian	(573) 221-0111 x 213	cgolian@hannibal-mo.gov
Board of Public Works – Beverly Watson Stewart	(573) 221-8050 x 6013	bjwatson@hannibalbpw.org

DISCLAIMER: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

ELIGIBILITY & ENROLLMENT

Employee Eligibility

All Active and retired employees of the City of Hannibal/Board of Public Works are eligible to enroll in benefits. An employee is considered to be full-time if he or she normally works at least 30 hours per week and is on the regular payroll of the City of Hannibal/Board of Public Works. As a new employee, you have 30 days from your initial start date to enroll in benefits.

- **Medical, Dental & Vision:** You may enroll for health and dental insurance coverage immediately on the 1st of the month following your date of hire.
- **Other Coverages:** Will take effect on the 1st of the month following your date of hire.

**These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.*

Dependent Eligibility

Medical, Dental & Vision: Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an “eligible dependent” under these plans.

Definition of “Eligible Dependents”

The below definitions refer to **Medical, Dental, and Vision Coverages**.

- Your legal spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, “spouse” shall not mean a common law spouse or domestic partner.
- The employee’s dependent children, until the end of calendar year in which they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee’s children (or children of the employee’s spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent’s marital or tax exemption status changes and they are no longer eligible for continued coverage. {If Applicable}

Tax Elections

Employee medical and dental premiums will be deducted on a pre-tax basis through payroll deduction. Due to IRS rules, pre-tax contributions cannot be revoked or changed during the plan year, unless you experience a qualifying “Status Change” as described herein.

How to Make Changes - Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event.

Qualifying life events:

- Marriage, divorce, legal separation or death of a spouse
- Birth or adoption of a child
- Change in child’s dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan.

Important Notice

City of Hannibal/Board of Public Works provides eligible employees with coverage that exceeds the government’s standards for minimum value and affordability. If you are eligible for the City of Hannibal/Board of Public Works’ health plan, you will not qualify for a premium tax credit.

MEDICAL INSURANCE

HealthLink

We provide you the option to purchase affordable medical coverage. The below plans allow you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider (Open Access III Providers and PPO Providers). This is a summary of our medical insurance and for a comprehensive review of your medical benefits, please see the Schedule of Benefits within the Summary Plan Design document posted on our website.

MEDICAL COVERAGE HIGHLIGHTS	HealthLink		Non-Network Providers
	Open Access III Providers	PPO Providers	
Annual Deductible			
Individual	\$500	\$1,000	\$2,000
Family	\$1,000	\$2,000	\$4,000
Coinsurance (percent paid after you reach your annual deductible)			
Plans Pays	100%	80%	50%
You Pay	0%	20%	50%
Annual Out-of-Pocket Maximum			
Individual	\$2,500	\$3,000	\$5,000
Family	\$5,000	\$6,000	\$7,500
Covered Services			
Preventive Care	100% covered	100% covered	50% after deductible
Primary Care Office Visit	100% after deductible	80% after deductible	50% after deductible
Specialist Office Visit	100% after deductible	80% after deductible	50% after deductible
Emergency Room	100% after deductible	100% after deductible	100% after deductible
Hospitalization	100% after deductible	80% after deductible	50% after deductible

PRESCRIPTION DRUG COVERAGE HIGHLIGHTS	Drugs available only through the Prescription Drug Program		
Generic	25% copay		
Brand	25% copay		
Brand Non-Preferred	25% copay		
Specialty	100% after 25% copay, with a \$2,500 out-of-pocket max per Calendar Year		

UTILIZATION REVIEW

HealthLink

Precertification

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance

Health Reimbursement Account

Services rendered at an Open Access III Provider that are more than 50 miles from Hannibal, MO are eligible for a reimbursement of \$250 per occurrence with a maximum of \$500 per person/\$1,000 per family. See Summary Plan Design document posted on our website for more details.

Utilization Review Requirements

Please refer to the HealthLink pre-certification list for full details. It is the Employee's responsibility to obtain pre-certification or benefits will be reduced by a \$500 penalty. Penalty does not apply toward the Calendar Year deductible or out-of-pocket maximum.

Emergency Admission Requirements

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator within 48 hours of the first business day after the admission.

Hospital Services

In the Open Access III Providers Network, Inpatient Services and Outpatient Surgery will be subject to a \$500 copay then 100% after deductible if performed at any facility owned or operated by **Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic Hannibal and Quincy, Blessing Physician Services, Quincy Medical Group, and Northeast MO Ambulatory Surgery Center. DOES NOT APPLY TO EMERGENCY SERVICES, MATERNITY SERVICES OR PHYSICIAN OFFICE VISITS.**



IN-NETWORK (OPEN ACCESS III AND PPO) VS OUT-OF-NETWORK

The Basics

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates. For our health plan, an in-network provider falls under the Open Access III Provider and PPO Provider category, with Open Access III Providers providing better pre-negotiated rates than PPO Providers.

Out-of-network Provider—A provider who is not contracted with your health insurance company.

Getting the Most Out of Your Care

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network.

If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Billing & Claim Differences

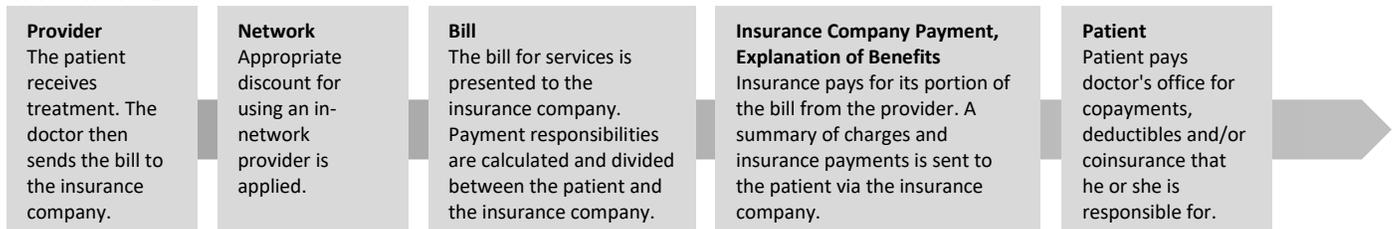
Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

Preventive Care

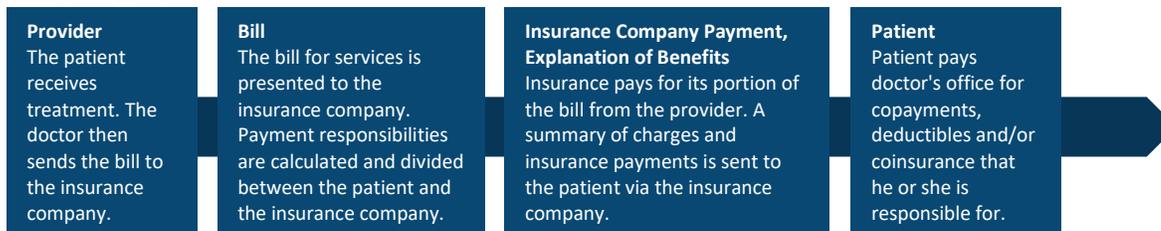
Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

In-network Bill



Out-of-network Bill



VIRTUAL DOCTOR VISITS

Blessing Care on Demand – Be Well at Work

Available to all employees, regardless of health plan enrollment.

Blessing Care on Demand can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions. With 24/7/ access to providers, you can access medical care, from home or on the road—and in some cases, doctors can write a prescription to a local pharmacy near you.*



All Users Must Complete the Following Steps:

1. Download the new Amwell: Doctor Visits 24/7 app.
2. Complete the sign up process in the app. You will need to enter your service key to waive the fee for your visit.
3. Once you login with your service key, the \$49 fee will be waived at the end of your visit.

Access Code: Hannibal1

How Blessing Care on Demand works in 4 easy steps:

1. Employee requests a visit with a clinician via smart phone, computer, or tablet.
2. Within minutes they're connected to an experienced, board-certified provider or nurse practitioner.
3. Provider will treat the employee, may make a diagnosis and recommend a course of treatment. If appropriate, the treatment may include a prescription or for more complicated health issues, the employee would be referred back to the health-system for in-person care.
4. After the visit, employees will receive an easy-to-read email visit summary

When Can I Use It?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.

Common Conditions We Treat

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore Throat
- Pink eye
- Urinary tract infections
- And more!

Save Money and Time!

Once you login with your service key, the \$49 fee will be waived at the end of your visit. Blessing Care on Demand provides significant savings over urgent care and emergency room visits. Plus, you can use it from the convenience of home or work, allowing you to avoid the hassle of sitting in a waiting room.

Visit BlessingCareOnDemand.com

For a phone visit call 1-844-9DOCNOW

BE WELL AT WORK

Hannibal Clinic Blessing Health System

Available to all employees, regardless of health plan enrollment.

Along with Blessing Care on Demand, all employees have access to Be Well at Work. This program includes primary care services, a wellness program that includes preventative services and education, along with a fitness center. See below for details:



Primary Care Services:

- Primary Care Visits: members 2+ years of age
- Pediatric Primary Care Visits: members 0 – 2 years of age (5 locations)
- Minor Illness, Injury, Sports & Acute Condition Visits: walk-in convent care clinic (5 locations)
- Chronic Condition Visits & Management
- Care Coordination
- Laboratory Tests: Common lab test (specialty and genetic are not covered)
- Immunizations/Routine Office Injections
- General X-Ray: technical & reading

Fitness Centers

- Cooking Demonstrations Classroom
- Personal Training
- Health Education Programs
- State-of-the-Art Fitness Equipment

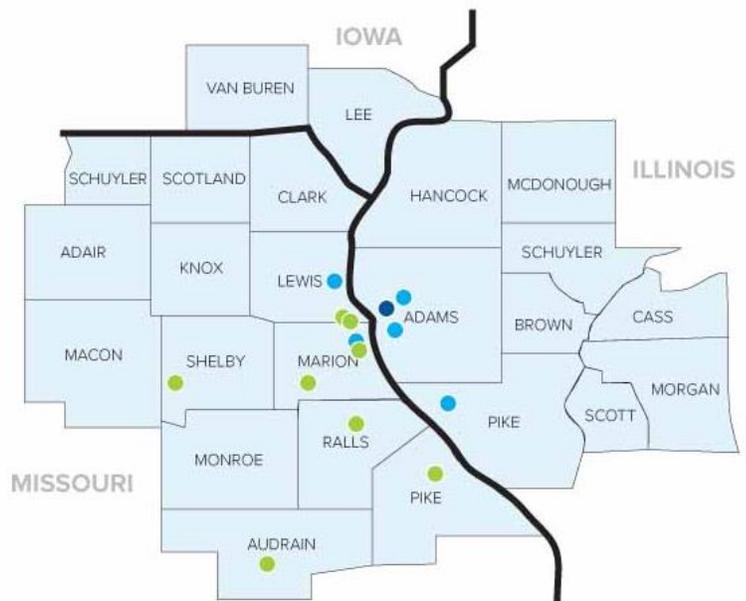
Access Points

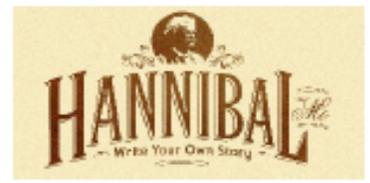
For Be Well access point locations, please call or log on to find your convenient location

- Illinois: 217.214.6300
- Missouri: 573.231.3850
- <https://www.blessinghealth.org/bewellclinics>

Wellness Program

- Annual Flu Shot Clinic
- Annual Biometric Testing
- Health Risk Assessment
- Employee Health Portal
- Wellness Education
- Wellness Center
 - Blessing Wellness Center (Quincy) & Illini Fitness (Pittsfield)





Employee Guide

HooPayz® is a comprehensive, time and money saving resource that will help you and your family make informed, cost saving health benefit decisions.

Spend Less on Quality Care

**Don't pay more than you should.
We can help you SAVE.**

With a Personal Advisor, you don't need to figure out healthcare on your own. We work to reduce your out-of-pocket cost, lower your stress, and improve your benefit literacy so you have the confidence to care for yourself and your family.

\$767*

*Average savings per price check and bill review request for HooPayz members. Your actual results will vary.

HooPayz protects you and your family financially by helping you use your health insurance correctly so you don't pay more than you should for healthcare services.

How Does HooPayz Work?

When you or your family needs help with your health insurance, finding a provider, or resolving medical bills, call a HooPayz Personal Advisor at 866-981-4991. We will find you the best solution.

Who is Eligible?

HooPayz is available to you and your family including spouses and children who are part of your employee health benefits.

Personal Advisor Services

Call **866-981-4991** to submit a request to your Personal Advisor.

Find Fair Health Prices

Lower your out-of-pocket costs by comparing prices between high quality providers. Your Personal Advisor will find lower cost options that work for you and your family. This service includes your medical, dental, prescription, and vision benefits.

Claims Assistance & Billing Issues

HooPayz will explain your benefits and help you with balance billing, out-of-network provider fees, appeals with providers, and ensure your benefits are applied correctly so you don't over-pay.

Medical Bill Dispute & Negotiation

If you have a dispute about the amount you owe a provider or are concerned about billing errors, your Personal Advisor will review your bill and then contact the provider on your behalf. We will negotiate discounts and payment options.

Find Physicians, Specialists, Dentists & more

When you need a new doctor, we'll find local, in-network, high-quality providers that are accepting new patients for your medical, dental, and vision needs.

Is My Privacy Protected?

We use best practices to keep your information confidential. Your employer will not have access to your personal health information unless you ask for coordination.

When is HooPayz Available?

24/7! Submit your requests by phone any time, and your HooPayz Personal Advisor will get started on your case the very next business day.



DENTAL INSURANCE

RightChoice

In addition to protecting your smile, dental insurance helps pay for dental care. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

DENTAL COVERAGE HIGHLIGHTS	In-Network
Annual Deductible	\$50/Single \$100/Family
Annual Benefit Maximum	\$1,000
Orthodontia Lifetime Maximum	\$1,000
Preventive Care	100% covered, no deductible
Basic Services	80% after deductible
Major Services	50% after deductible
Orthodontia Services	50% no deductible

VISION INSURANCE

Anthem

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. ****Note: This is a voluntary benefit and if it is not elected on the enrollment form you will not be enrolled in the coverage***

VISION COVERAGE HIGHLIGHTS	In-Network	Out-of-Network
Exam Once every 12 months	\$10 copay	\$42 Reimbursement
Lenses Once every 12 months	\$25 Copay	Single: \$40 Reimbursement Bifocal: \$60 Reimbursement Trifocal: \$80 Reimbursement
Frames Once every 24 months	\$130 allowance + 20% off balance	\$45 Reimbursement
Contact Lenses Once every 12 months; in lieu of lenses/frames glasses	\$130 allowance + 15% off balance	\$105 allowance

BASIC LIFE INSURANCE

Anthem

Life insurance can help provide for your loved ones if something were to happen to you. The City of Hannibal and Board of Public Works provides full-time employees with **\$20,000** in group life insurance. For Firemen and Policemen, the City provides **\$50,000** in group life insurance. The City of Hannibal and Board of Public Works pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information.

Your designated beneficiary will receive a benefit to help ease their financial burden if you die. If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed. Please update your beneficiaries periodically!

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Benefits may be reduced for employees over age 65 per ADEA.



BENEFIT TERMS

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a \$1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is \$800. Because John hasn't paid anything toward his deductible yet this year, and because the \$800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

ANNUAL REQUIRED NOTICES

City of Hannibal Health Law Notices

Michelle's Law Notice

If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits During Family Medical Leave

Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf of such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such

employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) – Applies to Group Health Plans Only

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, contact they may State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2019. Contact the respective State for more information on eligibility –

ALABAMA-Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA-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>

ARKANSAS-Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Website:
<https://www.healthfirstcolorado.com/>
Phone: 1-800-221-3943
CHP+ Website:
<https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
Phone: 1-800-359-1991

FLORIDA-Medicaid

Website: <http://flmedicaidprecovery.com/hipp/>
Phone: 1-877-357-3268

GEORGIA-Medicaid

Website: www.medicaid.georgia.gov
- Click on Health Insurance Premium Payment (HIPP) Phone: 678-564-1162 ext 2131

INDIANA-Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <http://www.indianamedicaid.com> Phone 1-800-403-0864

IOWA-Medicaid

Website: <http://dhs.iowa.gov/hawk-i> Phone: 1-800-257-8563

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/>
Phone: 1-785-296-3512

KENTUCKY-Medicaid

Website: <https://chfs.ky.gov> Phone: 1-800-635-2570

LOUISIANA-Medicaid

Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
Phone: 1-888-695-2447

MAINE-Medicaid

Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS-Medicaid and CHIP

Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>
Phone: 1-800-862-4840

MINNESOTA-Medicaid

Website: <https://mn.gov/dhs/people-serve/seniors/health-care/health-care->

programs/programs-and- services/other- insurance.jsp
Phone: 1-800-657-3739

MISSOURI-Medicaid

Website:<http://www.dss.mo.gov/mhd/participant/s/pages/hipp.htm>
Phone: 573-751-2005

MONTANA-Medicaid

Website:<http://dphhs.mt.gov/MontanaHealthcare/Programs/HIPP>
Phone: 1-800-694-3084

NEBRASKA-Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA-Medicaid

Medicaid Website: <http://dhcfp.nv.gov> Medicaid
Phone: 1-800-992-0900

NEW HAMPSHIRE-Medicaid

Website: <https://www.dhhs.nh.gov/oii/hipp.htm>
Phone: 603-271-5218
Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY-Medicaid and CHIP 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

NEW YORK-Medicaid

Website:https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA-Medicaid

Website: <https://dma.ncdhhs.gov/> Phone: 919-855-4100

NORTH DAKOTA-Medicaid

Website:<http://www.nd.gov/dhs/services/medical/serv/medicaid/>
Phone: 1-844-854-4825

OKLAHOMA-Medicaid and CHIP

Website: <http://www.insureoklahoma.org> Phone: 1-888-365-3742

OREGON-Medicaid and CHIP

Website:<http://healthcare.oregon.gov/Pages/index.aspx> <http://www.oregonhealthcare.gov/index-es.html> Phone: 1-800-699-9075

PENNSYLVANIA-Medicaid

Website:<http://www.dhs.pa.gov/provider/medical/assistance/healthinsurancepremiumpaymenthippogram/index.htm>
Phone: 1-800-692-7462

RHODE ISLAND-Medicaid

Website: <http://www.eohhs.ri.gov/> Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA-Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA-Medicaid

Website: <http://dss.sd.gov> Phone: 1-888-828-0059

TEXAS-Medicaid

Website: <http://gethiptexas.com/> Phone: 1-800-440-0493

UTAH-Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip> Phone: 1-877-543-7669

VERMONT-Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA-Medicaid and CHIP

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

WASHINGTON-Medicaid

Website: <http://www.hca.wa.gov/>
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA-Medicaid

Website: <http://mywvhipp.com/>
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN-Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/publications/p1/p10095.p df>
Phone: 1-800-362-3002

WYOMING-Medicaid

Website:
<https://health.wyo.gov/healthcarefin/medicaid/>
Phone: 307-777-7531

To see if any other States have added a premium assistance program since July 31, 2019, 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

Important Disclosures

Women’s Health and Cancer Rights Act of 1998

The Federal Women’s Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If the participant is eligible for mastectomy benefits under health coverage and elects breast reconstruction in connection with such mastectomy, she is also covered for the following:

- a. Reconstruction of the breast on which mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- c. Prostheses;
- d. Treatment of physical complications of all states of mastectomy, including lymphadenomas.

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of “medically necessary.” Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Maternity Coverage Length of Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer’s medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer’s plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child’s medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is “qualified.” If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee’s paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

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

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.56% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit. *

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

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

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

Special Enrollment Periods

Special Enrollment Rights – If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan on the first day of the month after the Plan receives the enrollment form.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP) - If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply. The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

HIPAA Notice of Privacy Practices

Effective Date: March 1, 2013

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The City of Hannibal Group Medical Plan (the "Plan"), which includes medical HRA, dental, vision, and flexible spending account coverages offered under the City of Hannibal Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures City of Hannibal has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may

also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor: As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law: When required to do so by any federal, state or local law.

4. Health Oversight Activities: To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety: As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court

or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes: To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation: If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions: For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation: As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
City of Hannibal is required maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at City of Hannibal, 320 Broadway, Hannibal, MO 63401, 573-221-0154.

Right to Inspect and Copy Individual Health Information: An individual

may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at City of Hannibal, 320 Broadway, Hannibal, MO 63401, 573-221-0154. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health

Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at City of Hannibal, 320 Broadway, Hannibal, MO 63401, 573-221-0154. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of

Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4)

disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at City of Hannibal, 320 Broadway, Hannibal, MO 63401, 573-221-0154. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential

Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at City of Hannibal, 320 Broadway, Hannibal, MO 63401, 573-221-0154. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice:

Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at City of Hannibal, 320 Broadway, Hannibal, MO 63401, 573-221-0154 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at City of Hannibal, 320 Broadway, Hannibal, MO 63401, 573-221-0154. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated.

Important Notice from City of Hannibal About Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Hannibal 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. City of Hannibal has determined that the prescription drug coverage offered by the City of Hannibal 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 City of Hannibal coverage will not be affected.

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

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

You should also know that if you drop or lose your current coverage with City of Hannibal 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 person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Hannibal changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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: 03/31/20

Name of Entity/Sender: City of Hannibal

Contact--Position/Office: Human Resources

Address: 320 Broadway, Hannibal, MO 63401

Phone Number: 573-221-0154

