Cherokee County

1831

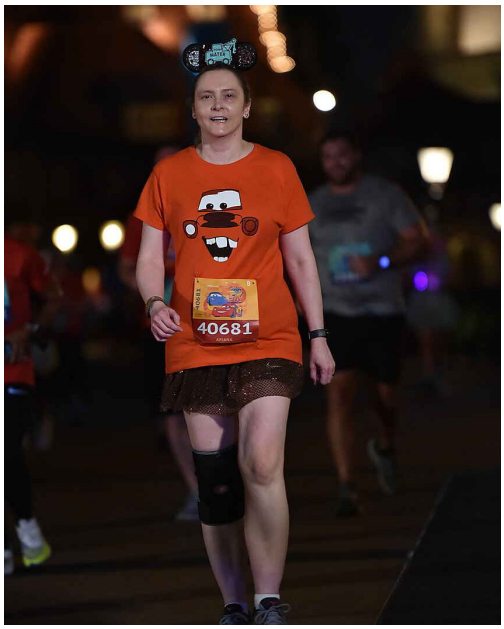
GEORGIA

2024
Benefit Guide

Cherokee County Board of Commissioners

We are happy to provide you with this Benefit Guide to summarize your employee benefits for the 2023 plan year. Cherokee County Board of Commissioners recognizes that benefits are an important part of your life as an employee.

Our benefits program will help you choose what works best for your needs and your budget. But this document is not just an enrollment guide; it is a resource for you and your family to use throughout the year. Inside you will find a summary of each benefit plan and helpful tips you may have not known about in the past. This guide is designed to break down the insurance rates to help you make an informed decision regarding the selection and management of the services and benefits provided to you as an employee of Cherokee County.



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 29-30 for more details.

CONTENTS

IMPORTANT NOTICE TO EMPLOYEES:

This Benefit Guide provides a general description of the various benefits available to you through the Cherokee County Board of Commissioners Employee Benefits program. The details of these plans and policies are contained in the official plan and policy documents.

This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

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SUMMARY OF BENEFITS & COVERAGE (SBC) NOTICE

Attached are your Federally Mandated Summary of Benefits and Coverage (SBC) documents for all offered medical plan options. In the following pages you will find simpler formatted, easy to understand plan summaries which provide a general description of the various benefits available to you through the Cherokee County Board of Commissioners Employee Benefits Program.

To access your SBCs you may Scan or Click the QR code below with your phone.

If you would prefer a printed copy, please contact your HR department.

TERMS TO KNOW

SCAN OR CLICK THE QR CODE TO WATCH A SHORT VIDEO ON THE TERM YOU WOULD LIKE TO KNOW

ELIGIBILITY & ENROLLMENT

EMPLOYEE ELIGIBILITY

All full time employees working an average of 30 hours per week are eligible to enroll in benefits. For specific details, please refer to the plan documents. New full time employees' benefits eligibility for all lines of coverage will begin on the 1st of the month following the first full month of full time employment.

SAMPLE OF SAVINGS USING PRE-TAX DEDUCTIONS

INCOME FACTORS	PRE-TAX CONTRIBUTIONS	POST-TAX CONTRIBUTIONS
Employee Gross Pay	$40,000	$40,000
Pre-Tax Premium	$417	-
Taxable Income	$39,583	$40,000
Assumed Tax Rate1	25.65%	25.65%
Net Pay	$29,429.96	$29,740.00
After Tax Premium		$417
Take Home Pay	$29,429.96	$29,323

[1]Assumed Tax Rate of 18% Federal Income Tax and 7.65% FICA (Social Security and Medicare)

MID-YEAR ENROLLMENT CHANGES

SECTION 125 CAFETERIA PLAN

Employees receive the tax benefits of a Section 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

Current IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event. Changes must be reported within 30 days of the actual event.

Some common qualifying events may include marriage, divorce, or death of a spouse, birth, adoption or change in legal custody, loss of other coverage, enrollment in the Marketplace Exchange, change in Medicare or Medicaid entitlement, or military leave.

FOR YOUR FAMILY

Legislation regulates eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible Dependents includes:

- Legal Spouse
- Dependent children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

* To verify if a dependent is eligible for coverage please contact the Human Resources Department at Benefits@cherokeega.com.

DEPENDENT VERIFICATION OF ELIGIBILITY

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

Spouse Verification Documentation: Marriage Certificate

Child Verification Documentation: Birth Certificate, court document awarding custody or requiring coverage

You can provide these documents to your Benefits Department at Benefits@cherokeega.com.

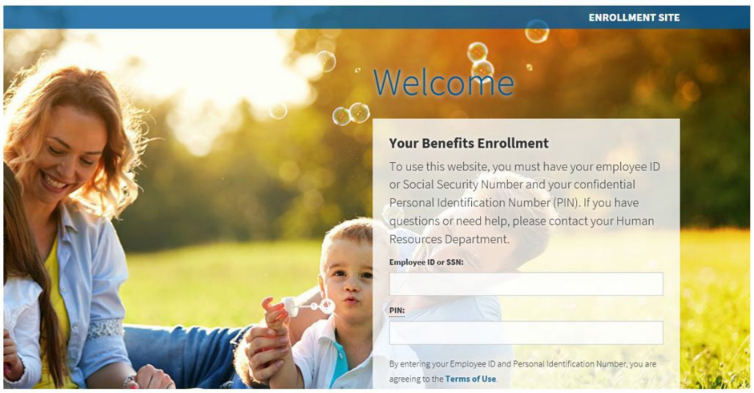
To determine if any of these apply to you, please check with your Human Resources representative.

PLEASE NOTE:

The IRS does not consider financial hardship a qualifying event to drop coverage.

HOW TO ENROLL

selerix
benefit solutions simplified



Cherokee County Board of Commissioners will continue to use the online benefit enrollment system.

To enroll, please visit:

www.benselect.com/Enroll/Login.aspx

You can click or scan the QR code to the right.

Log in instructions:

- Enter your SSN or Employee Number
- Your PIN is the last 4 digits of your SSN followed by the last 2 digits of your birth year
- Contact humanresources@cherokeega.com if you experience login issues

2024
ANNUAL ENROLLMENT
OCTOBER 16-27, 2023

QUICK LINKS TO YOUR PROVIDERS

Medical Benefits: Cigna

Scan or Click the QR code to access Cigna's Provider Search

www.cigna.com >>>

Cigna®

Dental Benefits: Delta Dental

Scan or Click the QR code to access Delta Dental's Provider Search

www.deltadentalins.com >>>

DELTA DENTAL®

Medical Benefits: Northside Plan

Scan or Click the QR code to access Northside and CHOA's Provider Search

www.nhnmanager.com >>>

NORTHSIDE HEALTH NETWORK
Children's Healthcare of Atlanta

Vision Benefits: National Vision Administrators, LLC

Scan or Click the QR code to access NVA's Provider Search

www.e-nva.com >>>

NVA
National Vision Administrators, L.L.C.

NHN MENTAL HEALTH & OUT OF AREA

Benefits: First Health Network

Scan or Click the QR code to access First Health Provider Search

www.providerlocator.firsthealth.com >>>

First Health Network

MEDICAL INSURANCE

TRUSTMARK

Scan or Click the QR code to access Trustmark's website >>>

Phone: 1-877-279-5285

Website: www.mytrustmark.com

IN-NETWORK MEDICAL BENEFITS	NORTHSIDE HEALTH NETWORK	CIGNA PPO
Deductible (Individual / Family)	$750 / $2,250	$750 / $2,250
Is Deductible Calendar Year or Policy Year?	Calendar Year	Calendar Year
Is Deductible Embedded or Non Embedded	Embedded	Embedded
Out of Pocket Maximum (Individual / Family)	$2,000 / $6,000	$2,000 / $6,000
Coinsurance	20%	20%
Prescription Drugs	$10 / $35 / $80	$10 / $35 / $80
Mail Order Drugs (90 Day Supply)	$25 / $50 / $50	$25 / $50 / $50
International Pharmacy Program	Brand Only - $0	Brand Only - $0
Specialty Rx	20% Coinsurance to a Maximum of $200 Per Prescription	20% Coinsurance to a Maximum of $200 Per Prescription
PHYSICIAN OFFICE VISITS		
Primary Care Physician / Virtual PCP	$25	$25
Teladoc (Virtual Visit)	$0	$0
Urgent Care Center	$30	$30
Retail Clinic	Not Covered	$25
Specialist	$30	$30
Referral Needed for Specialist?	No	No
PREVENTIVE CARE - NO COST		
Routine Adult Physical Exams Well Woman Exams Routine Mammograms and Colonoscopies Well Child Exam & Immunizations	Covered 100%	Covered 100%
DIAGNOSTIC / LABORATORY		
Level 1 Imaging	Covered 100%	Covered 100% at Know the Costs / Deductible then 20% at other in-network providers
Diagnostic Imaging Level 2	Deductible then 20%	Deductible then 20%
Lab Services	Covered 100%	Covered 100%
HOSPITALIZATION / OUTPATIENT SERVICES		
Inpatient Hospitalization (Facility)	Deductible then 20%	$500 Per Admission Plus Deductible then 20%
Outpatient Surgical Care (Hospital Facility)	Deductible then 20%	Deductible then 20%
Emergency Room	$250	$250
OUT-OF-NETWORK BENEFITS		
Deductible (Individual / Family)	$6,000 / $18,000	$6,000 / $18,000
Out of Pocket Maximum (Individual / Family)	$9,000 / $27,000	$9,000 / $27,000
Coinsurance	40%	40%
EMPLOYEE BI-WEEKLY PAYROLL DEDUCTIONS		
Employee Only	$43.26	$54.08
Employee + 1 Dependent	$101.30	$126.62
Employee + Family	$151.26	$189.08

*This information summarizes the Cherokee County Board of Commissioners Medical benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

Provider Questions go to Trustmark

This patient's health plan uses a third-party administrator (TPA) to process claims and manage other aspects of their health benefits, including contracting for PPO network access.

Trustmark Health Benefits is the TPA for this patient's plan. CIGNA is the PPO network this patient can access for in-network care.

Trustmark vs. Network Responsibility

The information below outlines some of the general responsibilities of Trustmark and CIGNA

Trustmark's Responsibility

- Answer provider eligibility questions and benefit verification
- Answer provider claims questions
- Receive and process claims
- Manage precertification and appeals
- Provide customer service

CIGNA's Responsibility

- Provide network access
- Resolve provider contract issues

Questions and Claims Submissions

Log in to the Trustmark provider portal, myTrustmarkBenefits.com, or call Trustmark at 877.279.5285 for all claims and eligibility questions. This number is also located at the top of the patient's ID card.

Submit all claims to CIGNA at the address listed on the patient's ID card under *Medical Claims Submission:* EDI: Payer ID 62308

Mail: CIGNA, PO BOX 188061, Chattanooga, MI 37422-8061

Do not submit direct questions to CIGNA. Submitting questions to the network instead of Trustmark will result in payment delays and incorrect denials.

Expect **more.**
Benefit more.

Use myTrustmarkBenefits.com for anytime provider self-service.

Self-funded plans are administered by Trustmark Health Benefits, Inc.
400 Field Drive • Lake Forest, IL 60045
800.832.3332 • TrustmarkHB.com

Cherokee County
1831
GEORGIA

Trustmark
benefits beyond benefits

R450-2797

Included with your Medical plan

Cherokee County
1831
GEORGIA

Guided Access to Excellent Surgical Care

What is SurgeryPlus?

SurgeryPlus is an additional medical insurance benefit your employer has made available to you for planned, non-emergency surgery. You're automatically enrolled in SurgeryPlus at no additional cost to you. Learn more at **www.SurgeryPlus.com**.

The SurgeryPlus Difference

Excellent Care

You have access to a network of thousands of highly qualified and the best available surgeons

Meaningful Savings

Your company wants you to receive the best, most affordable care, so they help cover the most expensive costs of your surgery

Guided Support

Your personal Care Advocate will support you at every step of the way

What is Covered

We cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use the SurgeryPlus benefit. Your coverage includes:

- ✓ Access to our network of the best available surgeons
- ✓ Consults and appointments with your SurgeryPlus surgeon
- ✓ Anesthesia
- ✓ Procedure and facility (hospital) fees

Surgery Plus

Scan or Click the QR code to access Surgery Plus' website >>>

Phone: 1-855-715-1683Website: www.cherokeecounty.surgeryplus.com

Included with your Medical plan

SCRIPTSOURCING PROVIDES A UNIQUE OPPORTUNITY TO HELP EMPLOYEES SAVE MONEY ON NAME BRAND MEDICATIONS.

Enrollment is simple!

Simply call **410-902-8811**, and a Prescription Advocate will walk you through the enrollment process.

Some of the advantages of joining the ScriptSourcing program are:

- Employees and Dependents pay $0 Copay for name-brand maintenance medications
- Prescriptions are shipped directly to your home with no shipping or handling costs
- No out-of-pocket expenses
- ScriptSourcing saves the health plan money, which translates into lower premiums

CALL: 410-902-8811

ScriptSourcing
6080 Falls Road
Suite 201
Baltimore, MD 21209
www.scriptsourcing.com

scriptsourcing

Included with your Medical plan

Know the Costs®

For Cigna Participants Only

MRI | CT | Ultrasound | X-Ray | Nuclear Medicine | PET | Bone Density | Sleep Studies

Know the Costs ® (KTC) is a radiology benefit service that allows you to obtain certain outpatient radiology imaging and **NO COST** to you.

How to make the most of your benefit:

- If your doctor orders imaging, be sure to tell them you have the KTC radiology benefit.
- Contact us prior to imaging appointments to ensure you're scheduled at a KTC facility or locate a participating KTC facility.
- Don't present your health insurance card, only your KTC card with group number.
- When completing registration paper work, list KTC as your primary insurance.
- Sleep studies available at Coosa Medical Group.
- If the imaging provider bills your insurance, we may be unable to reverse the filing.

How to Reach us:

info@KnowTheCosts.com

833-KTC-4YOU

Members

Call *Know the Costs*® before Scheduling Outpatient Imaging

NHN Participants

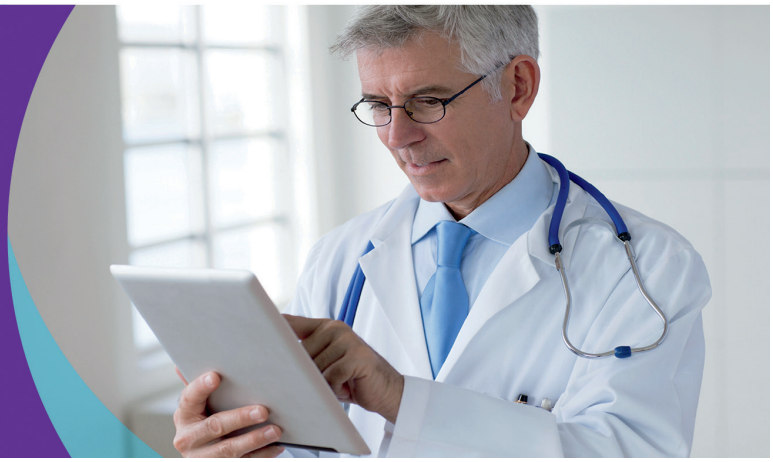
Participants who are enrolled in the NHS (Northside Health Network) should use Northside & CHOA Imaging Centers.

Included with your Medical plan

TELADOC.

Trustmark
benefits beyond benefits

So many reasons to use Teladoc®



Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits.
It's an affordable option for quality medical care.

1. Talk to a doctor anytime, anywhere you happen to be
2. Receive quality care via phone, video or mobile app
3. Prompt treatment, talk to a doctor in minutes
4. A network of doctors that can treat every member of the family
5. Prescriptions sent to pharmacy of choice if medically necessary
6. Teladoc is less expensive than the ER or urgent care

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink Eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician

Talk to a doctor anytime!

Teladoc.com
1-800-TELADOC (835-2362)

Available on the iPhone App Store
ANDROID APP ON Google play

Included with your Medical plan

A **calm mind** is a tap away

How is your emotional well-being?

If something is weighing you down, talking to someone can help. Teladoc's licensed therapists are available seven days a week. Choose your therapist, pick a time that is convenient for you, and then talk to the therapist from the privacy of home or anywhere you feel comfortable.

Teladoc therapists can treat:

- Anxiety
- Depression
- Stress/PTSD
- Panic disorder
- Family and marriage issues
- And more

Get confidential therapy quickly and conveniently

Schedule a session today

Teladoc.com | Download the app | | |

TELADOC.

Made available by
Cherokee County BOC

An Overview of Your GuidanceResources® Program

No matter what's going on in your life, GuidanceResources® is here to help.

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges.This flyer explains how GuidanceResources can help you.

Confidential Counseling on Personal Issues

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service, staffed by experienced clinicians, is available by phone 24 hours a day, seven days a week. A GuidanceConsultant℠ is available to listen to your concerns and refer you to a local provider for in-person counseling or to resources in your community. Call any time with personal concerns, including:

- Depression
- Marital and family conflicts
- Job pressures
- Stress and anxiety
- Alcohol and drug abuse
- Grief and loss

Financial Information, Resources and Tools

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Getting out of debt
- Retirement planning
- Tax questions
- Estate planning

Legal Information, Resources and Consultation

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

- Divorce and family law
- Debt obligations
- Landlord and tenant issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

Online Information, Tools and Services

GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to www.guidanceresources.com.

Each time you return to the site, you will find personalized, relevant information based on your individual life needs. You can:

- Review in-depth HelpSheets℠ on topics you select
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools

WE ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK.

Call: 800.311.4327
TDD: 800.697.0353
Online: guidanceresources.com
Your company Web ID: GEN311

Trustmark
benefits beyond benefits

Livongo®

Included with your Medical plan

Diabetes Management, Simplified

A simple, advanced blood glucose meter, and as many strips and lancets as you need, 100% paid for by your employer.

It's all in the meter and on the house.

- Personalized tips with each blood glucose check
- Real-time support when you're out of range
- Strip reordering, right from your meter
- Optional family alerts keep everyone in the loop
- Send a health summary report directly from your meter
- Automatic uploads mean no more paper logbooks

Unlimited strips.
Unlimited lancets.
It's all free for you.

Join today at **join.livongo.com/TRUSTMARK/register** or call **(800) 945-4355**

Use registration code: **TRUSTMARK**

DENTAL INSURANCE

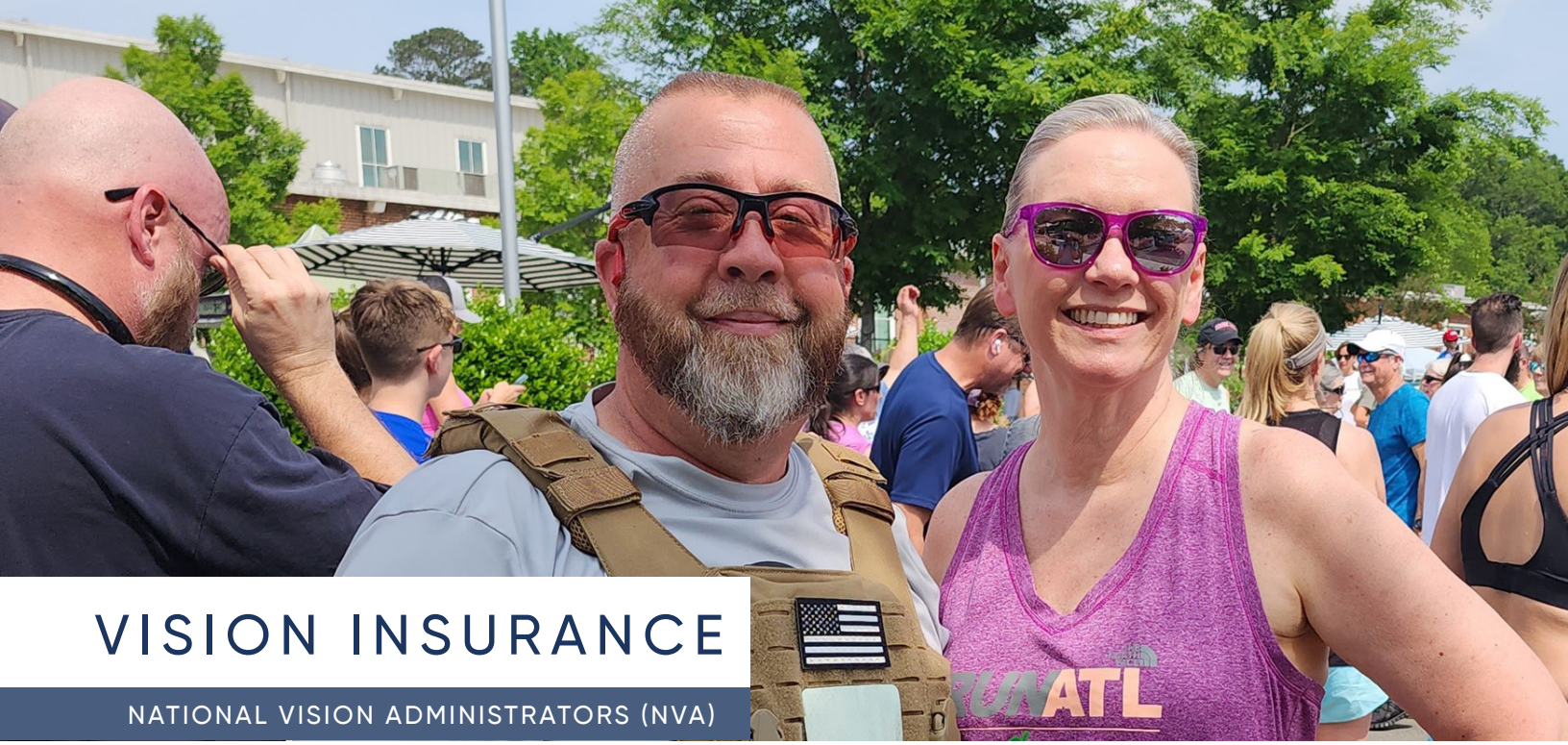
DELTA DENTAL

Scan or Click the QR code to access Delta Dental's website >>>
Phone: 1-800-521-2651
Website: www.deltadentalins.com

BENEFITS SUMMARY	DENTAL PLAN	
Annual Deductible (Individual/Family)	$50 / $150	
Annual Benefit Maximum	$1,500	
Orthodontia Lifetime Maximum	$1,000	
Waiting Period	None	
Network	PPO and Premier Network	
	IN-NETWORK	OUT-OF- NETWORK
TYPE A - DIAGNOSTIC & PREVENTIVE SERVICES - DEDUCTIBLE WAIVED		
Oral Evaluations Prophylaxis: Cleanings Fluoride Treatment (child only) Bitewing X-rays, Full Mouth X-rays Sealants Space Maintainers	Plan pays 100%	Plan pays 100%
TYPE B - BASIC SERVICES		
Fillings & Endodontic Treatments Extractions (routine and surgical) Palliatative Emergency Treatment Occlusal Guards (one per year)	Plan pays 80% after Deductible	Plan pays 80% after Deductible
TYPE C - MAJOR SERVICES		
Periodontal Services Inlays/Crowns/Bridges Oral Surgery & Dentures	Plan pays 50% after Deductible	Plan pays 50% after Deductible
ORTHODONTIA SERVICES		
Diagnostics and Treatments (child to age 19)	50%	50%

EMPLOYEE BI-WEEKLY PAYROLL DEDUCTIONS	
Employee Only	$6.50
Employee + 1 Dependent	$18.25
Employee + Child(ren)	$17.22
Employee + Family	$26.11

*This information summarizes the Cherokee County Board of Commissioners Dental benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



VISION INSURANCE

NATIONAL VISION ADMINISTRATORS (NVA)

Scan or Click the QR code to access NVA's website >>>
Phone: 1-800-672-7723
Website: www.e-nva.com

BENEFIT SUMMARY	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Eye Examination	$10 Copay	$21 Allowance	12 Months
Eyeglass Frames	$150 allowance then 20% discounted remaining balance	$75 Allowance	12 Months
STANDARD EYEGLASS LENSES			
Single Vision	$10 Copay	$18 Allowance	12 Months
Bifocal		$32 Allowance	
Trifocal		$56 Allowance	
CONTACT LENSES			
Conventional Contact Lenses	$120 allowance then 15% discount off remaining balance	$72 Allowance	12 Months
Disposable Contact Lenses	$120 Allowance	$72 Allowance	
Medically Necessary Contact Lenses	Covered in full	$200 Allowance	

EMPLOYEE BI-WEEKLY PAYROLL DEDUCTIONS	
Employee Only	$3.40
Employee + 1 Dependent	$6.78
Employee + Child(ren)	$6.40
Employee + Family	$9.80

*This information summarizes the Cherokee County Board of Commissioners' Vision benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

EMPLOYER-PAID BASIC LIFE AND AD&D INSURANCE

PRUDENTIAL

Scan or Click the QR code to access Prudential's website >>>
Phone: 1-800-534-0542
Website: www.prudential.com

Cherokee County Board of Commissioners pays 100% of the premium for your Basic Life/AD&D coverage as an Active employee.

Once you retire, you can elect to continue $25,000 up to age 65, but you will pay the full cost.

BENEFITS SUMMARY

LIFE BENEFIT AMOUNT	AD&D BENEFIT AMOUNT
Class 1: Active Employees: 1 times annual salary (from $25,000 to a maximum of $200,000)	Class 1: Active Employees: 1 times annual salary (from $25,000 to a maximum of $200,000)

BENEFITS WILL REDUCE BY
65% at age 65

*This information summarizes the Cherokee County Board of Commissioners Basic Life and AD&D benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

VOLUNTARY LIFE AND AD&D INSURANCE

PRUDENTIAL

Scan or click the QR code to access Prudential's website >>>
Phone: 1-800-534-0542
Website: www.prudential.com

BENEFITS SUMMARY

EMPLOYEE LIFE BENEFIT	SPOUSE LIFE BENEFIT	CHILD LIFE BENEFIT
Benefit Increment: $50,000 to a maximum of $250,000	Benefit Increment: $25,000, $50,000, or $100,000	Benefit Increment: $10,000
Guarantee Issue Amount: $150,000 when 1st eligible	Guarantee Issue Amount: $25,000 when first eligible	Guarantee Issue Amount: $10,000
AD&D BENEFIT		
$50,000 increments to a maximum of $250,000	$25,000 increments to a maximum of $100,000	$10,000

BENEFIT REDUCTION

65% at age 65

*This information summarizes the Cherokee County Board of Commissioners Voluntary Life benefits and AD&D plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

HOW TO CALCULATE YOUR VOLUNTARY LIFE PREMIUM

Child Life and AD&D policies, if elected, cover all eligible dependent children.

Premium is based on coverage units of $1,000

Formula: (Benefit Volume x Rate)/1000 = Monthly Premium

Example: 40 year old employee elects $200,000 in coverage

- Monthly Premium: ($200,000 x $0.194) / 1,000 = $38.80
- Payroll Deduction: ($38.80 x 12) / 26 = $17.90 per bi-weekly paycheck

Optional Life Employee and Spouse (based on Employee age)			
Employee Age Band	Employee Monthly Tobacco Rate per $1,000	Employee Monthly Non-Tobacco Rate per $1,000	Spouse Rates (Based on Spouse date of birth)
Under 25	$0.163	$0.091	$0.102
25-29	$0.163	$0.091	$0.102
30-34	$0.225	$0.104	$0.112
35-39	$0.318	$0.138	$0.142
40-44	$0.475	$0.194	$0.224
45-49	$0.797	$0.318	$0.400
50-54	$1.285	$0.535	$0.656
55-59	$1.795	$0.817	$0.948
60-64	$2.210	$1.106	$1.454
65-69	$3.901	$2.173	$2.684
70-74	$6.483	$4.057	$4.672
75+	$6.489	$4.057	$4.672

Optional Dependent Child(ren): $0.27 per $1,000 (covers all dependent children)

Optional AD&D: $0.204/ $1,000

SHORT-TERM DISABILITY INSURANCE (STD)

PRUDENTIAL

Scan or click the QR code to access Prudential's website >>>
Phone: 1-800-842-1718
Website: www.prudential.com

100% Employer-Paid!

BENEFITS SUMMARY

Elimination Period for Accident	7 days
Elimination Period for Illness	7 days
Must use accrued time before short term disability payments begin	
Weekly Benefit	60%
Maximum Benefit Period for Illness or Injury	12 weeks
Maximum Benefit Period for Maternity	2 weeks before delivery and 6 weeks after delivery
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	$25
Definition of Disability	Partial disability with 0 day residual benefits

LONG-TERM DISABILITY INSURANCE (LTD)

PRUDENTIAL

Scan or click the QR code to access Prudential's website >>>
Phone: 1-800-842-1718
Website: www.prudential.com

100% Employer-Paid!

BENEFITS SUMMARY

Elimination Period	90 days
Weekly Benefit	60%
Maximum Benefit Period	To age 65
Maximum Weekly Benefit	$6,000
Minimum Weekly Benefit	10% or $100, whichever is greater
Definition of Disability	24 month own occupation

*This information summarizes the Cherokee County Board of Commissioners Disability benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

TRAVEL ACCIDENT INSURANCE

PRUDENTIAL

Scan or Click the QR code to access Prudential's website >>>
Phone: 1-800-842-1718
Website: www.prudential.com

All full-time employees are covered by Worldwide emergency travel assistance through Prudential. When traveling for business or pleasure, in a foreign country or just 100 miles or more away from home, you and your family can count on getting help in the event of a medical emergency.

- Hospital admission guarantee
- Emergency medical evaluation
- Medically supervised transportation home
- Transportation for a friend or family member to join hospitalized patient
- Prescription replacement assistance
- Multilingual crisis management professionals
- Medical referrals to western-trained English speaking medical providers
- Care and transport of unattended minor children

VOLUNTARY SUPPLEMENTAL INSURANCE

COLONIAL LIFE

Scan or Click the QR code to access Colonial Life's website >>>
Phone: 1-800-325-4368
Website: www.coloniallife.com

Voluntary Supplemental Plans

You have the opportunity to apply for payroll deducted personal insurance products! These benefits are designed to enhance your current benefits portfolio and can be customized to fit your individual needs!

- Premiums paid through payroll deduction
- Cash benefits paid directly to you
- Benefits paid regardless of other in-force coverage

Colonial Group Medical Bridge (GMB7000) Plan 2

The plan provides a lump-sum benefit for a covered hospital confinement. Also included is an outpatient surgery benefit of $1,000 for Tier 1 surgeries or $1,500 for Tier II surgeries, a $100 Daily Hospital Confinement benefit, a $100 per day Rehabilitation Unit Confinement benefit and a $50 standard Wellbeing Assistance benefit.

GROUP MEDICAL BRIDGE 7000 - PLAN 2

Hospital Confinement Benefit
$500/$1,000 Outpatient Surgical Benefit (CY Max $1,500)
$100 Daily Hospital Confinement Benefit
$100 Rehabilitation Unit Benefit
$50 Wellbeing Assistance Benefit Standard

Hospial Confinement Benefit	$1,000	$1,500
Employee	$12.21	$14.72
Employee & Spouse	$26.49	$31.89
Employee & Chilc(ren)	$17.33	$20.77
Family	$31.62	$37.94

Colonial Group Cancer Insurance

Helps offset the out-of-pocket medical and non-medical expenses related to cancer, such as hospital confinement, cancer treatments (chemotherapy, radiation, experimental treatment, bone marrow, and peripheral stem cell transplant), surgical procedures, transportation and lodging. Also included is a $75 benefit for cancer screening tests, a $5,000 Initial Diagnosis Cancer benefit rider and a Specified Disease benefit rider.

GROUP CANCER WITH ADDITIONAL BENEFITS

Plan	Level 3 with $5,000 Initial Diagnosis Benefit Rider and Specified Disease Benefit Rider
Employee	$10.73
Family	$17.82

Colonial Group Critical Insurance

Complements your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect costs related to a covered critical illness, which can often be expensive and lengthy. You have the choice of benefit from a minimum of $5,000 up to a maximum benefit payment of $50,000. Payment for Subsequent Diagnosis of a different Specified Critical Illness and Subsequent Diagnosis for the same specified illness and a $50 Health Screening Benefit are included.

Group Critical Care 1.0 - Non-HSA Compliant Full CI Benefits with Subsequent Diagnosis plus a $50 Health Screening Benefit												
Age Band	Non-Tobacco Employee Only						Tobacco Employee Only					
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
17-29	1.85	2.35	2.86	3.37	3.88	4.38	2.35	3.37	4.38	5.4	6.42	7.43
30-39	2.22	3.09	3.97	4.85	5.72	6.6	3.12	4.89	6.67	8.45	10.22	12
40-49	3.07	4.8	6.53	8.26	9.99	11.72	4.8	8.26	11.72	15.18	18.65	22.11
50-59	4.41	7.48	10.55	13.62	16.68	19.75	7.48	13.62	19.75	25.89	32.03	38.17
60-74	6.32	0.31	16.29	21.28	26.26	31.25	11.31	21.28	31.25	41.22	51.18	61.1
	Non-Tobacco Employee & Spouse						Tobacco Employee & Spouse					
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
17-29	2.84	3.6	4.36	5.12	5.88	6.65	2.42	3.51	4.59	5.68	6.76	7.85
30-39	3.39	4.71	6.02	7.34	8.65	9.97	3.16	4.98	6.81	8.63	10.45	12.28
40-49	4.66	7.25	9.83	12.42	15	17.58	4.85	8.35	11.86	15.37	18.88	22.38
50-59	6.85	11.63	16.41	21.18	25.96	30.74	7.52	13.71	19.89	26.08	32.26	38.45
60-74	9.81	17.54	25.27	33	40.73	48.46	11.38	21.42	31.45	41.49	51.53	61.57
	Non-Tobacco 1 Parent Family						Tobacco 1 Parent Family					
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
17-29	1.92	2.49	3.07	3.65	4.22	4.8	2.42	3.51	4.59	5.68	6.76	7.85
30-39	2.28	3.23	4.18	5.12	6.07	7.02	3.16	4.98	6.81	8.63	10.45	12.28
40-49	3.12	4.89	6.67	8.45	10.22	12	4.85	8.35	11.86	15.37	18.88	22.38
50-59	4.45	7.57	10.68	13.8	16.92	20.03	7.52	13.71	19.89	26.08	32.26	38.45
60-74	6.39	11.45	16.5	21.55	26.61	31.66	11.38	21.42	31.45	41.49	51.53	61.57
	Non-Tobacco Family						Tobacco Family					
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
17-29	2.88	3.69	4.5	5.31	6.12	6.92	3.65	5.22	6.78	8.35	9.92	11.49
30-39	3.44	4.8	6.16	7.52	8.88	10.25	4.75	7.43	10.11	12.78	15.46	18.14
40-49	4.71	7.34	9.97	12.6	15.23	17.86	7.29	12.51	17.72	22.94	28.15	33.37
50-59	6.9	11.72	16.55	21.37	26.19	31.02	11.68	21.28	30.88	40.48	50.08	59.68
60-74	9.85	17.63	25.41	33.18	40.96	48.74	17.58	33.09	48.6	64.11	79.62	95.12

Colonial Group Accident Preferred:

Offsets unexpected medical expenses resulting from fractures, dislocations, burns, etc. Provides for initial care and treatment and follow up care.

Bi-Weekly Rates			
Employee Only	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
$7.28	$11.90	$12.94	$17.56

Trustmark Universal Life Events Insurance

Plan is permanent life insurance that helps shield your family from financial hardship if you or your spouse are suddenly out of the picture. Includes Long-Term Care Benefit of 4%. You can apply for coverage for your spouse, children and grandchildren even if you choose not to participate.

Bi-Weekly Rates		
$20/Bi-Weekly Non-Tobacco with LTC Rider	Age	Benefit Amount
	27	$100,229
	37	$65,492
	47	$36,924
	57	$20,224
	Guaranteed Cash Value at Age 65	
	27	$4,930
	37	$3,190
	47	$2,130
	57	$60

FLEXIBLE SPENDING ACCOUNT (FSA)

AMERIFLEX

Scan or Click the QR code to access Ameriflex's website >>>
Phone: 1-888-868-3539
Website: www.myameriflex.com

Flexible Spending Accounts (FSAs) have become a popular vehicle for reducing rising health care costs. By contributing pre-tax dollars into an FSA, you can save an average of 20% on eligible expenses every year.

You may participate in the following spending accounts:

Health Care Flexible Spending Account

Employees use pre-tax dollars to pay for insurance deductibles, co-payments, glasses and contact lenses, orthodontia, over-the-counter medications, and hundreds of other health care-related expenses not covered by their insurance plans.

The maximum contribution amount for period 1/1/2024 through 12/31/2024 is $3,050.

Dependent Care Flexible Spending Account

Employees use pre-tax dollars to be reimbursed for work-related day care expenses for their children or dependent adults.

The maximum contribution amount for period 1/1/2024 through 12/31/2024 is $5,000 if you are married and filing a joint return or if you are a single parent. If you are married but filing separately, the annual maximum contribution is $2,500.

Medical FSA / Dependent Care FSA - Key Differences

	MEDICAL FSA	DEPENDENT CARE FSA
Medical Plan Rules	Contributions to a medical FSA can only be made if you are not enrolled in an High Deductible Health Plan (HDHP) like, a Health Savings Plan	Contributions to a Dependent Care FSA account can be made no matter what plan or medical coverage you have.
Contribution Limit	$3,050	$5,000 ($2,500 if your spouse file separate tax returns)*
Frontloaded	YES You can access your total annual contribution right away	NO Funds are available only as contributed

* This account is funded based on your pre-tax contributions. Only the amount currently in your account is eligible for reimbursement.
** For a complete list of Eligible FSA expenses and guidelines, visit the IRS website at www.irs.gov. Publication 502 includes eligible Medical FSA expenses; Publication 503 includes eligible Dependent Care FSA expenses.
*** Eligible dependents include children up to age 13 or disabled dependent adults.

Please note: Under the CARES Act effective March 27, 2020, claims for most over-the-counter medicine, medical supplies and feminine hygiene products can be purchased through an FSA without a prescription. This reverses the prior rule from January 1, 2011 in which a prescription was required.
The Act is effective retroactively to January 1, 2020.

CHEROKEE COUNTY DEFINED BENEFIT PENSION PLAN

ACCG RETIREMENT SERVICES

What is a Defined Benefit Plan?

A defined benefit plan is the most popular type of primary plan offered by local governments in Georgia. This type of plan is called a "defined benefit" plan because the retirement benefits you will receive are set, or "defined" by the terms of the plan. Typically, the benefit amount is based on a formula that takes into account your salary and years of service in the organization. The plan provides a fixed monthly benefit payment for life, or you may choose from several other payment options that will determine the amount of your monthly benefit. Participation in the DB plan is mandatory for all Full-Time employees. Employees are automatically enrolled at time of hire.

Scan or Click the QR code to access ACCG's website >>>

Phone: 770-952-5225 | 1-800-736-7166

Website: www.accgretirement.org

Regional Client Manager: Jacques Jones
(470) 352-1222 | jjones@accg.org

Please visit our website and register at www.accgretirement.org or by going to mypension.accgretirement.org to view your account.

CHEROKEE COUNTY DEFINED CONTRIBUTION 457(B) PLAN

VOYA FINANCIAL

What is a Defined Contribution Plan?

A defined contribution plan is a retirement plan in which the employee contributes money that they can then invest. This type of plan is called a "defined contribution" plan because you decide how much you want to contribute to your account, and your payout at retirement depends on the performance of your chosen investments. You choose how you want your money invested. Since the Cherokee County BOC plan is a 457(b) plan, you can withdraw you benefits after separation of employment before age 59 ½ without the 10% early withdrawal penalty. The 457(b) plan offers both pre-tax regular contributions and post-tax ROTH contributions.

Participation in the DC plan is voluntary for all FT Employees. Employees can enroll in this plan at any time.

Scan or click the QR code to access Voya's website >>>

Phone: 678-360-9677, Ext. 1

Website:
https://voyaretirement.voya.com
Financial Advisor: Joe D. Friend III, CRPC

(678) 360-9677

To Enroll in the 457(b) plan, go to:

- Enrollment website: enroll.voya.com
- Plan#: 664562
- Verification Code: 137-477

To access your account, update beneficiaries, change contribution percentage or investments, visit https://voyaretirement.voya.com

CONTACT INFORMATION

LINE OF COVERAGE	CARRIER	CUSTOMER SERVICE
Medical	TPA - Trustmark	877-279-5285 www.mytrustmark.com
	Cigna Network	800-667-1654 www.cigna.com
	NHN Network	877-279-5285 www.nhnmanager.com
	CHOA	877-279-5285 www.nhnmanager.com
	First Health	providerlocator.firsthealth.com
	Teladoc	800-835-2362 www.teladoc.com
	Surgeryplus	855-715-1683 www.cherokeecounty.surgeryplus.com
Rx	US Rx Care	877-200-5533 www.us-rxcare.com
International Pharmacy Program **Manufacturers Assistance Program**	ScriptSourcing	866-488-7874 www.scriptsourcing.com
Dental	Delta Dental	800-521-2651 www.deltadentalins.com
Vision	NVA	800-672-7723 www.e-nva.com
Basic & Voluntary Life/AD&D	Prudential	800-534-0542 www.prudential.com/gi
Short Term & Long Term Disability	Prudential	800-842-1718 www.prudential.com/gi
Travel Accident Insurance	Prudential	800-842-1718 www.prudential.com/gi
Employee Assistance Program	Compsych	800-311-4327 www.guidanceresources.com
Flexible Spending Accounts	Ameriflex	888-868-3539 www.myameriflex.com
Voluntary Benefits	Colonial	800-325-4368 www.coloniallife.com
	Trustmark	800-918-8877 www.trustmarksolutions.com
Cherokee County Contact Information	Benefits and Claims Questions	Benefits@cherokeega.com
	Pension and Voya 457(b) Questions	Lewis Williams 678-493-6020 clwilliams@cherokeega.com

MANDATORY NOTICES

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

Important Notice:
Medicare Part D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cherokee County Board of Commissioners 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. Cherokee County Board of Commissioners has determined that the prescription drug coverage offered by the Trustmark 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 group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and Medicare will be your primary coverage and the group plan will become your secondary coverage.

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your reenrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be cancelled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

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 under the group plan 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 your Human Resources 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 the group plan coverage 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"

Important Notice:
Medicare Part D Creditable Coverage Disclosure

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).

Contact Human Resources for more information:

Cherokee County Board of Commissioners

1130 Bluffs Pkwy, Canton GA 30114

Benefits@cherokeega.com

Telephone Number: 678-493-6000

HIPAA Notice of Special Enrollment Rights

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

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

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

To request special enrollment or obtain more information, please contact Human Resources.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Model General Notice of COBRA Continuation of Coverage Rights

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event,

Mandatory Notices

COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the

Mandatory Notices

Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Plan and COBRA continuation coverage can be obtained on request:

Cherokee County Board of Commissioners

1130 Bluffs Pkwy, Canton GA 30114

Benefits@cherokeega.com

Telephone Number: 678-493-6000

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

State Continuation of Coverage

Due to size, your group plan does not fall under Federal COBRA guidelines. However, you may have a state continuation option available to you. Contact your insurance carrier or Human Resources for more information. Additional information can be found on your state's department of insurance website.

Wellness Plan Notice

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. We will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Contact Human Resources for more information.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.
Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5

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percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (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 percent of such costs.)

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

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Women's Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

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 (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; and
- 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. Therefore, the deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 1, 2023. Contact your State for more information on eligibility.

State Contacts

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:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program: 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+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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 ext 2131, 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: 1-800-766-9012

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: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

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=e n_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: 617-866-8102

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/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: HHSHIPPProgram@mt.gov

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/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

State Contacts

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:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
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
http://www.oregonhealthcare.gov/index-es.html
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: Children's Health Insurance Program (CHIP) (pa.gov)
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: http://gethipptexas.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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
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.govbadgercareplus/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 January 1, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Cherokee County

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GEORGIA