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 page 3 for more details.

IMPORTANT LEGAL NOTICES

Notice of Your HIPAA Special Enrollment Rights

Loss of Other Coverage - If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. **You will be required to submit a signed statement that this other coverage is the reason for waiving enrollment originally.** To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption - 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/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after the marriage, birth, adoption or placement for adoption.

Medicaid Coverage - The Cherokee County Board of Commissioners (CCBOC) group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. Termination of Medicaid or CHIP Coverage - If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. Eligibility for Premium Assistance Under Medicaid or CHIP- If the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan **within 60 days** after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

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

Children's Health Insurance Program (CHIP)

If you are eligible for health coverage but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, **you must request coverage within 60 days of being determined eligible for premium assistance**.

Georgia Medicaid
Website: http://dch.georgia.gov
Phone: 1-800-869-1150

Notice Regarding the Women's Health and Cancer Rights Act

On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. This new law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services.

These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:

- Interfere with a woman's rights under the plan to avoid these requirements, or
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

If you have any questions about the current plan coverage, please contact the CCBOC Human Resources Department.

Protecting Your Health Information Privacy Rights

We are committed to the privacy of your health information. The administrators of the health benefit plan use strict privacy standards to protect your health information from unauthorized use or disclosure. The plan's policies protecting your privacy rights and your rights under the law are described in the plan's Notice of Privacy Practices. Please contact the CCBOC Human Resources Department to request a copy of the Notice.

When Can You make Election Changes?

During each annual enrollment period, you will have the opportunity to review your benefit elections and make changes for the coming plan year.

Certain coverages, such as the Medical, Dental and Vision, and the Flexible Spending Accounts, allow limited changes to elections during the year. Under these benefits, you may only make changes to your elections during the year if you have a change in family status, a change in cost or coverage occurs (but not for a health care flexible spending account), or are ordered by a court to provide health care benefits for a dependent. Family status changes include:

- Marriage, death of spouse, divorce, a legal separation or annulment;
- Gain or loss of an eligible dependent for reasons such as birth, adoption, placement for adoption, or death;
- Dependent satisfies or no longer satisfies eligibility requirements for reasons such as reaching the dependent child age limit, incurring a change in student status or other circumstances;
- Changes in your spouse's or dependent's employment affecting benefit eligibility;
- Changes in your spouse's benefit coverage with another employer that affects benefit eligibility;
- Change in employee work status;
- Change in residence (but not for health care flexible spending account).

The change to your benefit elections must be consistent with the change in family status. You have 30 days from the date of a change in family status to submit an enrollment change form and documentation of the family status change to the CCBOC Human Resources Department. In most cases, your election will become effective the date of the change in family status (date of birth, date of marriage, etc.). Otherwise, you must wait until the next annual enrollment period to make a change to your elections.

Important Notice from the Cherokee County Board of Commissioners About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CCBOC 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. The CCBOC has determined that the prescription drug coverage offered by the HMO and POS 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 CCBOC coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current CCBOC coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period unless you experience a qualified life event. Note that your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan and keep your coverage under the HMO or POS 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 with CCBOC 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 CCBOC 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:	11/01/2011
Name of Entity/Sender:	**Cherokee County Board of Commissioners**
Contact--Position/Office:	**Benefits Administrator/Human Resources**
Address:	1130 Bluffs Parkway, Canton, Ga 30114
Phone Number:	**678-493-6016**

Report Eligibility Changes in a Timely Manner
It is your responsibility to notify the CCBOC Human Resources Department when a dependent becomes eligible or ceases to be eligible for coverage under our benefit plans. All eligibility changes should be reported within 30 days of the event. Failure to report changes in a timely manner can impact your ability to add newly eligible dependents or discontinue pre-tax premium contributions on ineligible dependents.

In addition, failure to report a loss of eligibility due to legal separation or divorce or a dependent that has otherwise ceased to be eligible, such as a child reaching the maximum dependent child age limit, can impact your dependent's rights for group health plan coverage under the federal law known as COBRA. If you fail to report the loss of eligibility within 60 days of the event, your dependents may be left with no continuation coverage under our plan. Please see your COBRA notice or your group health plan summary plan description for additional information.

Patient Protection Disclosure
The CCBOC HMO Plan 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. Until you make this designation, Blue Cross Blue Shield of Georgia designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Blue Cross Blue Shield of Georgia at 1-800-221-4473. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the BCBSGA HMO Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Blue Cross Blue Shield of Georgia at 1-800-221-4473.

Notice About The Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.