2020 EMPLOYEE BENEFITS

CONTENTS

YOUR BENEFITS PROGRAM

The City of Horn Lake's most important asset is our people. That's why we offer you an exceptional benefits program with many options, designed to meet your needs and the needs of your family. In this booklet you will find summaries of City of Horn Lake's medical, dental, vision, basic life and AD&D, voluntary life, disability, voluntary accident, voluntary critical illness, flexible spending account and pet insurance plans.

This booklet contains important information about your benefits. Please take the time to review it and share the information with your family.

CLAIM QUESTIONS OR ISSUES

McGriff Insurance Services is the advisory firm representing City of Horn Lake. We have a team of account managers to help you resolve any problems you have with your employee benefits. If you have a problem or a question about a claim:

1

Call your insurance carrier's customer service department. Phone numbers can be found on your ID cards and on page **11** of this booklet.

2

If the carrier does not resolve your problem, contact Pam Coley at **901.684.3287** or pam.coley@mcgriffinsurance.com

3

If you are still not satisfied after steps 1 and 2, please contact Human Resources at City of Horn Lake.

BENEFITS ELIGIBILITY

Full-time employees working 30 or more hours per week are eligible for benefits on the first of the month following 30 days of employment.

Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian.

You can enroll the following dependents in our group benefit plans:

- Your legal spouse **(If your spouse is eligible for medical insurance through his/her employer, then he/she is not eligible to be on the City's plan. An affidavit will need to be completed stating your spouse does not have another medical option for he/she to be on the City's medical plan.)**
- Children under age 26 no matter marital or student status
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

Other dependents who may live with you, but are NOT eligible to be added to your benefit plans:

- Grandchildren, nieces, nephews or other children who do not meet specifications listed above
- Common law spouses or domestic partners (same or opposite sex)
- Ex-spouses
- Parents, step-parents, grandparents, aunts, uncles, or other relatives who are not qualified legal dependents (even if they live in your house)

MAKING CHANGES TO YOUR BENEFITS

Most benefit deductions are withheld from your paycheck on a pre-tax basis (medical, dental, vision) and therefore your ability to make changes to these benefits is restricted by the IRS. Once enrolled, most pre-tax benefit elections cannot be changed until the next annual Open Enrollment period, unless you have a qualifying life status change.

To make benefit changes as a result of a Life Status Change as allowed under Section 125 of the IRS Code, you must:

- Notify Human Resources within 30 days* of the date of the qualifying event
- Provide proof of your life status event
- Complete the enrollment form and return to your HR department

*Refer to your Plan Administrator as some events may allow for up to 60 days

The Most Common Life Status Changes

- Marriage, divorce, legal separation
- Birth or adoption
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order or other court order

MEDICAL BENEFITS

City of Horn Lake offers a medical plan with UnitedHealthcare.

Your Health Partner

Access the UHC website at www.myuhc.com to search for doctors and facilities.

UnitedHealthcare®

MEDICAL BENEFITS	UHC MEDICAL PLAN
In Network Deductibles (Individual/Family)	$2,000/$4,000
Coinsurance (In Network)	Plan pays 80%, employee pays 20% after deductible
Out-of-Pocket Maximum (Individual/Family)	$5,000/$10,000
Office Visits ▪ Preventive Care ▪ Primary Care Physician ▪ Specialist Physician ▪ Virtual Visit ▪ Urgent Care	 Plan pays 100% $40 copay $60 copay $10 copay $30 copay
Inpatient Services	Employee pays 20% after deductible
Outpatient Services	Employee pays 20% after deductible
Emergency Room	Employee pays 20% after deductible
Prescription Drug ▪ Tier 1—Retail Pharmacy ▪ Tier 2—Retail Pharmacy ▪ Tier 3—Retail Pharmacy ▪ Mail Order (90-day limit) Tiers 1/2/3	 $15 copay $35 copay $75 copay $45/$105/$225

WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to Doctor On Demand for virtual visits.

	Conditions Treated*	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	▪ Sudden numbness, weakness ▪ Uncontrolled bleeding ▪ Seizure or loss of consciousness ▪ Shortness of breath ▪ Chest pain ▪ Head injury/major trauma ▪ Blurry or loss of vision ▪ Severe cuts or burns ▪ Overdose	▪ Costs are highest ▪ No appointment needed ▪ Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	▪ Minor cuts, sprains, burns, rashes ▪ Fever and flu symptoms ▪ Headaches ▪ Chronic lower back pain ▪ Joint pain ▪ Minor respiratory symptoms ▪ Urinary tract infections	▪ Costs are lower than an ER visit ▪ No appointment needed ▪ Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	▪ General health issues ▪ Preventive services ▪ Routine checkups ▪ Immunizations and screenings	▪ May include coinsurance and/or deductible ▪ Appointment usually needed ▪ May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	▪ Common cold/flu ▪ Rashes or skin conditions ▪ Sore throat, earache, sinus pain ▪ Minor cuts or burns ▪ Pregnancy testing ▪ Vaccinations	▪ Costs are same or lower than office visit ▪ No appointment needed ▪ Wait times typically 15 minutes or less
Virtual Visits		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app.	▪ Cold and flu symptoms such as a cough, fever and headaches ▪ Allergies ▪ Sinus infections ▪ Family health questions	▪ Costs can be lower than an office visit ▪ No appointment needed ▪ Immediate, private, and secure visits

*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

DENTAL BENEFITS PROVIDED THROUGH UNITEDHEALTHCARE

Finding a Provider

UHC'S online directory makes it easy to find in-network dentists. Just follow these easy steps:

- Visit www.myuhc.com
- Search for a PPO network provider by location

To find out if your dentist is in-network, call 877-816-3596.

It's About More Than a Pretty Smile

Our oral health affects our ability to speak, smell, taste, chew, and swallow. However, oral diseases, which can range from cavities to oral cancer, cause pain and disability for millions of people each year.

Visit Your Dentist Regularly

Regular preventive visits to your dentist can help protect your health, and we are talking about more than just your mouth. Recent studies have linked gum disease to damage elsewhere in the body. According to the Centers for Disease Control and Prevention, there may be associations between oral infections and diabetes, heart disease, stroke, and preterm, low-weight births. Research is underway to further examine these connections.

Our plan covers preventive services at 100% with no deductible for preventive services.

DENTAL BENEFITS	NETWORK	NON-NETWORK
Calendar Year Deductible	$50 individual $150 family	$50 individual $150 family
Preventive Services Oral exams, dental cleanings, X-rays, fluoride treatments, sealants, etc.	100% no deductible	100% no deductible
Basic Services Fillings, simple oral surgery, anesthesia	80% after deductible	80% after deductible
Major Services Crowns, inlays, onlays, bridges, dentures, endodontics, periodontics	50% after deductible	50% after deductible
Orthodontia Children through age 18 up to $1,000 lifetime maximum	50% no deductible	50% no deductible
Maximum Annual Benefit (Per individual per calendar year)	$1,000	$1,000

VISION CARE PROVIDED THROUGH UNITEDHEALTHCARE

Humana members can take care of their vision and have routine eye exams, while saving money on all of their eye care needs. To start using your benefit, visit www.myuhcvision.com to find a provider or call 800-638-3120.

Did you know?

Taking care of your vision can also mean early detection for symptoms of:

- Diabetes
- Hypertension
- High cholesterol
- Tumors
- Thyroid disorders
- Neurological disorders

A qualified vision care professional can help treat and manage:

- Cataracts
- Corneal diseases
- Diabetic retinopathy
- Eye infections
- Glaucoma
- Macular degeneration

	IN-NETWORK	OUT-OF-NETWORK
Exam	$10 copay	Up to $40
Standard Plastic Lenses ▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	$25 copay	 Up to $40 Up to $60 Up to $80 Up to $80
Frames	$130 allowance, 30% off balance over $130	Up to $45
Contact Lenses* ▪ Conventional ▪ Medically necessary	 $130 allowance Covered in full after copay (if applicable)	 $105 allowance $210 allowance
Frequency ▪ Examination ▪ Frames ▪ Lenses and Contact Lenses	 Once every 12 months Once every 24 months Once every 12 months	 Once every 12 months Once every 24 months Once every 12 months

*Contacts are in lieu of lenses and frames benefits.

BASIC LIFE AND AD&D, VOLUNTARY LIFE INSURANCE

Basic Life and AD&D

City of Horn Lake provides all employees a benefit equal to $30,000 of basic employee life and accidental death and dismemberment insurance and pays for the **full cost of coverage** through MetLife This benefit reduces by 33% at age 65 and 50% at age 70. Please contact HR if you would like to update your beneficiary information.

Voluntary Life Insurance

In addition to the insurance provided at no cost by City of Horn Lake, you can purchase additional voluntary life coverage for yourself, and additional life for your spouse and child(ren) through MetLife. You must purchase employee coverage to be able to purchase coverage for your spouse and/or child(ren).

Will Prep Services

MetLife offers valuable legal resources through Hyatt Legal Plans to assist you with creating or updating a binding will at no additional cost. Simply call Hyatt Legal Plans 1-800-821-6400.

MetLife

EMPLOYEE VOLUNTARY LIFE
$10,000 increments to $500,000 maximum (not to exceed 5 times your annual salary.) Guarantee Issue: $130,000
SPOUSE VOLUNTARY LIFE
50% of employee amount in increments of $5,000 to $100,000 maximum but cannot exceed 50% of the employee's benefit. Guarantee Issue: $50,000
CHILD VOLUNTARY LIFE
You may purchase $1,000, $2,000, $4,000, $5,000 or $10,000 worth of life insurance for your dependent children.

VOLUNTARY SHORT–TERM DISABILITY

PROVIDED THROUGH METLIFE

Your short-term disability (STD) insurance provides coverage of 60% of gross wages up to a maximum of $1,000 per week for a qualified disability. You may select units of $50 with a minimum election of $100.

- Benefits begin on the 15th day after your injury of 15th day of sickness. Your benefit could continue for up to 11 weeks, but will cease when you are able to return to work.

Some exclusions and pre-existing benefits may apply.

Your Cost for Coverage

The cost for disability coverage is based on your salary and/or age and will be calculated when you make your benefit elections.

VOLUNTARY ACCIDENT INSURANCE

This is a voluntary accident off the job insurance policy. Benefits are paid directly to you to be spent any way you choose when a covered injury results directly and independently of all other causes from a covered accident. There are no health questions or pre-existing condition limitations. If you elect coverage for yourself, you can elect coverage for your eligible family members. This benefit also contains a $50 Wellness benefit.

MetLife

VOLUNTARY CRITICAL ILLNESS INSURANCE

Critical Illness insurance pays a fixed benefit upon initial diagnosis of a covered critical illness. Benefits are payable directly to you to be spent any way you choose. It provides flexible coverage options to meet your individual needs. You may elect coverage for yourself in units of $5,000 up to $15,000. If you elect coverage for yourself, you can elect coverage for your family members. Your spouse and children are eligible for 50% of the employee benefit. There is a 3/6 month pre-existing clause to this benefit, and it is portable. This benefit also contains a $50 Wellness benefit. Critical Illness insurance is based on age and income and will be calculated when you make your benefit elections.

Current covered conditions include: Alzheimer's, Coronary Artery Bypass Graft, Full Benefit Cancer, Partial Benefit Cancer, Heart Attack, Kidney Failure, Major Organ Transplant, and Stroke.

PET INSURANCE

Pet Insurance is offered through Nationwide for cats or dogs. You can get coverage through payroll deduction for everything from everyday care to serious illness with **My Pet Protection** or **My Pet Protection with Wellness** with a 90% reimbursement after a $250 annual deductible. To obtain information on the coverage and to enroll in the plan, go to the website https://eb8.petinsurance.com/companysearch, then put in City of Horn Lake and answer the questions.

Cost Per Paycheck	My Pet Protection Dogs	My Pet Protection with Wellness Dogs	My Pet Protection Cats	My Pet Protection with Wellness Cats
Mississippi	$18.63	$31.14	$11.18	$18.68
Arkansas	$17.53	$29.31	$10.52	$17.59
Tennessee	$20.82	$34.80	$12.49	$20.88

FLEXIBLE SPENDING ACCOUNT

For the 2020 plan year, DataPath will be the City of Horn Lake's FSA Administrator. There are a variety of benefits of using an FSA, including the following:

It saves you money. Allows you to put aside money tax-free that can be used for qualified medical expenses.

It's a tax-saver. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

It is flexible. You can use your FSA funds at any time, even if it's the beginning of the year. Your FSA plan year is from 01/01 – 12/31.

Rollover Provision At the end of the current plan year, up to $500 of unused funds in your Health Care Flexible Spending Account may be rolled over into the subsequent plan year. After the end of the plan year, you may submit expenses for reimbursement prior to the claims filing deadline of April 15th. Any eligible expenses properly submitted prior to the claims filing deadline will be paid to the amount of your rollover being finalized. Any amount remaining in your Health Care FSA in excess of $500 at the end of the plan year and after the claims filing deadline will be forfeited to Proliant in the same manner your entire healthcare FSA balance was subject to forfeiture under the prior governing rules of the Plan. The rollover provisions do not apply to unused funds in your dependent care FSA.

EXAMPLES OF ELIGIBLE EXPENSES

Healthcare FSA	Dependent Care FSA
Deductibles (medical or dental)	Nursery School and Child Care Center Fees
Copayments (medical, Rx, Dental, vision)	In-Home Child Care Expenses
Eyeglasses, Contacts	After School Care
Hearing Devices	Adult Day Care
Breast Pumps and Accessories	Disabled or Elderly Care Expenses
Insulin Supplies	
Orthodontia	

BENEFITS COSTS

Per Paycheck				
	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
MEDICAL	You Pay $0 COHL Pays $193.34	You Pay $147.31 COHL Pays $326.13	You Pay $103.60 COHL Pays $248.88	You Pay $259.18 COHL Pays $314.53
DENTAL	You Pay $2.07 COHL Pays $5.34	You Pay $9.63 COHL Pays $6.10	You Pay $14.81 COHL Pays $9.16	You Pay $22.43 COHL Pays $7.38
VISION	You Pay $0.64 COHL Pays $1.74	You Pay $3.44 COHL Pays $1.58	You Pay $4.36 COHL Pays $1.52	You Pay $7.34 COHL Pays $1.33
BASIC LIFE/AD&D	Paid by City of Horn Lake	N/A	N/A	N/A
VOLUNTARY LIFE	Rate Chart Below	Rate Chart Below	Rate Chart Below	Rate Chart Below

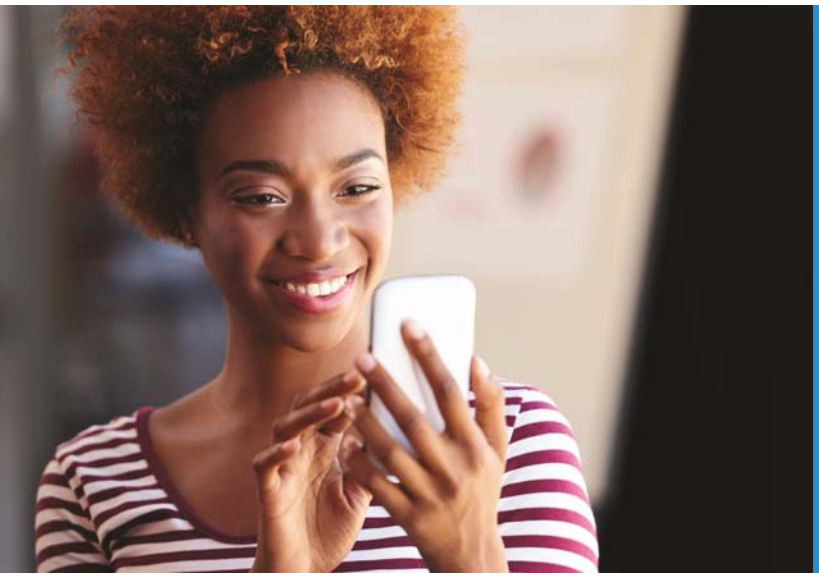
Employee Age	Employee & Spouse Coverage – Bi-Weekly Premium For Voluntary Life Insurance *Spouse Premium is Based on Employee's Age*					
	$1,000	$10,000	$20,000	$40,000	$50,000	$100,000
Under 30	$0.05	$.49	$.99	$.91	$1.14	$2.28
30-34	$0.05	$.49	$.99	$.91	$1.14	$2.28
35-39	$0.06	$.66	$1.33	$2.66	$3.32	$6.65
40-44	$0.11	$1.04	$2.08	$4.15	$5.19	$10.38
45-49	$0.15	$1.54	$3.08	$6.15	$7.68	$15.37
50-54	$0.24	$2.42	$4.84	$9.67	$12.09	$24.18
55-59	$0.42	$4.13	$8.26	$16.52	$20.65	$41.31
60-64	$0.46	$4.59	$9.18	$18.37	$22.96	$45.92
65-69	$.51	$5.05	$10.12	$20.23	$25.29	$50.58
70+	$.69	$6.91	$13.82	$27.64	$34.55	$69.09

Dependent Child Life Insurance Coverage Monthly Premium for:	
$1,000	$0.11
$2,000	$0.21
$4,000	$0.43
$5,000	$0.53
$10,000	$1.06

Bi-Weekly Payroll Deductions For Voluntary Accident Insurance	
Employee Only	$5.51
Employee + Spouse	$9.61
Employee + Children	$11.30
Employee + Spouse/Children	$14.15

YOUR BENEFIT RESOURCES

	PHONE	WEB/EMAIL
Medical - UnitedHealthCare	866.633.2446	www.myuhc.com
Dental - UnitedHealthCare	877.816.3596	www.myuhc.com
Vision - UnitedHealthCare	800.638.3120	www.myuhc.com
Basic Life & AD&D Insurance, Voluntary Life, Disability, Critical Illness and Accident Benefits—MetLife	800.275.4638	www.metlife.com
Flexible Spending Account - DataPath	877.685.0655	www.dpath.com
Pet Insurance - Nationwide	877.738.7874	https://poi8.petinsurance.com/benefits/the-city-of-horn-lake
Arianne Linville - **COHL HR**	662.342.3482	alinville@hornlake.org
Pam Coley - **McGriff Insurance Services**	901.684.3287	pam.coley@mcgriffinsurance.com



INSURANCE COMPANY WEBSITES AND APPS

Registering on your insurance company websites and downloading the smart phone apps gives you instant access to valuable resources. In most cases you can access:

- Specific plan details
- ID cards
- In-network provider search
- Your claims history
- And other tools and resources

TERMS TO KNOW

Deductible - Amount an employee pays out of pocket prior to the insurance company paying a percentage of the provider charges.

Coinsurance - The amount of payment split between the employee and the insurance company. Example: Insurance company pays 80% and employee pays 20% of the charges after the deductible is met.

Out of Pocket Maximum - The maximum an employee is responsible for paying out of pocket in any one calendar year prior to the insurance company paying the entire eligible amount for the remaining of the calendar year.

Network Providers - Doctors, Hospitals and other healthcare providers who have an agreement/ contract with insurance companies agreeing to charge a discounted amount for services they render.

Pre-Authorization - Certain procedures or hospitalizations may require that the provider receive authorization. The provider is typically the one to go through this process with the insurance company and obtain pre-authorization.

Pre-Determination - If you are having a major procedure done, your doctor or dentist can submit a pre-determination to the insurance company so you can know in advance of treatment how much of the bill you will be responsible for.

Explanation of Benefits (EOB) - The EOB is mailed to the employee after a claim is received and processed by the insurance company. The EOB will describe how the claim was processed and outline what portion of the charges are applied to the deductible, what portion the employee is responsible for, and explain if there is a denial or error processing the claim.

Appeal - If your health insurance company doesn't pay for a specific health care provider or service, you have the right to appeal the decision and have it reviewed by an independent third party.

Guaranteed Issue - The maximum amount of voluntary life insurance you can choose when making your initial election that does not require the answering of medical questions.

Evidence of Insurability (EOI) - The form containing medical questions that are required to be answered if you decide to elect voluntary life insurance after you have previously declined coverage, or if you decide to increase your current coverage. This may also be needed if you decide to add disability coverage after you have previously declined.

Important Notices - 2020

There are several important notices in this guide that the **City of Horn Lake Health and Welfare Plan** (referred to as the "Plan"), as sponsored by **City of Horn Lake** (referred to as the "Company") is required to provide to employees. Please be sure to review these notices and contact Human Resources with any questions.

The notices included are:

1. **Medicare Part D Disclosure Notice**
2. **The Women's Health and Cancer Rights Act of 1998 (WHCRA) Notice**
3. **Newborns' Act Health Disclosure**
4. **Special Enrollment Notice**

1. 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 **City of Horn Lake** 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.

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).

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Company has determined that the prescription drug coverage offered by the Plan, 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 coverage through the Company will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits, and this Plan will coordinate with Medicare Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage through the Company, be aware that you will also drop coverage for other health expenses and that you and your dependents may not be able to get this coverage back until an Open Enrollment period or you experience a qualifying event.

You can retain your existing coverage and elect not to enroll in a Medicare Part D prescription drug plan. 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 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 through the Company and do not 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 the Company changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov;
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help; or
- 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).

Date:	**January 1, 2020**
Name of Entity/Sender:	**City of Horn Lake**
Contact-Position/Office:	**Arianne Linville, Human Resources Director**
	3101 Goodman Road West
Address:	**Horn Lake, MS 38637**
Phone Number:	**662-342-3482**

2. *Women's Health and Cancer Rights Act of 1998 (WHCRA) Notice*

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 this plan. Contact your plan administrator at **662-342-3482** for more information.

3. *Newborns' Act Disclosure*

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

4. *Special Enrollment Notice*

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

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

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer of your request of enrollment in writing within 30 days of the date coverage ends, you and your eligible dependents may be eligible to enroll in coverage under our health plan.

Marriage, Birth or Adoption

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. However, you must request enrollment within 30 days after the marriage, birth or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

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.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

To request special enrollment or obtain more information, contact: **Arianne Linville | 662-342-3482 | alinville@hornlake.org**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Arianne Linville @ 662-342-3482.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
City of Horn Lake	64-0536486
5. Employer address	**6. Employer phone number**
3101 Goodman Road West	662-342-3482

7. City	8. State	9. ZIP code
Horn Lake	MS	38637

10. Who can we contact about employee health coverage at this job?	
Arianne Linville	
11. Phone number (if different from above)	**12. Email address**
	alinville@hornlake.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are:

    As defined by plan.

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    As defined by plan.

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
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	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
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 71	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	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
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

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-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.

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