

2024 | All Employees

Benefits Guide

Your Benefits, Your Choice

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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.

Welcome

We understand that your life extends beyond the workplace. That’s why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

How to Enroll

- **Current Employees:** Open Enrollment is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 30 days. Some benefits have “guarantee issue” at your first opportunity only, so please carefully consider this before you decline any coverage.

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. Examples include:

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





Contacts

THE CITY OF HANNIBAL/BOARD OF PUBLIC WORKS BENEFITS CONTACT

City of Hannibal – Melissa Cogdal	(573) 221-0111 x 213	mcogdal@hannibal-mo.gov
Board of Public Works – Beverly Watson Stewart	(573) 221-8050 x 6013	bjwatson@hannibalbpw.org

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	Anthem	(208) 344-7900	www.ameriben.com
Prescription Drug	EmpiRx	(877) 241-7123	www.portal.myempirxhealth.com
Dental Insurance	The Standard	(800) 547-9515	standard@employeebenefitservice.com
Vision Insurance	The Standard	(800) 547-9515	standard@employeebenefitservice.com
Life/Vol. Life Insurance	The Standard	(800) 628-8600	lifepro@standard.com
Vol. Short Term Disability (STD)	The Standard	(800) 628-8600	SecureSTDForms@standard.com
Vol. Long Term Disability (LTD)	The Standard	(800) 628-8600	newclm@standard.com
Worksite (Accident, Critical Illness & Hospital Indemnity)	The Standard	(800) 634-1743	Ask a question: Suppclaimsupport@standard.com Submit Claim: SupplementalNewClaim@standard.com
Telehealth	LiveHealth	(888) 548-3432	help@livehealthonline.com
EAP	Mark Twain Behavioral Health	(573) 221-2120	www.Mtbh.org
Health Advocacy/Telehealth	HealthJoy	(877) 500-3212	www.healthjoy.com

Eligibility

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 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.*

Retiree Eligibility

Medical, Dental & Life: Retiree Health & Life Coverage is available to those employees that retire under retirement guidelines, for three years, or until age 65 (whichever comes first). Premiums and rates will be consistent with any active employee.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of “Eligible Dependents”

Medical, Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** 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.
- **Your dependent children under age 26.** This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page 12 for definitions of an “eligible dependent” under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a “spouse”, and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.



Medical

Anthem of MO



Locate an in-network provider near you at www.anthem.com or call 800-676-2583.

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical		
	In-Network	Out-of-Network
Annual Deductible		
Individual	\$500	\$2,000
Family	\$1,000	\$4,000
Coinsurance (Plan Pays)	100%	50%
Annual Out-of-Pocket Maximum		
Individual	\$2,500	\$5,000
Family	\$5,000	\$7,500
Services	In-Network	Out-of-Network
Preventive Care	Covered 100%	50% after deductible
Primary Care Office Visit	100% after deductible	50% after deductible
Specialist Office Visit	100% after deductible	50% after deductible
Urgent Care	100% after deductible	100% after deductible
Emergency Room	100% after deductible	50% after deductible
Hospitalization	100% after deductible	50% after deductible
Prescription Drugs	In-Network	Out-of-Network
Annual Out-of-Pocket Maximum		
Individual	\$2,500	
Family	\$5,000	
Generic	25% copay	
Brand	25% copay	
Brand Non-Preferred	25% copay	
Specialty	100% after 25% copay	

Telemedicine

LiveHealth Online: Anthem Network

Available to all employees, regardless of health plan enrollment.

Telemedicine 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.

Using your computer, tablet, or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

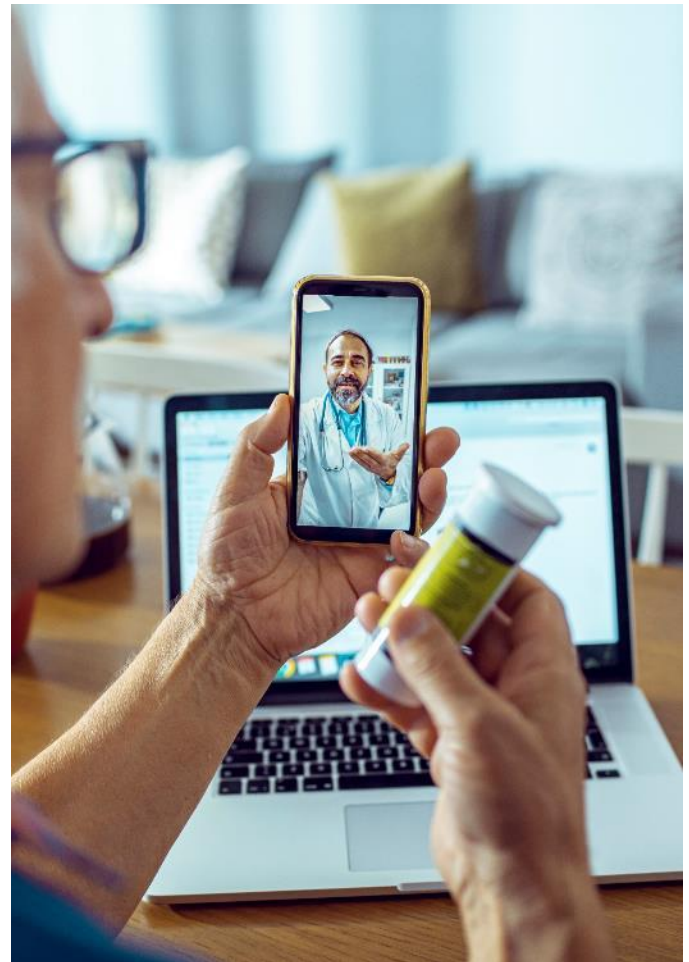
In some cases, doctors can write a prescription to a local pharmacy near you.

Telemedicine	
Medical Visit	www.http://livehealthonline.com 1-888-LiveHealth (548-3432)
Mental Health Visit	LiveHealth Online Psychology
Commonly Treated Medical Conditions	Allergies Colds, respiratory problems, flu Ear infections Sore throat Pink eye Urinary tract infections

When can I use telemedicine?

- 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.
- For short-term prescription refills.

¹ Prescription services may not be available in all states.



Save time and money with telemedicine.

Telemedicine can provide significant savings over urgent care and emergency room visits. On top of that, you can connect with a doctor from the convenience of home or work, allowing you to avoid the hassle of traveling or sitting in a waiting room.

Virtual Doctor Visits/ Concierge

HealthJoy

Available to all employees, regardless of health plan enrollment.

HealthJoy 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 HealthJoy App 24/7/365
2. Complete the sign up process
3. Add Family Members
4. Log In

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.

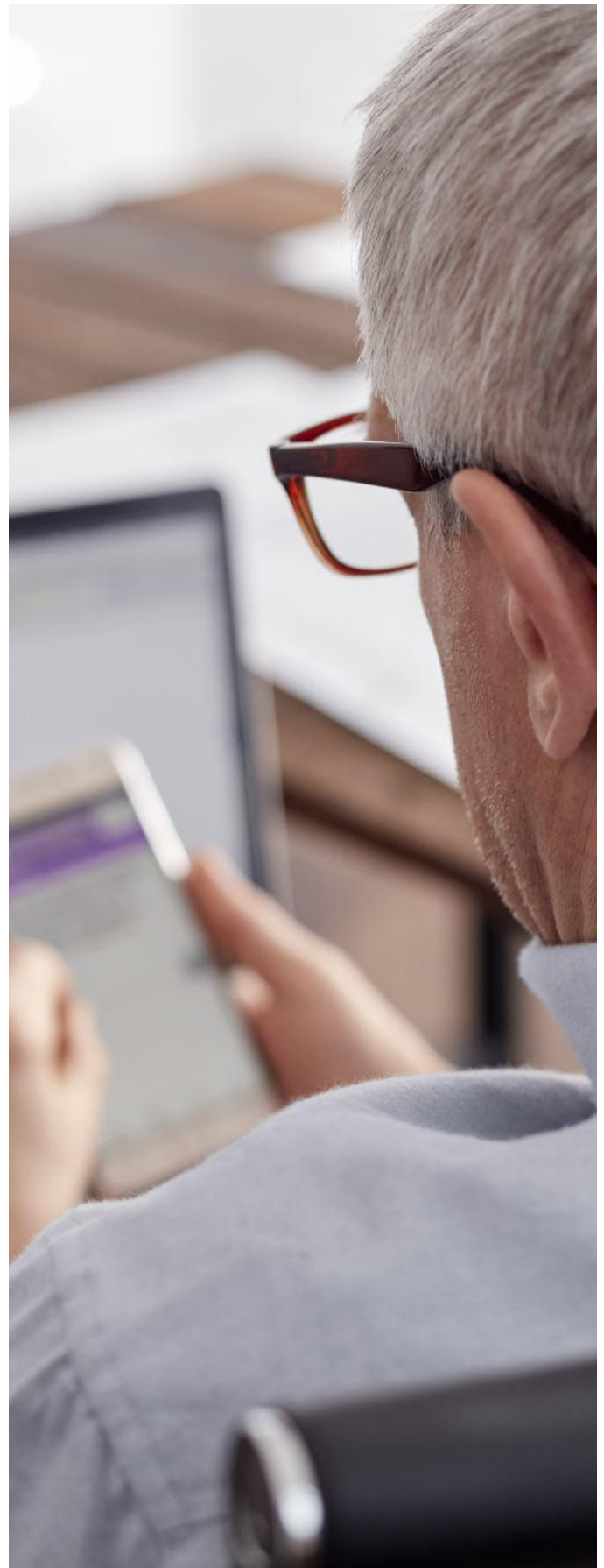
Common Conditions We Treat

- Abrasions, bruises
- Colds, flu, fever
- Allergies, hives, skin infection
- Sore Throat, cough, congestion
- Bites & stings
- Urinary tract infections
- Eye infections, conjunctivitis
- And more!

Save Money and Time!

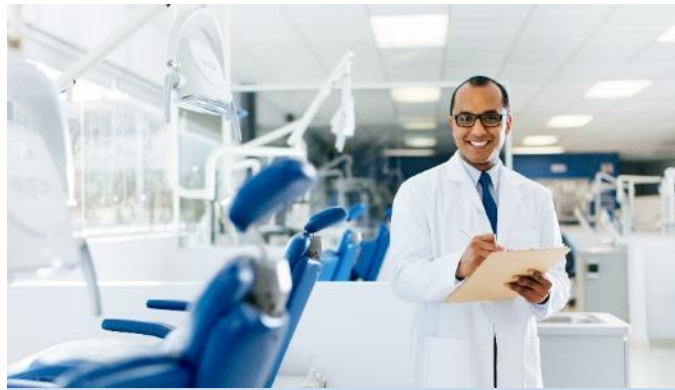
HealthJoy provides significant savings over urgent care and emergency room visits. Plus, you can use it from the convenience of home or work, allowing you to avoid the hassle of sitting in a waiting room.

- (877) 500-3212
- support@healthjoy.com



Dental

The Standard



Locate an in-network provider near you at www.standard.com or call (800) 547-9515.

Dental	In-Network
Annual Deductible	\$50 per individual \$150 per family
Annual Benefit Maximum	\$1,000
Lifetime Orthodontia Maximum	\$1,000
Plan Pays	
Preventive Care (Deductible waived)	100% covered
Basic	80%
Major	50%
Orthodontia	50%

Vision

The Standard



Locate an in-network provider near you at www.standard.com or call (800) 547-9515

Vision	In-Network
Exam	\$10 copay
Lenses	\$25 copay
Frames	\$130 allowance
Contact Lenses	\$130 copay
Frequencies	
Exams	1 per 12 months
Lenses or Contacts	1 per 12 months
Frames	1 per 24 months

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Life/AD&D

The Standard

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D

Benefit Amount	See HR for benefit
Benefit Cost	Employer-paid – No cost to you!

Voluntary Term Life/AD&D

Benefit Amount	Employee: Up to \$500k Spouse: Up to \$250k [^] Child(ren): \$5k or \$10k [^]
Guaranteed Issue Amount¹	Employee: \$200k Spouse: \$30k Child(ren): \$5k or 10k
Benefit Cost	To view your personalized rates, refer to your benefit highlight sheet or HR for details.

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

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Dependent Delayed Effective Date:

Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.

Definition of “Eligible Dependents”

It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.



Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

* The value of employer-funded life insurance benefits in excess of \$50,000 is taxable to you.

[^] Dependent elections require employee enrollment and may be limited by employee volume.

¹ If you enroll when first offered, you may receive up to the listed amount without having to answer medical questions.

¹ Special open enrollment opportunity – THIS YEAR ONLY, elect up to the guaranteed issue amount without answering health questions.

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

Disability

The Standard

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Short-Term Disability	
Benefit Amount	Replaces 60% of earnings, up to \$1,500 per week
Benefit Begins	Injury: after 14 days Illness: after 14 days
Benefit Duration	Up to 11 weeks
Pre-Existing Condition Limitations	3-month look back period. 12-month exclusion period.
Benefit Cost	To view your personalized rates, refer to your benefit highlight sheet or HR for details.

Short-term disability excludes work-related injury or illness.

Long-Term Disability	
Benefit Amount	See HR for benefit
Benefit Begins	After a period of 90 days
Benefit Duration	To SSNRA
Pre-Existing Condition Limitations	3-month look back period. 12-month exclusion period.
Benefit Cost	To view your personalized rates, refer to your benefit highlight sheet or HR for details.



Pre-Existing Condition Limitations:

If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Please review the full plan documents for plan details including exclusions and limitations.

This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Supplemental Health

The Standard

The following benefits may protect your financial security in the event of an unexpected medical expense.

Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

Benefit Amount	Benefit amounts vary by severity. See schedule of benefits for details.	
Wellness Benefit	\$100	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Ambulance Emergency room visits Hospital admission	Surgical benefits Follow-up treatments
Other Benefits	Travel Lodging Child organized sports-rider	Accidental death and dismemberment

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Benefit Amount	Employee: Up to \$30k Spouse: Up 100% of Employee benefit Child: Up to 50% of Employee benefit	
Wellness Benefit	\$100	
Pre-Existing Condition Limitations	None	
Common Covered Conditions	Cancer Heart attack Stroke	Major organ failure Degenerative neurological disorders



Get paid for taking care of your health!

If you are enrolled in coverage, you can receive a wellness benefit payment each year when you have a qualifying screening or test.

Hospital Indemnity

Helps cover the cost of hospital stays—including pregnancy and childbirth.

Benefit Amount	\$1,000 hospital admission benefit \$100 daily confinement
Wellness Benefit	\$100
Pre-Existing Condition Limitations	None

Supplemental Health Cost

To view your personalized rates, refer to your benefit highlight sheet or HR for details.

Actively-at-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Dependent Delayed Effective Date:

Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.

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



Employee Assistance Program

Mark Twain Behavioral Health and Quincy Medical Group

Available to all employees.

Life. Just when you think you’ve got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you and your family find solutions and peace of mind.

Confidential Support

- Alcohol or substance abuse
- Childcare
- Eldercare
- Financial problems
- Gambling addiction
- Grief and loss
- Job pressures
- Mental health
- Legal concerns
- Relationships

Connect with a counselor.
(573) 221-2120
www.quincymedgroup.com

Locations:

1. 154 Forest Dr., Hannibal, MO: (573) 221-2120
2. 105 Pfeiffer Ave., Kirksville, MO: (600) 665-4612
3. 309 N Missouri St., Macron, MO: (600) 395-9114

Healthcare Tips

Get the Most Out of Your Care

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

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.



Where Should I Go for Care?
<http://www.cottinghambutler.com/KnowWhereToGo/>

Billing & Claim Differences

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

<p>Provider</p> <p>The patient receives treatment.</p> <p>The doctor then sends the bill to the insurance company.</p>	>	<p>In-Network Discount</p> <p>Appropriate discount for using an in-network provider is applied.</p>	>	<p>Bill</p> <p>The bill for services is presented to the insurance company.</p> <p>Payment responsibilities are calculated and divided between the patient and the insurance company.</p>
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<p>Patient</p> <p>Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.</p>	<	<p>Insurance Company Payments, Explanation of Benefits (EOB)</p> <p>Insurance pays for its portion of the bill from the provider.</p> <p>A summary of charges and insurance payments is sent to the patient via the insurance company.</p>
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Take advantage of 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, 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.



Know Where to Go for Care



Where Should I Go for Care?

<http://www.cottinghambutler.com/KnowWhereToGo/>

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs \$1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room (\$\$\$\$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Uncontrollable bleeding
- Shortness of breath
- Poisoning

Urgent Care (\$\$\$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office (\$\$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

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.

City of Hannibal and Board of Public Works: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. 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 a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

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, they may contact the 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 visit 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, 2023. V 0.2.0. The most recent CHIP notice can be found at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra>. Contact the respective State for more information on eligibility –

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

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility:
<https://dhss.alaska.gov/dpa/Pages/default.aspx>

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+ Website: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website: <https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

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: <https://www.in.gov/medicaid/>
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: <https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366
 Hawki Website: <http://dhs.iowa.gov/Hawki>
 Hawki Phone: 1-800-257-8563
 HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
 HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
 Website: <https://www.kancare.ks.gov/>
 Phone: 1-800-792-4884
 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
 Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
 Phone: 1-855-459-6328
 Email: KIHIPPPROGRAM@ky.gov
 KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
 Phone: 1-877-524-4718
 Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid
 Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
 Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
 Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
 Phone: 1-800-442-6003
 TTY: Maine Relay 711
 Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>
 Phone: 1-800-977-6740
 TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP
 Website: <https://www.mass.gov/masshealth/pa>
 Phone: 1-800-862-4840
 TTY: 711
 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
 Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
 Phone: 1-800-657-3739

MISSOURI – Medicaid
 Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
 Phone: 573-751-2005

MONTANA – Medicaid
 Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: 1-800-694-3084
 Email: HSHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
 Website: <http://www.ACCESSNebraska.ne.gov>
 Phone: 1-855-632-7633
 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/programs-services/medicaid/health-insurance-premium-program>
 Phone: 603-271-5218
 Toll-free number for the HIPP program: 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://medicaid.ncdhhs.gov/>
 Phone: 919-855-4100

NORTH DAKOTA – Medicaid
 Website: <https://www.hhs.nd.gov/healthcare>
 Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
 Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

OREGON – Medicaid
 Website: <http://healthcare.oregon.gov/Pages/index.aspx>
 Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
 Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
 Phone: 1-800-692-7462
 CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
 CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
 Website: <http://www.eohhs.ri.gov/>
 Phone: 1-855-697-4347 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: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
 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: <https://dvha.vermont.gov/members/medicaid/hipp-program>
 Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
 Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
 Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
 Website: <https://www.hca.wa.gov/>
 Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
 Website: <https://dhhr.wv.gov/bms/http://mywvhipp.com/>
 Medicaid Phone: 304-558-1700
 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
 Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 Phone: 1-800-362-3002

WYOMING – Medicaid
 Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
 Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2023, 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 ❖

Notice Regarding Wellness Program

Be Well at Work is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the

Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations. Employees are not required to complete the HRA or participate in the biometric screening, this is a non-incentivized program.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and City of Hannibal and Board of Public Works may use aggregate information it collects to design a program based on identified health risks in the workplace, Be Well at Work will never disclose any of your personal information except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) "a registered nurse," "a doctor," or "a health coach" in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personal records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data

breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. ❖

Patient Protection Notice

If the City of Hannibal and Board of Public Works generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. ❖

Newborns' and Mothers' Health Protection Act

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 9.12% 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 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 no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

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

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 and Board of Public Works Group Medical Plan (the "Plan"), which includes medical, dental, vision coverages offered under the City of Hannibal and Board of Public Works 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 and Board of Public Works 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 and Board of Public Works is required to 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 and Board of Public Works, 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 and Board of Public Works, 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 and Board of Public Works, 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 and Board of Public Works, 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 and Board of Public Works, 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 and Board of Public Works, 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 and Board of Public Works, 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 and Board of Public Works 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 Board of Public Works 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 and Board of Public Works has determined that the prescription drug coverage offered by the City of Hannibal and Board of Public Works 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 and Board of Public Works coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Hannibal and Board of Public Works 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 Board of Public Works 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 and Board of Public Works 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: 9/20/2023

Name of Entity/Sender: City of Hannibal and Board of Public Works

Contact--Position/Office: Human Resources

Address: 320 Broadway, Hannibal, MO 63401

Phone Number: 573-221-0154 ❖

