2021-2022

Employee Benefit Guide

Contents

Your Benefits Package

Please review this guide to learn about the benefit options available to you, so you can make informed decisions about your benefits for 2021-2022. When you make well-informed decisions, you can help reduce your out-of-pocket health care costs, and help control the rising costs of health care premiums.

This Benefit Summary does not provide all of the details about all of the benefit programs. Additional information is available in each program's Certificate of Coverage (COC). The COC's are available by request from the Human Resources Department.

This brochure summarizes the coverage that is available during the upcoming 2021-2022 plan year. If you have any questions, please contact Human Resources. Additional carrier contact information is shown at the end of this guide.

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Welcome

Eligibility

The City of Horn Lake is committed to providing a health care benefits program that offers choices and competitive coverage for you and your family If you are an active, full-time employee working, you are eligible to enroll in the benefits descried in this guide. The following family members are eligible for Medical, Dental, Vision coverage:

- Legal Spouse *(If you 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 in order to be on the City's medical plan)*
- Child(ren) up to age 26 regardless of student or marital status. *Extended coverage may be available for children with special needs. Please see policy for details.*

New Hires

Benefits begin on the 1st of the month following 30 days of employment.

Qualifying Events

Under IRS Section 125 regulations after your Initial / Annual Enrollment period is closed, you cannot make changes to the benefits you elect / waive until the next annual enrollment period unless you experience a qualifying event. Events falling within the following categories are considered qualifying events:

- Marriage, divorce, death of spouse, legal separation, or annulment
- Birth, adoption, placement for adoption, death, qualified medical child support order (QMCSO), or dependent ceases to satisfy eligibility requirements
- Employee or spouse termination / commencement of employment
- Change from part-time to full-time

In order to be eligible to make changes, you must notify HR within 30 days of a qualifying event.

Medical & Prescription Drugs

We are committed to providing you with comprehensive medical benefits to meet your needs. This section will provide a brief summary of our medical plan. With any plan you can visit the physician of your choice, however, if you visit an out-of-network physician in addition to a higher deductible and coinsurance, you may also be balance billed. To find providers in the UHC Network, Choice Plus, see the instructions on the following page to look up providers. **Please note that Baptist East in Memphis is an out of Network Hospital.**

Costs for coverage are paid through pre-tax payroll deductions. By paying on a pre-tax basis, your cost is lower because the earnings you use to pay premiums are not subject to federal tax withholding or Social Security (FICA) taxes. For greater detail on each of the plans listed, please refer to the summary plan descriptions.

UHC Medical Plan		
Plan Features	**In-Network**	**Out-Of-Network**
Calendar Year Deductible	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Coinsurance	70/30%	60/40%
Out-of-Pocket Maximum (includes deductible and all copays except Rx copays)	$6,000 Individual $12,000 Family	$12000 Individual $24,000 Family
Primary Physician Office Visit **PCP – Children under age 19**	$25 copay No Copay	Employee pays 40% after deductible
Specialist Physician Office Visit	$45 copay	Employee pays 40% after deductible
Virtual Visit	No Copay	Not Covered
Preventive Care Services	Plan pays 100%	Not covered
Hospital/Emergency Room/Urgent Care		
Inpatient	Employee pays 30% after deductible	Employee pays 40% after deductible
Outpatient	Employee pays 30% after deductible	Employee pays 40% after deductible
Emergency Room Charges	Employee pays 30% after deductible	
Urgent Care	$50 Copay	Employee pays 40% after deductible
Pharmacy		
Retail (up to a 30-day supply) Generic/Formulary/Non-Formulary	$15/ $35 / $75 copay	$15/ $35 / $75 copay
Mail Order (up to 90-day supply) Generic/Formulary/Non-Formulary	$45 / $105 / $225 copay	Not covered

This is a summary of benefits for informational purposes only. Please refer to the Carrier Certificate of Coverage for complete terms of coverage and eligibility.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to **welcometouhc.com > Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to **welcometouhc.com > Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With **myuhc.com®,** you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.

Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

UnitedHealthcare

Dental

Dental Benefits are provided through United Healthcare. Dental care may be obtained from any dental provider; however choosing dental services from a dentist participating in-network will provide you with substantial savings. UHC's online directory makes is easy to find in-network dentals. Visit www.myuhc.com and search for a PPO network provider by location You can also call 877-816-3596 for help in finding a dentist in-network. Please note that out of networks dentist may also balance bill you for amounts over the allowed charges. Our plan covers preventive services at 100% with no deductible.

UnitedHealthcare®

UHC Dental Plan		
	In-Network	Out of Network
Annual Deductible Individual Family	 $50 $150	 $50 $150
Annual Plan Maximum	$1,000 per member	
Preventive Services *Exams, cleanings, X-rays*	100% deductible waived	100% deductible waived
Basic Services *Fillings, simple extractions*	80% after deductible	80% after deductible
Major Services *Oral surgery, root canal, crowns*	50% after deductible	50% after deductible
Orthodontia *Deductible does not apply* *Children through age 18*	50% to a $1000 Lifetime Maximum	

Vision

The Vision Plan offers you and your family a comprehensive vision program that reduces the cost of eye exams, eyeglasses and contact lenses. You can obtain products or services through any provider you choose, although you'll generally pay less with in-network providers. To search for UHC Providers visit myuhcvision.com or call 800-638-3120 for assistance

UnitedHealthcare®

UHC Vision Plan		
	In-Network	Out of Network
Exam Copay	$10 Copay	
Frequency		
Eye Exam	Once every 12 Months	
Lenses – Eyeglasses or Contact	Once every 12 Months	
Frames	Once every 24 Months	
Eyeglass Lenses & Frames		
Single Lenses	$25 Copay	Up to $40
Bifocal Lenses	$25 Copay	Up to $60
Trifocal and Lenticular Lenses	$25 Copay	Up to $80
Frames	$130 allowance, 30% off balance	Up to $45
Contact Lenses *Elective or Disposable Lenses* *Medically necessary* *In Lieu of Lenses and frames benefit*	 $130 Allowance Covered in full after copay	 $105 allowance $210 allowance

When life gets challenging, you've got caring, confidential help.

If you need guidance navigating mental health, financial or legal concerns, take advantage of the Employee Assistance Program (EAP) for 24/7 support—at no extra cost.

It's good to know you're not alone.

Reaching out to an EAP consultant is a good first step. They're trained to understand your concerns so they can connect you with the consultant or service best able to help you:

- Address depression, anxiety or substance use issues.
- Improve relationships at home or work.
- Manage stress.
- Work through emotional issues or grief.
- Assistance with legal and financial concerns.

One call puts you in touch with a clinician, counselor, mediator, lawyer or financial adviser who could help change your life for the better.

Call the member phone number on your health plan ID card and ask to speak to an EAP consultant. Or, contact EAP directly 24/7 at 1-888-887-4114.

UnitedHealthcare

Flexible Spending Account (FSA)

For the 2021 Plan year, Data Path is the City of Horn Lake's FSA Administrator. Planning ahead for future medical expenses and putting money in a health flexible spending account (FSA) will help you save on taxes. You will also keep a reserve of money available, that you can use at the time of service. The main advantage of FSA funds is that you can pay for qualifying expenses tax-free. When enrolling in this plan you will receive a benefits debit Mastercard that is linked to your FSA account.

Healthcare Reimbursement FSA

Health FSAs offer an option for setting aside money to use for qualified medical expenses. These accounts offer a convenient way to prepare for out-of-pocket medical expenses. Your FSA funds be used for your medical expenses, as well as your spouse and dependents. The FSA Plan Year is from January 1 to December 31.

At the beginning of the year, you can elect up to the max of $2750 to have withdrawn from your paychecks to put into your FSA, and your employer will deposit the money into the account in equal allotments throughout the year. The IRS has outlined rules regarding eligibility, contributions and reimbursements.

FSAs operate under a use-or-lose rule, meaning that if you don't use the money in your FSA by the end of the plan year you lose it. *See below for details on the Rollover Provision.*

Rollover Provision – At the end of the current plan year, up to $500 of unused funds in your Healthcare FSA may be rolled over into the subsequent plan year. After the end of the plan year, you may submit expenses for reimbursement within 90 days. Any eligible expenses properly submitted prior to the claims filing deadline will be paid from the amount of your rollover. Any remaining after the claims riling deadline will be forfeited 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 FSA.

Dependent Care FSA

Each pay period, money moves from your paycheck into your dependent FSA. When you need to pay for dependent care expenses, like elder care of preschool, you can use the money from your account. And as long as you're paying for an eligible expense, the money is tax-free. **The Dependent Care FSA Maximum**, which is set by statute and is not subject to inflation-related adjustments, **is $5,000 a year for individuals or married couples filing jointly, or $2,500 for a married person filing separately.**

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	

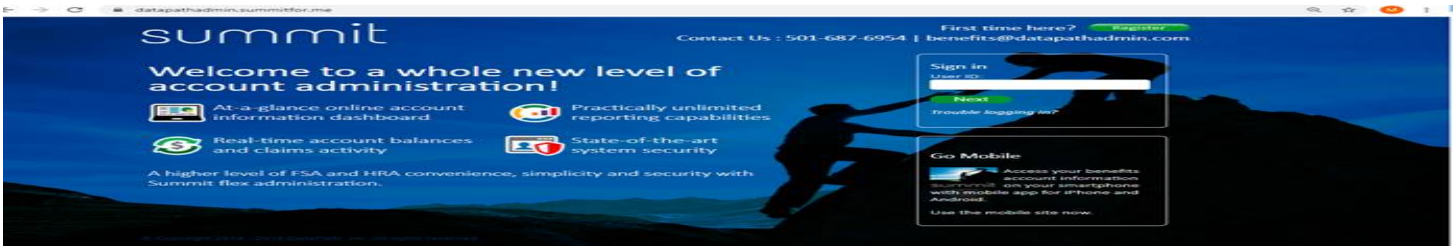
For the **2021** calendar year, an individual can contribute up to $2,750 to a health care **FSA**

DataPath FSA Registration in Summit

FSA Account Login Access

To view account balances and manage your account go to:

datapathadmin.summitfor.me



Click on Register. This screen will pop-up

Enter the Employer ID: 10310 for City of Horn Lake. This screen will pop-up:

The participant id is provided on the Participant Account Balance Report for each participant. Once they enter the number assigned to them, this screen will pop-up: You will need to complete and write down you login information for future use.

Basic Life and AD&D

Basic Life and AD&D

The City of Horn Lake provides full time employees with Basic Life and Accidental Death & Dismemberment (AD&D) coverage in the amount of **$50,000.** This benefit reduces by 33% at age 65 and 50% at Age 70. **This coverage through United Healthcare is provided to you at no cost as it is funded entirely by the City of Horn Lake.**

Voluntary Life and AD&D

All eligible employees may purchase additional life coverage. New Hires may elect coverage for you, your spouse and child(ren) up to the guaranteed issue with no evidence of insurability (EOI) "health questionnaire" required. If an amount greater than the guarantee issue is selected, an EOI form will be required. **If you waive(d) this coverage when first eligible, an EOI form is required for any amount of insurance. Please see the following page, for instructions on what is needed to apply for coverage when an EOI is needed.** The chart below is a brief outline of the plan. Please see the summary plan description for complete plan details.

	Employee	Spouse	Child(ren)
Benefit Amount	Increments of $10,000	Increments of $5,000	Birth – 14 days: $500 14 days – 26 years: $10,000
Maximum Benefit	$500,000 not to exceed 5x's salary	50% of employee amount up to $250,000	
New Hire Guarantee Issue	$130,000	$50,000	
Benefits reduced by:	33% at 65, 50% at 70		Covered to age 26

Conversion Privilege & Portability Option: When you terminate employment, retire or lose insurance eligibility due to status change, you have the Conversion Privilege on the Base Life and the Conversion / Portability Option on the Voluntary Life available to continue your current group term life insurance. You have 30 days immediately following loss of coverage to apply and submit first premium payment. Subject to the terms described in the certificate of coverage. Please contact HR or United Healthcare for information on this option.

Important! Remember to update your beneficiary information today

UnitedHealthcare
Evidence of Insurability

Evidence of Insurability.

General information and instructions for employees electing Basic Life, Basic Dependent Life, Supplemental Life, Supplemental Dependent Life, Short-Term Disability or Long-Term Disability.

What is EOI?

Evidence of insurability, or EOI, is proof of good health. By completing an EOI application, you are providing the additional information we need to review your request for coverage. You will still be eligible for any guaranteed issue amount of coverage available to you, regardless of whether or not your EOI application is approved.

When is EOI required?

You will be asked to provide EOI if:

- You request an increase to any existing benefit that you elected during an earlier initial or annual enrollment period; or
- You do not elect coverage within 31 days of your initial eligibility period but decide to elect it later; or
- You elect Basic or Supplemental Life or Basic or Supplemental Dependent Life within your initial eligibility period and the amount you elect is more than the guarantee issue amount.

If you have any question about whether or not the benefits you have elected will require you to provide Evidence of Insurability, please contact your human resources department.

Your responsibilities.

- Your employer will give you the appropriate application form. The first page of the document provides instructions for completing the form.
- Some of the information on the form may be pre-filled with information, such as the group number or information about your benefit elections. If you believe any of this information is incorrect, please contact your human resources department for clarification. Otherwise, please do not make changes to any pre-filled information.

CONTINUED

Evidence of Insurability checklist

- ☐ Obtain the application form from your employer.
- ☐ Fill out the application completely, then sign and date and send to us. If your spouse election requires EOI, make sure your spouse signs as well.
- ☐ Respond promptly to any requests from us for additional information.

UnitedHealthcare
Group Medical Underwriting Services
P.O. Box 17829
Portland, ME 04112

Fax #: 1-855-290-5224
Email: eoi_underwriting@uhc.com

UnitedHealthcare®

Short-Term Disability

Disability insurance provides income protection in case you are sick or injured, and cannot work. Short-term disability income benefits are available to you to provide income benefits if you become disabled from a non-work related injury or sickness. You pay full cost of this coverage. If you wish to add Short-Term Disability after your original hire date you may need to submit an Evidence of Insurability form and receive approval from the Insurance Carrier. Your short-term disability (STD) insurance provides coverage of 60% of gross wages up to a maximum amount per week for a qualified disability. The cost for disability coverage is based on your salary and/or age and will be calculated when you make your benefit elections. Some exclusions and pre-existing condition limitations may apply. When meeting with a Colonial Benefit Counselor, you will view the options available for you to select.

Voluntary Critical Illness with Cancer 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 $20,000. 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. Critical Illness insurance is based on your age and will be calculated when you make your benefit elections. Please refer to the critical illness certificate for information about pre-existing condition limitations, covered services, and explanations of other limitations or exclusions. Rates are based on your age and tobacco status. Your Colonial Benefit Counselor can help with enrolling in a plan based on your individual needs.

Voluntary Medical Bridge Insurance

Group Medical Bridge Insurance is offered through Colonial and it provides benefits for Hospital Confinement, Air Ambulance, Ambulance, Prescription Co-Pays, surgeries, diagnostic procedures, and other costs that medical plans may not cover. A hospital admission can result in significant financial hardship. You may have a large deductible to meet; after satisfying your deductible you may have to pay a percentage of the hospital related charges, not only for the facility, but also for surgeons, anesthesiologists, radiologists, etc. A hospital indemnity policy is designed provide assistance– payable directly to you – to help offset those expenses. Please refer to the hospital indemnity certificate for information about pre-existing condition limitations, covered services, and explanations of other limitations or exclusions. A pre-existing condition is any sickness or physical condition whether diagnosed or not, for which a covered person was treated, had medical testing, received medical advice or had taken medication before the coverage effective date and will not be covered for 12 months from the original effective date. When electing coverage for yourself, your spouse and children are eligible for 50% of the employee benefit. See the following page for the cost per payroll for this coverage. This benefit also contains a $50 Wellness benefit.

Voluntary Accident

This is a voluntary accident insurance policy for on and off the job coverage. Benefits are paid directly to you to be spent any way you choose when a covered injury happens. Where most medical insurance plans only pay a portion of the bills, Accident Insurance is here to help. This policy can help pick up where other insurance leaves off, and provide cash to cover the expenses. If you elect coverage for yourself, you can elect coverage for your eligible family members. The Colonial Benefits Counselor can assist you with enrolling for a plan that fits your individual needs.

Voluntary Medical Bridge Insurance – Benefit Cost

Bi-Weekly Payroll Deductions	Age 17-49	Age 50-59	Age 60-64	Age 65-99
Employee Only	$17.10	$22.87	$29.82	$40.89
Employee + Spouse	$32.05	$45.30	$61.06	$83.95
Employee + Child(ren)	$26.72	$32.49	$39.44	$50.52
Family	$39.76	$53.01	$68.77	$91.66

Pet Insurance Through Nationwide

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.

Bi-Weekly Payroll Deductions	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

Your Cost for Coverage

Your per payroll deductions for coverage are shown in the table below:

Benefit Plan	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Medical				
Employee Cost Per Payroll	$0	$147.31	$103.60	$259.18
COHL Cost Per Payroll	$191.54	$321.71	$245.49	$309.18
Dental				
Employee Cost Per Payroll	$2.07	$9.63	$14.81	$22.43
COHL Cost Per Payroll	$5.74	$6.96	$10.47	$9.01
Vision				
Employee Cost Per Payroll	$0.64	$3.44	$4.36	$7.34
COHL Cost Per Payroll	$1.74	$1.58	$1.52	$1.33

Your payroll deductions for Voluntary Life and Voluntary AD&D are shown in the tables below: Amounts not shown will be calculated when enrolling.

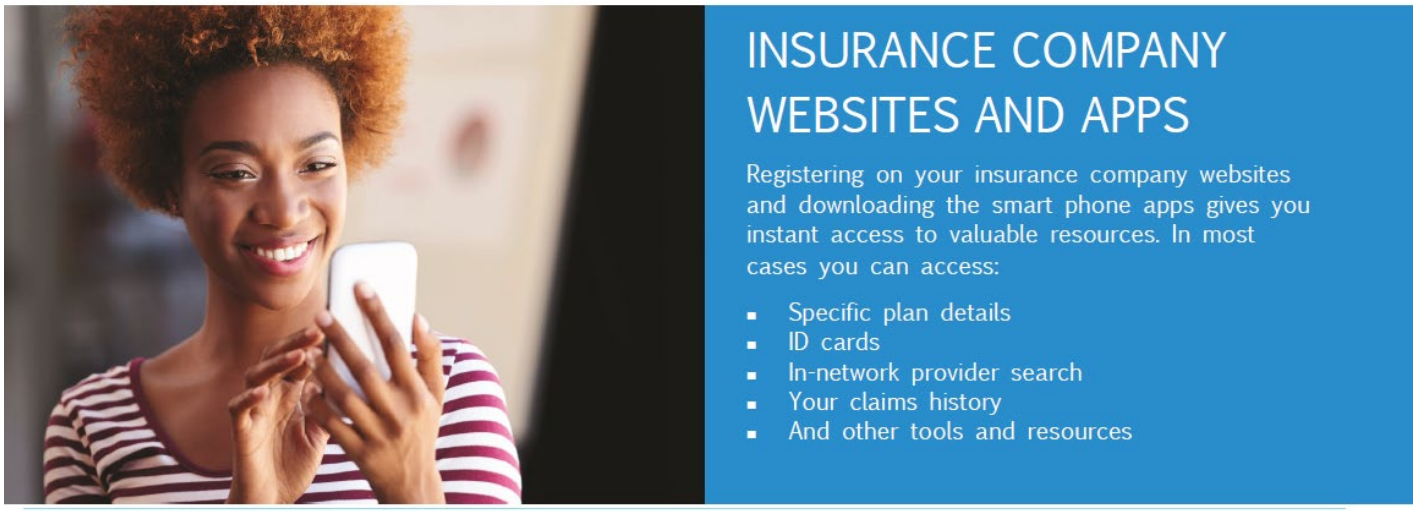
Voluntary Life and AD&D	Age	Bi-Weekly Cost per $1,000	Biweekly Cost per $10,000	Biweekly Cost per $20,000	Biweekly Cost per $40,000	Biweekly Cost per $50,000	Biweekly Cost per $100,000
Employee / Spouse *(Spouse premium is based on Employee's Age)*	Rates are based on five year increments and age bracket increases are done annually.						
	<34	$0.05	$0.49	$0.99	$1.98	$2.47	$4.94
	35 - 39	$0.06	$0.66	$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	$0.51	$5.05	$10.12	$20.23	$25.29	$50.58
	70+	$0.69	$6.91	$13.82	$27.64	$34.55	$69.09

Voluntary Life and AD&D	Death Benefit	Bi-weekly Cost
Dependent Child(ren)	$10,000	$1.06

Important Contacts

BENEFIT	CARRIER	WEBSITE	PHONE
Medical	United Healthcare	MYUHC.com	866-633-2446
Dental	United Healthcare	MYUHC.com	877-816-3596
Vision	United Healthcare	MYUHC.com	800-638-3120
Life and AD&D	United Healthcare	MYUHC.com	866-638-3120
Short-Term Disability, Medical Bridge, Critical illness, and Accident Plans	Colonial	Coloniallife.com	800-438-6423
Employee Assistance Program - EAP	United Healthcare	MYUHC.com	888-887-4114
Flexible Spending Account	DataPath	dpath.com	877-685-0655
Pet Insurance	Nationwide	https://poi8.petinsurance.com/benefits/the-city-of-horn-lake	877-738-7874

Tools | UnitedHealthcare app



The UnitedHealthcare app is available for download for iPhone® or Android™.

Medicare Part D Creditable Coverage Notice

Important Notice from City of Horn Lake.
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 offered by the UHC Medical Plan through 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.

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. **City of Horn Lake has determined that the prescription drug coverage offered by the UHC 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 through 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 City of Horn Lake will not be affected. You can keep this coverage if you elect Part D, and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current group health coverage through City of Horn Lake, be aware that you and your dependents will be able to get this coverage back. If you are able to get this coverage back, reentry into the plan is subject to the underlying terms of the 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 group health coverage through City of Horn Lake 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 Plan Administrator 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 City of Horn Lake changes. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage, and therefore, whether or not you are required to pay a higher premium (a penalty).

For purposes of this notice, the Plan Administrator is:

Arianne Linville

662-342-3482

WHCRA Enrollment/Annual 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. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

For purposes of this notice, the plan administrator is:

Arianne Linville
662-342-3482

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

Special Enrollment Notice

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

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

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator listed below:

Arianne Linville
662-342-3482

CHIPRA Premium Assistance Notice

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed 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-KIDSNOW**, or **www.insuredkidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – MEDICAID	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA – MEDICAID	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855-692-6442
ARKANSAS – MEDICAID	**FLORIDA - Medicaid**
Website: http://myarhipp.com/ Phone: 855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 877-357-3268
GEORGIA - Medicaid	**MISSOURI - Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

INDIANA - Medicaid	MONTANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877-438-4479 All other Medicaid Website: https://www.in.gov.medicaid/ Phone: 800-457-4584	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800-694-3084
IOWA – Medicaid and CHIP (Hawki)	**NEBRASKA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 888-346-9562	Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: https://www.kancare.ks.gov Phone: 800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)	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: 800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877-543-7669
OREGON – Medicaid	**VERMONT – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 800-432-5924 CHIP Phone: 855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 855-MyWVHIPP (855-699-8447)
SOUTH DAKOTA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 800-362-3002
TEXAS – Medicaid	**WYOMING - Medicaid**
Website: http://gethipptexas.com/ Phone: 800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, 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 a 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.

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 does not 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."

If the Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to City of Horn Lake 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 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;
- If the Plan provides retiree health coverage, 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 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. You must provide this notice to Arianne Linville.

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 the Social Security Administration (SSA) to be disabled and you timely notify the Plan Administrator **in writing**, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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.

In order for this disability extension to apply, you must timely notify the Plan Administrator **in writing** of the SSA disability determination before the end of the 18-month period of continuation coverage and within 60 days after the later of (i) the date of the initial qualifying event; (ii) the date on which coverage would be lost because of the initial qualifying event; or (iii) the date of the SSA disability determination. **This notice must be mailed to Arianne Linville at 3101 Goodman Road West, Horn Lake, MS 38637**. Oral notice, including notice by telephone, is not acceptable. The written notice must include the name and address of the employee covered under the plan; the name of the disabled qualified beneficiary; the date that the qualified beneficiary became disabled; and the date that the SSA made its determination of disability. Your notice must also include a copy of the SSA disability determination. If these procedures are not followed or if written notice is not provided to the Plan Administrator within the required time period, there will be no disability extension of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of any revocation of Social Security disability benefits.

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, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

(see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods). 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

City of Horn Lake
3101 Goodman Road West
Horn Lake, MS 38637
662-342-3482

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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

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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**
	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 the plan

☐ Some employees. Eligible employees are:

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

As defined by the 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.

Notes

This Summary of Benefits Guide does not provide all the details about all the Benefit Plans. If you have additional questions please contact HR. Should a discrepancy arise between this document and the plan documents, the plan documents will prevail.