CITY of DEBARY

www.debary.org

· THE RIVER CITY ·

Health Benefits Overview

January 1, 2021 - December 31, 2021

TABLE OF CONTENTS

Helpful Tools	3
Medical Coverage	4
Dental Coverage	5
Vision Coverage	6
Disability Coverage	7
Group Life & Qualifying Events	8
Vol. Group Life	9
Important Notices	10-13

General Information

What is a "Copayment"?

- A copayment is a pre-determined amount you must pay out-of-pocket when seeing a service provider. It is paid directly to the provider and is due at the time services are rendered.

What is a "Deductible"?

- A deductible is a pre-determined amount that is paid by you before the insurer begins to pay.

What is "Coinsurance"?

- Coinsurance is the percentage paid by the insurer and the percentage paid by you after you have met the deductible.

What is "Precertification"?

- Certain services, such as hospitalization or outpatient surgery, may require prior authorization with your insurer to verify coverage for those services. When required, your participating physician must obtain a precertification for you prior to your treatment.

Where can I find my in-network provider?

- Directories of participating service providers may be found on your insurer's website. If you do not have internet access, you may call member services to find an in-network provider near you.

Should I use an Urgent Care Center or the Emergency Room?

- Urgent Care Centers are another great alternative to the Emergency Room when your doctor's office is closed. The co-payments are less that an Emergency Room visit.

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available January 1, 2021-December 31, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Cigna

Visit www.myCIGNA.com

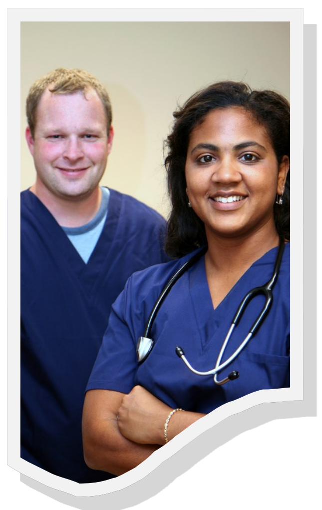
- Online access to claim and benefit information
- Resources for managing your health care including Cost and Quality, Health Management, and Medical Research
- Find and compare providers

If you prefer phone, call the number on the back of your ID card

- Toll free 24/7/365 live access to representatives who will help you understand your benefits
- Access to registered nurses who can provide you with guidance using the Health Information Line
- Confirm coverage of you or your enrolled dependents
- Get additional information on your prescription plan or access processed claims
- Learn more about service that are offered to you

Mobile Apps- Stay connected using Cigna Apps

- myCigna App manages your healthcare and gives access to providers, deductibles and claim information
- Coach by Cigna App focuses on exercise, food, sleep, stress, weight
- Cigna Wellbeing App focuses on wellness tools and health tips
- Cigna Compass Mobile App gives personalized guidance to your healthcare journey



Ways to save on Benefit Costs

- Stay in-network
- Use Convenience Care and Urgent Care Centers instead of the Emergency Room
- Use generic instead of brand named prescriptions

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available January 1, 2021-December 31, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Medical Coverage Options

Provided by: Cigna | 866-494-2111 | www.mycigna.com

Healthcare Services	OAP HSA Advantage A Plan 1
Name of Network	Cigna HSA
Calendar Year Deductible	
Individual	$1,500
Family	$3,000
Annual Out-of-Pocket Maximum (Includes deductible, copays, coinsurance)	
Individual	$2,600
Family	$5,200
Coinsurance (Coins) (Amount paid after deductible is met)	
You pay…..	10%
Copays	
Primary Care Physician	Deductible + Coinsurance
Specialist	Deductible + Coinsurance
Telehealth	Deductible + Coinsurance
Adult and Child Wellness Exams	$0 Copay
Hospital Services	
Inpatient Hospital Per Admission	Deductible + Coinsurance
Emergency Room	Deductible + Coinsurance
Urgent Care	Deductible + Coinsurance
Diagnostic Services	
Independent Facility– Lab / X-ray	Deductible + Coinsurance
Independent Facility– Adv Imaging (CT, PET, MRI)	Deductible + Coinsurance
Prescription Drugs	
Retail (1 month supply)	DEDUCTIBLE APPLIES
Generic Drugs	$10 Copay
Brand Drugs	$50 Copay
Non-Preferred Brand Drugs	$80 Copay
Specialty Drugs	
Mail Order (3 month supply)	2.5x's Copay
Non-Network	
Calendar Year Deductible Ind/(Family)	$3,000 / $6,000
Out of Pocket Max Ind/(Family)	$5,200 / $10,400
Coinsurance	50%

Medical plan rates

Based on your bi-weekly deduction

Who is covered	OAP HSA Advantage A Plan 1
Employee	$0.00
Employee + Spouse	$217.79
Employee + Child(ren)	$185.11
Employee + Family	$403.00

*Rates subject to final enrollment and underwriting

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available January 1, 2021 – December 31, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Dental Coverage PPO

Provided by: Cigna | 866-494-2111 | www.mycigna.com

PPO dental plans give you freedom to use in-network or out-of-network dentists. Since network providers offer reduced contracted rates, you save money by using network providers for all your dental needs. All benefits received from out-of-network dentists are subject to "reasonable and customary" fees. Any amount that exceeds this fee is the patient's responsibility.

PPO Dental Services	HIGH PLAN In-Network	LOW PLAN In-Network
Annual Maximum Benefit	$1,750	$1,250
Calendar Year Deductible	$0	$0
PREVENTATIVE PROCEDURES:	Deductible Waived	
Routine Exams, Teeth Cleaning Bitewing X-rays Full Mouth X-rays Fluoride Treatments (under age 19)	Plan pays 100%	Plan pays 100%
BASIC PROCEDURES:	Deductible Applies	
Fillings Periodontics Simple Extractions Root Canal Therapy	Plan pays 80%	Plan pays 80%
MAJOR PROCEDURES:	Deductible Applies	
Oral Surgery Crowns and Bridges Full & Partial Dentures	Plan Pays 50%	Plan pays 50%
OUT OF NETWORK:	**HIGH PLAN Out-of-Network**	**LOW PLAN Out-of-Network**
Annual Maximum Benefit Calendar Year Deductible Preventative/Basic/Major*	$1,750 $0 100% / 80% / 50% *	$1,250 $0 100% / 80% / 50% *

* Percent of **allowed** charges

Dental plan rates

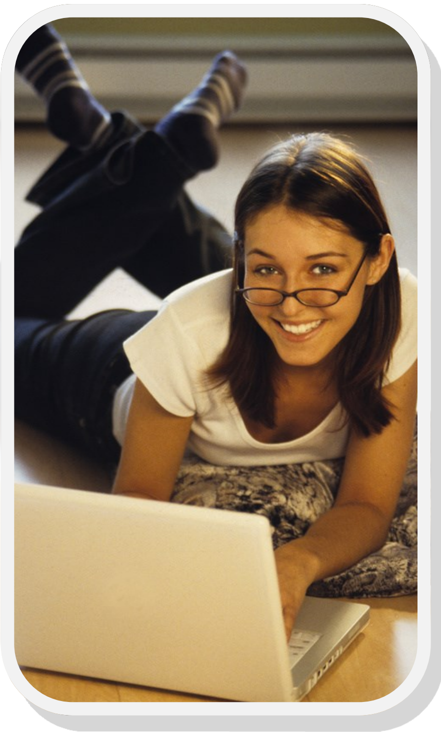
Dental plan rates based on your bi-weekly deduction

Who is covered	HIGH PLAN	LOW PLAN
Employee	$0.92	$0.00
Employee + One	$10.87	$9.07
Employee + Two or More	$26.45	$23.68

Vision Coverage

Cigna

Provided by: Cigna | 866-494-2111 | www.mycigna.com



This plan covers eye exams, prescription lenses and frames, or contact lenses for you and your dependents when you receive services from in-network or out-of-network providers. As you can see from the table below, staying in-network cuts costs down and gives you more of a benefit.

To find a participating provider log on to www.mycigna.com.

Vision Coverage Rates:
Based on your bi-weekly deduction

Who is covered	Vision Plan
Employee	$0.00
Employee + Spouse	$2.53
Employee + Child(ren)	$2.58
Employee + Family	$5.63

Vision Services	In-Network	Out-of-Network
Eye Exams	$10 Copay	Up to $45 Reimbursement
Frequency	12 months	12 months
BASIC LENSES		
Frequency	12 months	12 months
Single vision	$25 Copay	Up to $32 Reimbursement
Bifocal vision	$25 Copay	Up to $55 Reimbursement
Trifocal vision	$25 Copay	Up to $65 Reimbursement
FRAMES		
Frequency	12 months	12 months
Benefit	$130 allowance	Up to $71 Reimbursement
CONTACTS		
Frequency	12 months	12 months
Benefit	$130 allowance	Up to $105 Reimbursement

*Contacts and frames cannot be purchased in the same year

Cigna

Provided by: Cigna | 866-494-2111 | www.mycigna.com

Short-Term Disability

If you become disabled because of a non-occupational illness or injury and cannot work, you can be covered by the short-term disability insurance policy. Benefits can begin on the 1st day following an accident and the 8th day of a sickness. The short-term disability plan replaces up to 60% of your basic weekly earnings, with a maximum weekly benefit of $1,000. You can receive short-term disability benefits for up to 13 weeks.

City of Debary provides eligible employees Short-Term Disability at NO COST.

Long-Term Disability

If you become unable to perform your regular job duties for an extended period of time due to sickness, or accidental injury, you can be covered by the long-term disability (LTD) policy.

Your income replacement benefit would equal 60% of your basic monthly earnings. The maximum monthly benefit you can receive is $5,000. Benefits begin after you have been unable to work for 90 days due to a covered sickness or accident and will continue to be paid for up to 2 years in own occupation.

Your LTD benefit will be reduced by any disability income you receive from other sources, such as Social Security, worker's compensation, and/or state disability plans, to provide you with a combined monthly benefit equal to 60% of your basic monthly earnings.

The LTD plan contains a pre-existing condition exclusion. The exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought care within the 3 month period prior to the effective date of coverage and the disability begins within 12 months of the effective date of coverage.

City of Debary provides eligible employees Long-Term Disability at NO COST.

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available January 1, 2021-December 31, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Basic Life/AD&D Coverage

Cigna

Provided by: Cigna | 866-494-2111 | www.mycigna.com

Basic Life/ AD&D Life insurance protects your family or other beneficiaries in the event of your death. The death benefit helps replace the income you would have provided and can help meet important financial needs. It can help pay your mortgage, rent, run your household, send your children to college, pay off debts, etc.

City of Debary provides eligible employees $50,000 basic life insurance and AD&D at no cost.

The following are attached to this group term life insurance policy:

Accelerated Death Benefit

Seatbelt-Air Bag Benefit

Waiver of Premium

Conversion

Reduction Schedule:

65% at age 65
40% at age 70
25% at age 75

Guarantee Issue $50,000, Minimum Benefit Amount $50,000, Maximum Benefit Amount $50,000
To find more information, refer to your Certificate of Benefits.

Qualifying Life Events

If you experience any of the below qualifying life events, you must contact Human Resources within 30 days of the event to be able to make changes to your benefits. Proof of the event is required in order to successfully make the requested changes to your plans.

⇒ Marriage	⇒ Divorce or legal separation (subject to State regulations)
⇒ Death of spouse, child or other qualified dependent	⇒ Birth or adoption of child
⇒ Loss of other group coverage	⇒ Change in employment status for employee, spouse or dependent
⇒ Change in residence due to an employment transfer	⇒ Change of dependent status

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available January 1, 2021 – December 31, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Voluntary Life/AD&D Coverage

Cigna

Provided by: Cigna | 866-494-2111 | www.mycigna.com

Summary of Voluntary Life Insurance

If you chose to enroll in voluntary life insurance, you may also insure your spouse and eligible dependent children up to the age of 26. A summary of your life insurance coverage is listed in the table below, if you should have questions on this policy see your Cigna Certificate of Benefits, or visit www.mycigna.com.

Summary of Insurance	
Guaranteed Issue	$100,000
Minimum Benefit Amount	$10,000
Maximum Benefit Amount	$500,000
Increments of...	$10,000
Spouse Coverage	
Spouse Guarantee Issue	$25,000 (Terms at 70)
Increments of...	$5,000
Child(ren) Coverage	
Birth to 6 months	$500
Age 6 months to 26 years	$1,000—$10,000

Additional Information

- Age reduction scale:
  - 35% of original amount at age 65
  - 60% of original amount at age 70
  - 75% of original amount at age 75
- Age-bracketed premiums: Premiums increase on plan anniversary after you enter next 5 year age group
- Evidence of Insurability form Is required for employees who do not enroll during their initial eligibility period or who want to increase coverage or add dependent coverage at Open Enrollment

If your age is...	Your cost for each $1,000 of supplemental life is...
<20	$0.097
20-29	$0.129
30-34	$0.129
35-39	$0.149
40-44	$0.196
45-49	$0.276
50-54	$0.414
55-59	$0.642
60-64	$0.963
65-69	$1.604
70-74	$3.229
75-79	$6.482
80-84	$12.838
85-89	$23.634
90+	$38.537

Dependent Children Monthly Cost:

If your coverage level is...	Your cost for each $1,000 of supplemental life is...
Child Life	$0.24

How to figure your voluntary life cost per paycheck:

1. Indicate your elected benefit amount (EBA)
2. Divide EBA by $1,000
3. Enter age rate from cost table
4. Multiply Step 2 by Step 3
5. Multiply Step 4 by 12 then divide by 26 to calculate your cost per paycheck

Important Notices

Special Enrollment Rights Notice

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 towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
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.
Special enrollment rights also may exist in the following circumstances:

- ⇒ If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- ⇒ If you or your dependents become eligible for a State premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.
- ⇒ 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.

Note: The 60 day period for requesting enrollment applied only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applied to most special enrollments.

Women's Health & Cancer Rights Act of 1998

The Women's Health and Cancer Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For Individuals receiving mastectomy –related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- ⇒ All stages of reconstruction of the breast on which the mastectomy was performed;
- ⇒ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ⇒ Prostheses; and
- ⇒ Treatment of physical complications of the mastectomy, including lymphedema.
- ⇒ These benefits will be provided subject to the same deductibles and coinsurance amounts applicable to other medical and surgical benefits provided under the health plan offered by your employer.
- ⇒ Please keep this information with your other group health plan documents. If you have any questions about the Plan's coverage of mastectomies and reconstructive surgeries, please contact the Human Resources Department.

Health Insurance Portability and Accountability Act (HIPAA) Notice

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

This Information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of such an event.

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.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at (312)353-0900.

If you have any questions about this notice or the law, please contact your Plan Administrator at the number or location provided in your benefits booklet or Summary Plan Description.

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

Notice of Privacy Practices: Plan administrators, clearinghouses, business associates, and health care providers that transmit health information electronically or use electronic health records may not redistribute or unlawfully use electronic health records without permission from the insured. The insured may request information on how their electronic records are distributed, how frequently they are distributed, and who they are distributed to by contacting the U.S. Department of Health and Human Services.

Health Insurance Marketplace Coverage Notice

The Health Insurance Marketplace is available to assist you as you evaluate health insurance options for you and your family. This notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer. The Marketplace is designed to help you find private health insurance and compare private health insurance options. You may also be eligible for a new kind of tax credit under section 36B of Internal Revenue Code that could potentially lower your monthly premium. If you purchase a qualified health plan through the Marketplace, you may lose the employer contribution (if any) to any health benefit plan offered by your employer and all or a portion of that contribution may be excludable from income for federal income tax purposes . More information on the health insurance Marketplace may be found at https://www.healthcare.gov.

Notice of Rescission

(a) ***Prohibition on rescissions -*** (1) A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual):

I. performs an act, practice, or omission that constitutes fraud

II. makes an intentional misrepresentation of material fact,

as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.) A rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose.

A cancellation or discontinuance of coverage is not a rescission if -

I. The cancellation or discontinuance of coverage has only a prospective effect;

II. The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRA premiums) towards the cost of coverage;

III. The cancellation or discontinuance of coverage is initiated by the individual (or by the individual's authorized representative) and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or

IV. The cancellation or discontinuance of coverage is initiated by the exchange pursuant (the insured).

Michelle's Law

Michelle's Law protects a postsecondary student from losing full-time student status under an employer's medical coverage if the student is (i) a dependent child of a participant or beneficiary under the terms of the plan; and (ii) enrolled in a plan on the basis of being student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence from school. A dependent covered under the law is entitled to the same benefits as if the dependent continued to be enrolled as a full-time student. The law also recognizes that changes in coverage (whether due to plan design or a subsequent annual enrollment election) pass through to the dependent for the remainder of the medically necessary leave of absence.

Mental Health Parity & Addiction Equity Act 2008 (MHPAEA)

Under the MHPAEA, the financial requirements and treatment limits that group health plans and health insurance issuers apply to mental health or substance use disorder benefits generally cannot be more restrictive than those applicable to medical and surgical benefits. If a plan covers mental health and substance use disorder, MHPAEA provides medical and surgical benefits and mental health and substance use disorder benefits. MHPAEA it must comply with the federal parity requirements. The MHPAEA contains the following parity requirements:

The financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket limits) applicable to mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.

Treatment limitations (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of coverage) must also comply with the MHPAEA's parity requirements. Non-quantitative treatment limitations (such as medical management standards, formulary design and determinations of usual, customary or reasonable amounts) are subject to a separate parity requirement.

If medical and surgical benefits are offered on an out-of-network basis, a plan or issuer must also offer mental health and substance use disorder benefits on an out-of-network basis.

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).

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Cobra provides eligible individuals and their dependents who would otherwise lose group health coverage as a result of a qualifying life event with an opportunity to continue group health coverage for a limited time period under certain circumstances such as:

- Voluntary or involuntary job loss
- Reduction in the hours worked
- Transition between jobs
- Death
- Divorce
- And other qualifying life events

If you are entitled to elect COBRA coverage, you will have 60 days (starting on the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage.

Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by groups with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

The duration of COBRA extends from the date of the qualifying event for a limited period of 18 or 36 months. The length of time depends on the type of qualifying life event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

COBRA Continuation coverage may be terminated earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis
- The employer ceases to employ any group health plan
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage;
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of open enrollment period. For more information on alternatives to COBRA coverage reach out to your HR Representative or Plan administrator.

Contact your plan administrator or Human Resources to determine how COBRA is administered at your workplace.

CHIP Model Notice

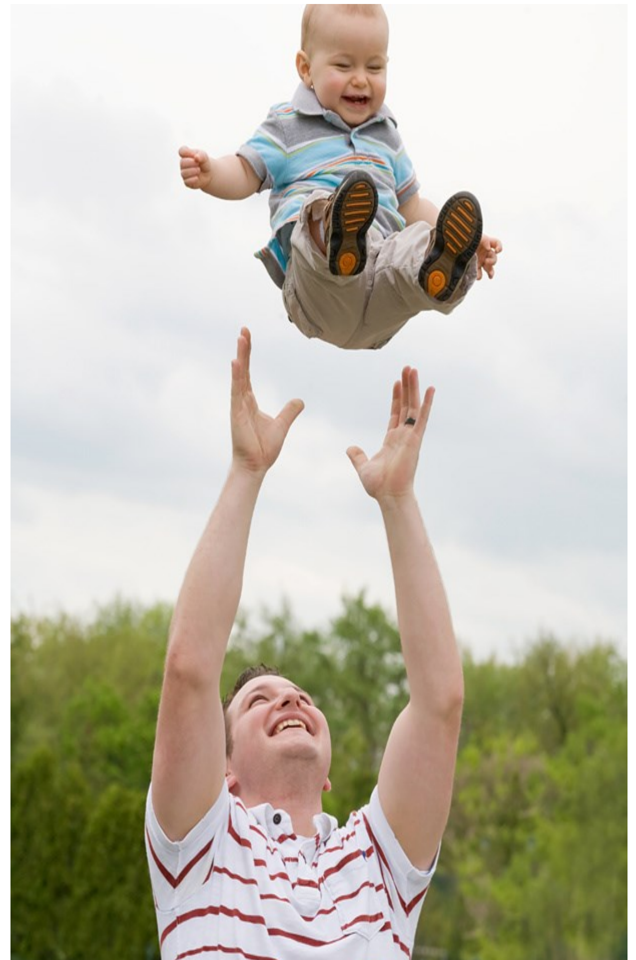
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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 on the following page, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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



If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ARKANSAS – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**COLORADO – Health First Colorado & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	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
FLORIDA – Medicaid	**GEORGIA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
INDIANA – Medicaid	**IOWA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 Other Medicaid: Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://chfs.ky.gov Phone: 1-800-635-2570
LOUISIANA – Medicaid	**MAINE – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll Free number for the HIPP program - 1-800-852-3345, ext. 5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html Phone: 1-800-701-0710
NEW YORK – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
NORTH CAROLINA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531	

To see if any other states have added a premium assistance program since July 31, 2019 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa (1-866-444-3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov (1-877-267-2323) , menu opt 4, ext 61565