2024 Employee Benefit Guide

Hanover County

If you 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. Refer to your legal notices packet for more details.

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This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

BENEFITS OVERVIEW

Hanover County is committed to providing our employees with a benefits program that is both comprehensive and competitive. Our benefits program offers health care, dental, vision, and voluntary benefits, as well as financial security to our employees and their families. This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that is right for you.

The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

Benefits Offered

- Medical
- Dental
- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
- Vision
- Voluntary Benefits

ELIGIBILITY

If you are an employee working 20 or more hours per week, and classified as benefited, the chart below lists the benefits you may be eligible for after meeting each plan's eligibility requirements.

Benefit	Eligibility Waiting Period	
	County, Library, Jail	School
Medical and RX	1st of Month following hire	1st of Month following hire
Dental	1st of Month following hire	1st of Month following hire
Vision	1st of Month following hire	1st of Month following hire
Basic Life and Accidental Death and Dismemberment	Day of Hire	Day of Hire
VRS Optional Life Insurance	1st of Month following day of Approval	1st of Month following day of Approval
Flexible Spending Accounts	1st of Month following hire	1st of Month following hire
Empower Retirement Plan	1st of the Month after Enrollment	Day of Hire (for some plans)
Virginia Retirement System	Varies by Hire Date	Varies by Hire Date
Pierce Voluntary benefits	1st of the Month following hire	1st of the Month following hire

Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Eligible dependents are defined as your legal spouse and eligible children who depend primarily on you for support. This includes: your own children, legally adopted children, stepchildren, a child for whom you have been appointed legal guardian, and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse to provide coverage.

Medical, Dental, and Vision Plan Dependent Coverage

You may cover your eligible dependent children up to the end of the year they turn 26, regardless of marital or student status (this does not include spouses of adult children).

WHAT'S NEW IN 2024?

- **Employee payroll contributions** - minimal increases to the medical employee contributions.
- **Medical Benefits:**
  - Standard plan: Decrease in copay for both Primary Care Physician and Specialist visits.
  - Standard and Premium plans: Copay only for Urgent Care.
  - All Plans: Bariatric Surgery is covered. Please note you must complete qualifications to be eligble for this type of service.
  - Good RX embedded in Aetna. This means you pay the lessor of Good RX or Aetna without having to do extra research.
  - CDHP: Individual deductible increase from $3,000 to $3,200 and family deductible increase from $6,000 to $6,400 per IRS regulations
- **Savings account limits:**
  - Health FSA limit increasing to $3,200.
  - Health FSA Carryover amount increasing to $640
  - HSA ER contribution increased to $1,450/Individual and $2,800/Family.
  - HSA limit increased to $4,150/Individual and $8,300/Family.

WHEN CAN I ENROLL?

New Hires/Newly Eligible for Benefits

When you start with Hanover County, you become eligible for benefits. You have 30 days to enroll from your date of hire. If you do not enroll within that time period, you will not be eligible for benefits until the next Open Enrollment, unless you have a Qualifying Life Event.

Open Enrollment

During Open Enrollment, you will have the opportunity to make changes to your benefit elections. You must enroll by the Open Enrollment deadline for your benefits to be effective January 1st. Except for a Qualifying Life Event, you will not be able to change your elections until the next year's Open Enrollment.

Qualifying Life Event

Choose your benefits carefully. Some of your deductions come out on a pre-tax basis. To be compliant with IRS regulations, you cannot make mid-year changes to Medical, Dental, Vision, or FSA plans without a qualified life event.

- Marriage or divorce;
- Death of your spouse, or dependent;
- Birth or adoption of a child;
- Your spouse terminating or obtaining new employment (that affects eligibility for coverage);
- You or your spouse switching employment status from full-time to part-time or vice versa (that affects eligibility for coverage);
- Spousal Open Enrollment changes; or
- Your dependent no longer qualifies as an eligible dependent.

Contact Human Resources for a complete explanation of Qualifying Life Events

You must notify and submit any applicable forms and/or documentation to Human Resources within **60 days** of the event. Human Resources will review your request and determine whether the change you are requesting is allowed. Only benefit changes which are consistent with the qualified life event are permitted.

MEDICAL BENEFITS

Administered by Aetna Inc

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Hanover County offers you a choice of three plans: CDHP, Standard, and Premium.

Within the Aetna Inc Network, you and your family members may visit any licensed provider and receive the greatest out-of-pocket savings if you see an OAP provider. If you choose to see an out-of-network provider, you will incur additional out-of-pocket expenses, and you may be billed for the difference in the cost of the services.

The Consumer Driven Health Plan (CDHP) option is a qualified plan for a Health Savings Account (HSA). With an HSA, you are able to set aside pre-tax funds into an account to be used for qualified medical expenses. For more information on how your HSA works, please see the HSA section of this booklet located on page 10.

Prescription coverage is offered through Aetna/CVS Caremark. Additional information on pharmacy benefits can be found at www.aetna.com and www.caremark.com.

	CDHP		Standard		Premium	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual/Family)	$3,200 / $6,400	$4,200 / $8,400	$1,000 / $2,000	$2,000 / $4,000	$500 / $1,000	$1,500 / $3,000
Annual Out-of-Pocket Maximum (Individual/Family)	$4,000 / $8,000	$8,000 / $16,000	$4,000 / $8,000	$8,000 / $16,000	$3,000 / $6,000	$6,000 / $12,000
HSA Contribution (Individual/Family)	$1,450 / $2,800		None		None	
Member Coinsurance	10%	40%	20%	40%	20%	40%
DOCTOR'S OFFICE						
Preventive Care	No Charge	Ded, then 30%	No Charge	Ded, then 30%	No Charge	Ded, then 30%
Primary Care Office Visit	Ded, then 10%	Ded, then 40%	$30 Copay	Ded, then 40%	$25 Copay	Ded, then 40%
Telehealth	$56 copay or less	N/A	$10 Copay	N/A	$10 Copay	N/A
Specialist Office Visit	Ded, then 10%	Ded, then 40%	$70 Copay	Ded, then 40%	$50 Copay	Ded, then 40%
Urgent Care	Ded, then 10%	Ded, then 40%	$75 Copay	Ded, then 40%	$50 Copay	Ded, then 40%
Diagnostic Lab/ Xray services / Advanced Imaging	Ded, then 10%	Ded, then 40%	*Lab/ Xray: 20% Imaging: Ded, then 20%	Ded, then 40%	*Lab/ Xray: 20% Imaging: Ded, then 20%	Ded, then 40%

*Coverage for the Diagnostic Laboratory is deductible then 20% if performed at an outpatient facility and 20%, waive deductible if performed at an independent Lab.

NOTE: Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits.

MEDICAL BENEFITS

Administered by Aetna Inc

	CDHP		Standard		Premium	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
HOSPITAL SERVICES						
Emergency Room	Ded, then 10%	Ded, then 10%	Ded, then 20%	Ded, then 20%	Ded, then 20%	Ded, then 20%
Inpatient Facility	Ded, then 10%	Ded, then 40%	Ded, then 20%	Ded, then 40%	Ded, then 20%	Ded, then 40%
Outpatient Surgery	Ded, then 10%	Ded, then 40%	Ded, then 20%	Ded, then 40%	Ded, then 20%	Ded, then 40%
Ambulance Service	Ded, then 10%	Ded, then 10%	Ded, then 20%	Ded, then 20%	Ded, then 20%	Ded, then 20%
MENTAL HEALTH SERVICES						
Inpatient Services	Ded, then 10%	Ded, then 40%	Ded, then 10%	Ded, then 40%	Ded, then 10%	Ded, then 40%
Outpatient Services	Ded, then 10%	Ded, then 40%	$25 Copay	Ded, then 40%	$25 Copay	Ded, then 40%
OTHER SERVICES						
Maternity Services	Ded, then 10%	Ded, then 40%	Ded, then 20%	Ded, then 40%	Ded, then 20%	Ded, then 40%
Chiropractic Care (30 visits)	Ded, then 10%	Ded, then 40%	$45 Copay	Ded, then 40%	$35 Copay	Ded, then 40%
Physical, Occupational and Speech Therapy Services	Ded, then 10%	Ded, then 40%	$45 Copay	Ded, then 40%	$35 Copay	Ded, then 40%
Routine Eye Exams	$10 Copay	$45 allowance	$10 Copay	$45 allowance	$10 Copay	$45 allowance
PRESCRIPTION DRUGS						
Deductible (Individual / Family)	$3,200 / $6,400*		$50 / $100	Not covered	$50 / $100	Not covered
Out of Pocket Max (Individual / Family)	$4,000 / $8,000*		$3,000 / $6,000		$3,000 / $6,000	
Retail (Administered by Aetna/CVS Caremark)						
Generic Drug	Ded, then $5	Not covered	$5	Not covered	$5	Not covered
Preferred Brand Drug	Ded, then $30	Not covered	$30	Not covered	$30	Not covered
Non-Preferred Brand Drug	Ded, then $50	Not covered	$50	Not covered	$50	Not covered
Specialty	20%, to a $200 max	Not covered	20%, to a $100 max	Not covered	20%, to a $100 max	Not covered
Mail Order						
Generic Drug	Ded, then $10	N/A	$10	N/A	$10	N/A
Preferred Brand Drug	Ded, then $75	N/A	$75	N/A	$75	N/A
Non-Preferred Brand Drug	Ded, then $100	N/A	$100	N/A	$100	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	N/A

NOTE: Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits.

*Combined Medical and Pharmacy Drug Deductible and Out of Pocket Maximum.

DENTAL BENEFITS

Administered by Aetna Inc

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Dental coverage is key to your overall health. Hanover County offers employees two dental plan options through Aetna Inc. Review the details about each plan carefully so you can determine which plan meets your needs. Your dental plans offer choices that cover four main types of expenses:

- Preventative and diagnostic services like routine exams and cleanings, fluoride treatments, sealants, and x-rays
- Basic services such as simple fillings and extractions, root canals, oral surgery, and gum disease treatment
- Major services such as crowns and dentures
- Orthodontia

To find a participating dentist, please visit www.aetna.com.

Services	High Plan	Low Plan
Aetna Network	Dental PPO/PDN with PPO II and Extend	Dental PPO/PDN with PPO II and Extend
Annual Deductible	$50 per person; $150 family	$50 per person; $150 family
Annual Benefit Maximum	$1,500	$1,000
Preventive Dental Services (cleanings, exams, x-rays)	100%; no deductible	100%; no deductible
Basic Dental Services (fillings, root canal therapy, oral surgery)	80% coverage, after the deductible	80% coverage, after the deductible
Major Dental Services (extractions, crowns, inlays, onlays, implants, bridges, dentures, repairs)	50% coverage after the deductible	N/A
Orthodontia Services	50% coverage to $1,500 lifetime maximum per patient	N/A

Dental Out of Network services will be paid at 80th Percentile.

VISION INSURANCE

Administered by Vision Service Plan

Regular eye examinations cannot only determine your need for corrective eyewear but may also detect general health problems in their earliest stages. While Hanover County's Aetna Inc medical plan provides coverage for routine eye exams ($10 copay), the VSP Vision Plan also provides coverage for routine eye exams as well as additional financial assistance for those in need of corrective lenses. Find a Vision Service Plan provider at www.vsp.com.

	In-Network	Out-of-Network
Eye Exam — once every 12 months	$10 copay; $60 Copay (Contact Lenses)	Up to $45
Lenses — once every 12 months		
Lenses and Frames	$25 Copay	N/A
Single Vision Lenses	Covered 100% after copay	Up to $30
Lined Bifocal Lenses	Covered 100% after copay	Up to $50
Lined Trifocal Lenses	Covered 100% after copay	Up to $60
Frames — once every 24 months	$130 allowance, or $150 Featured Frame Allowance	Up to $50
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames	$130 allowance plus 20%-25% savings on lens enhancements (Elective). Medical Necessity - Covered 100%	Elective Contact Lenses - Up to $100 Medical Necessity - Up to $210

EMPLOYEE SEMI-MONTHLY CONTRIBUTIONS

Aetna Medical - Rates				EMPLOYEE RESPONSIBILITY
PREMIUM PLAN	**TOTAL MONTHLY PREMIUM**	**EMPLOYER MONTHLY SHARE**	**EMPLOYEE MONTHLY SHARE**	**EMPLOYEE SEMI-MONTHLY SHARE**
Employee	$1,068.00	$951.00	$117.00	$58.50
Employee + Child	$1,614.00	$1,239.00	$375.00	$187.50
Employee + Spouse	$2,174.00	$1,429.00	$745.00	$372.50
Employee + 2 Children	$2,151.00	$1,530.00	$621.00	$310.50
Employee + Family	$3,016.00	$2,092.00	$924.00	$462.00
Married Employee Family Both spouses work for Hanover	$3,016.00	$2,298.00	$718.00	$359.00
STANDARD PLAN				
Employee	$704.00	$660.00	$44.00	$22.00
Employee + Child	$1,061.00	$902.00	$159.00	$79.50
Employee + Spouse	$1,428.00	$1,086.00	$342.00	$171.00
Employee +2 Children	$1,413.00	$1,107.00	$306.00	$153.00
Employee + Family	$1,982.00	$1,515.00	$467.00	$233.50
Married Employee Family Both spouses work for Hanover	$1,982.00	$1,721.00	$261.00	$130.50
Consumer Driven Health Plan w/H.S.A.				
Employee	$603.00	$577.00	$26.00	$13.00
Employee + Child	$912.00	$789.00	$123.00	$61.50
Employee + Spouse	$1,225.00	$921.00	$304.00	$152.00
Employee + 2 Children	$1,212.00	$959.00	$253.00	$126.50
Employee + Family	$1,701.00	$1,325.00	$376.00	$188.00
Married Employee Family Both spouses work for Hanover	$1,701.00	$1,531.00	$170.00	$85.00
VSP Vision - Rates				
	TOTAL MONTHLY PREMIUM	**EMPLOYER MONTHLY SHARE**	**EMPLOYEE MONTHLY SHARE**	**EMPLOYEE SEMI-MONTHLY SHARE**
Employee	$4.60	$0.00	$4.60	$2.30
Employee + 1 Child	$9.20	$0.00	$9.20	$4.60
Employee + Spouse	$9.20	$0.00	$9.20	$4.60
Employee + 2 Children	$9.30	$0.00	$9.30	$4.65
Employee + Family	$14.82	$0.00	$14.82	$7.41
Aetna Dental - Rates				
Aetna Low Option	**TOTAL MONTHLY PREMIUM**	**EMPLOYER MONTHLY SHARE**	**EMPLOYEE MONTHLY SHARE**	**EMPLOYEE SEMI-MONTHLY SHARE**
Employee	$25.72	$0.00	$25.72	$12.86
Employee + 1 Child	$57.86	$0.00	$57.86	$28.93
Employee + Spouse	$51.44	$0.00	$51.44	$25.72
Employee + 2 or More Children	$57.86	$0.00	$57.86	$28.93
Employee + Family	$83.58	$0.00	$83.58	$41.79
Aetna High Option				
Employee	$36.74	$0.00	$36.74	$18.37
Employee + 1 Child	$82.66	$0.00	$82.66	$41.33
Employee + Spouse	$73.47	$0.00	$73.47	$36.74
Employee + 2 or More Children	$82.66	$0.00	$82.66	$41.33
Employee + Family	$119.39	$0.00	$119.39	$59.70

HOW YOU CAN SAVE ON YOUR MEDICAL EXPENSES?

HEALTH SAVINGS ACCOUNT

Administered by Maestro

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan (CDHP) in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you. Hanover will contribute to your health savings account a total of $1,450 individual and $2,800 family in two installments in 2024 (on 1/15 and 7/15). New hires will receive a pro-rated amount based on their hire date with a different installment date(s).

Health Savings Account	
Use for:	Medical expenses, copays, deductibles, orthodontia, over-the-counter medications, etc.
Annual contribution limits	Maximum of $4,150 Individual Maximum of $8,300 Family *$1,000 catch up if over the age of 55

FLEXIBLE SPENDING ACCOUNT

Administered by Maestro

FSAs help you save money by allowing you to pay for certain types of health care and dependent care expenses on a pre-tax basis. You decide how much money to put aside each payday to cover these expenses up to the maximum. The IRS requires you to re-enroll each year. This is not automatically done and is required in order to receive the rolled over amount of up to $640 from your 2024 Medical FSA plan into your 2025 Medical FSA plan. This amount is then deducted from your pay before taxes and deposited into your FSA. When you need money to cover an eligible expense, you can get reimbursed using a variety of reimbursement methods. Remember to always keep your receipts.

Medical Spending Account	
Use for:	Copays, deductibles, orthodontia, and other IRS covered expenses
Annual contribution limit	Maximum of $3,200
Dependent Care Spending Account	
Use for:	Daycare, nursery school, elder care expenses, etc.
Annual contribution limit	Maximum of $5,000

IMPORTANT: USE IT OR LOSE IT!

According to IRS rules, any money remaining in a Medical or Dependent Care Spending Account after the deadline for filing claims will be forfeited. If you have money left in your Medical FSA at the end of 2023, you may carry over up to $610 for use in 2024 if you re-enroll in the next plan year. The money you carry over doesn't count against the IRS annual contribution maximum, which means you can start the year with an amount $610 greater than the IRS limit in your Medical FSA. You can use the amount throughout the 2024 plan year. This rule applies each subsequent calendar year. This does not apply to the Dependent Care FSA.

WELLNESS PROGRAMS

HANOVER COUNTY EMPLOYEE HEALTH CLINICS

Administered by Marathon Health

Effective January 2024, Hanover is proud to partner with Marathon Health for our employee health clinic. Marathon Health is one of the industry's leading providers of employer-sponsored healthcare, and they provide members with convenient, confidential, and high-quality care.

Employees, their spouses, and their dependent children will have access to three employee health clinics within the Marathon Health Network. Their services include advanced primary care, preventative care, occupational health, health coaching, chronic condition management, laboratory, medication management, behavioral health and more. Those covered by the Hanover Premium or Standard health insurance plans may be seen with $0 copay. Those covered by The Hanover HDHP plan may be seen with a $25 fee. Those with other health insurance plans may be seen with a copay based on their plan.

HANOVER COUNTY WELLNESS FINANCIAL INCENTIVE PROGRAM

Administered by Aetna Inc

Employees and spouses who enroll in a Hanover County medical plan may participate in the Hanover County Wellness Financial Incentive Program at no cost. The program is administered through Aetna Inc using their wellness platform and encourages participants to take actions towards good health, such as routine preventative screenings, health checks, and healthy lifestyle behaviors.

By participating in this confidential and valuable health improvement program, employees have the opportunity to earn up to $300 (employee only) or $600 (employee plus spouse) per year. All incentives will be paid via direct deposit (subject to payroll taxes) regardless of the type of Hanover health insurance plan selected.

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or your Human Resources Department.

BENEFIT	WHO TO CALL	WEBSITE	PHONE NUMBER
Human Resources	County/Library: Amy Ash	Jail/County/Library: https://www.hanovercounty.gov/1216/Benefit-Information	804-365-6542
	Schools: Candra Kenyon Wendy Owens	School: https://hcps.us/departments/human_resources/benefits_compensation	804-365-4580 804-365-4590
	Jail: Sarah Garrison Mayra Ramirez	Jail/County/Library: https://www.hanovercounty.gov/1216/Benefit-Information	804-537-6400 x3055 804-365-6400 x 3004
	Wellness: Jami Zanetta	Wellness: https://c2mb.ajg.com/hanovercounty/home/	804-365-7118
Medical	Member Services	www.aetna.com	833-732-1971
Prescription Drug	Member Services	www.aetna.com	833-732-1971
Dental	Member Services	www.aetna.com	833-732-1971
Vision	Member Services	www.vsp.com	800-877-7195
Flexible Spending Accounts	Maestro	https://msave.maestrohealth.com/Page/Home	888-488-5054
Health Savings Account	Maestro	https://msave.maestrohealth.com/Page/Home	888-488-5054
Empower Retirement Plan	Empower	https://participant.empower-retirement.com/participant/#/login	800-701-8255

GLOSSARY

Affordable Care Act and Patient Protection (ACA)
Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

Brand Name Drug
The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Coinsurance
A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)
A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible
The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Employer Contribution
The amount of money the employer provides to your benefit and the amount depends on who you cover.

Generic Drug
Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

Consumer Driven Health Plan (CDHP)
Consumer Driven Health Plans (CDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a Health Savings Account (HSA).

Health Savings Account (HSA)
A Health Savings Account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you.

Out-of-Pocket Maximum
The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Plan Year
The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preventive Care
Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Legal Notices

PATIENT PROTECTIONS DISCLOSURE

The Hanover County Health Plan generally allows 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 Aetna Inc 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 Aetna Inc at 833-732-1971 or www.aetna.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Aetna Inc 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 Aetna Inc at 833-732-1971 or www.aetna.com.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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 applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: CDHP (Individual: 10% coinsurance and $3,200 deductible; Family: 10% coinsurance and $6,400 deductible)

Plan 2: Standard (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)

Plan 3: Premium (Individual: 20% coinsurance and $500 deductible; Family: 20% coinsurance and $1,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 804-365-6075.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Legal Notices

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 July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-54477	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/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	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=enUS 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

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NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – 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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP)Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Legal Notices

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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)

Legal Notices

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
Hanover County is committed to the privacy of your health information. The administrators of the Hanover County Health Plan (the "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. You may receive a copy of the Notice of Privacy Practices by contacting Catherine Dickensheets at 804-365-6075.

HIPAA SPECIAL ENROLLMENT RIGHTS

Hanover County Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Hanover County Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by 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 your new dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Catherine Dickensheets at 804-365-6075.

Legal Notices

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above.
If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Legal Notices

NOTICE OF CREDITABLE COVERAGE

Important Notice from Hanover County

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 Hanover County 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. **Hanover County has determined that the prescription drug coverage offered by the medical 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 Hanover County coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Hanover County coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Hanover County 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 Hanover County changes. You also may request a copy of this notice at any time.

Legal Notices

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:	**January 01, 2024**
Name of Entity/Sender:	**Hanover County**
Contact—Position/Office:	**Catherine Dickensheets**
Office Address:	**7515 Library Drive** **Hanover, VA 23069** **United States**
Phone Number:	**804-365-6075**

Legal Notices

WELLNESS PROGRAM DISCLOSURES

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. Contact us at Aetna and 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.

NOTICE REGARDING WELLNESS PROGRAM

The Hanover County wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness financial incentive program will receive an incentive for completing initiatives such as routine preventative screenings, health checks, and healthy lifestyle behaviors. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive up to $300 (employee only) or $600 (employee plus spouse) per year. Incentives are available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Aetna. The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness financial incentive program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Hanover County may use aggregate information it collects to design a program based on identified health risks in the workplace, Aetna will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) you in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Catherine Dickensheets at 804-365-6075.

Legal Notices

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

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, 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."

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Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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: Catherine Dickensheets.

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/**.

Legal Notices

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 Medicare initial enrollment period, you have an 8-month special enrollment period[1] 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

Hanover County
Catherine Dickensheets
7515 Library Drive
Hanover, VA 23069
United States
804-365-6075

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

Legal Notices

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact Hanover County Human Resources for more information. Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

This benefit summary prepared by