Bartlett
TENNESSEE
HOMETOWN PROUD

The City of Bartlett

A GUIDE TO YOUR BENEFITS 2025-2026

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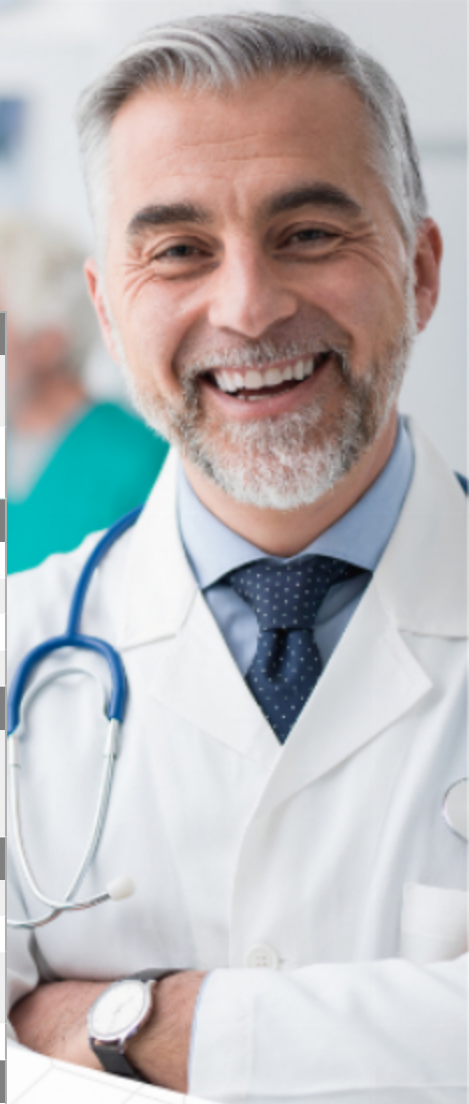
Medical Benefits

The Health Plan | City of Bartlett Employee Benefit Plan



OUT OF POCKET MAXIMUM	
Single/ EE+1/ Family (Medical copays only)	$2,000/ $3,750/ $5,500
Single/ EE+1/ Family (Includes med. and Rx)	$9,200 (Single)/ $18,400 (Non-Single)
COMMONLY USED SERVICES	
Primary Care Physician Office Visit	$30 copayment
Specialist Office Visit	$45 copayment
Urgent Care	$50 copayment
Emergency Room	$250 copayment
PREVENTIVE CARE	
Physicals per ACA, Well Child (including immunizations), Mammograms, Pap, Colonoscopy	$0
MAJOR MEDICAL EXPENSES	
Outpatient Surgery	$250 copayment
Inpatient Hospitalization / Surgery	$500 copayment, per admission
CT scan, PT scan, MRI	CT Scans - $150 copayment and MRI / PET Scans / Nuclear Medicine - $250 copayment
Hospital Newborn Delivery	$500 copayment, per admission
PRESCRIPTION DRUG COVERAGE	
Generic (Tier 1)	$10 copayment (30 day supply retail)
Generic (Tier 1)	$20 copayment (60 day supply retail); $30 copayment (90 day supply retail or mail order)
Brand Name (Tier 2)	20% coinsurance up to $200 (30 day supply retail)
Brand Name (Tier 2)	20% coinsurance up to $400 (60 days retail or mail order)
Non-Preferred (Tier 3)	20% + $50 copayment up to $200 (30 day supply retail)
Non-Preferred (Tier 3)	20% + $100 copayment up to $400 (60 day supply retail)
Mail Order/ Retail - 90 day Supply	3x Retail Pharmacy
PLAN INFORMATION	
Plan Year	July 1, 2025 - June 30, 2026
Network Type	The COPAY Plan uses direct contracts with hospital networks to reduce costs to the plan. All services are assigned a copay. Balance billing received from non-contracted facilities will be negotiated. Please contact MedBen (M-F 7:00 am - 5:30 pm), if you receive a bill for an amount above what your explanation of benefits (EOB) from MedBen says you owe.
Hospital Network	Baptist & St. Francis Hospitals & Physician Groups
Member Email	medben@medben.com
Customer Service Phone Number	1-800-686-8425

PREMIUM PER EMPLOYEE PAYCHECK	
Employee Only (EO)	$76.00
Employee + 1 (EE+1)	$151.00
Family (Fam)	$210.00

MedBen® health. benefits.

Plan Explanation

Our health insurance is offered through a copay plan provided by MedBen.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

ADDITIONAL MEDICAL BENEFITS

MENTAL/NERVOUS & SUBSTANCE ABUSE	
In-Patient	$500 per admission
Physician's Office Visit	100% after $30 copay
Intensive Outpatient Therapy	100% after $30 copay
***ADDITIONAL MEDICAL BENEFITS**	
Therapies (cognitive therapy, physical therapy, occupational therapy, speech therapy, pulmonary therapy)	100% after $30 copay (60 visits maximum)
Diabetic self-management and Cardiac rehab	100% after $45 copay each visit (60 visits maximum)
Chiropractic	100% after $45 copay (60 visits maximum)
Home Health Care	100% (60 visits maximum)(precertification required)
Extended Care Facility	$100 copay (60 visits maximum)
Hospice	100% (precertification required)
Urgent Care	100% after $50 copay
Ambulance Services	100% after $50 copay
Medical Supplies & DME	100% after $50 copay per device - (rental or purchase)
Chemotherapy Treatment	100% after $50 copay
Chemotherapy and Radiation Treatment at Baptist Facilities	$0 copay

**The Plan requires precertification by the Utilization Review Service prior to the commencement of the following services: all in-patient surgeries and procedures, any non-office based out-patient procedures, the purchase of durable medical equipment exceeding $1500, home health services, MRI, CAT and PET scans, just to name a few. Precertification confirms "Medical Necessity" ; therefore, services found not medically necessary, will not be approved for payment and are not be covered under the Plan. It is the member's responsibility to make sure precertification is obtained. Please refer to Article VI in the Plan Document for a complete list of services or supplies and an explanation of all precertification requirements. Precertification is not required for any imaging services performed at Diagnostic Imaging Facility and for outpatient services rendered at Baptist Health Service Group of Mid-South, Inc. or St. Francis/Tenet.*

Plan Document: The Plan Document is the governing document; therefore, any discrepancies which may be found in this summary are not binding. The Plan Document may be found by contacting the Benefits office for a copy.

*****Wellness:** For a detailed listing of preventive services, please refer to Section 3.1 under RECOMMENDED WELLNESS SERVICE in the plan document.

The **COPAY Plan** uses direct contracts with hospital networks to reduce costs to the plan. All services are assigned a copay. Balance billing received from non-contracted facilities will be negotiated. Please contact MedBen at (800) 686-8425 (M-F 7:00 am - 5:30 pm), if you receive a bill for an amount above what your explanation of benefits (EOB) from MedBen says you owe. You may also email medben@medben.com.

For pre-certification, call 48 hours before an elective hospitalization or surgery, or when a pregnancy is verified. To pre-certify, contact Hines and Associates at 888-461-0018.

Revised 04-17-2025

Dental Benefits

	Delta Dental | Option #1 ($2,000)		**Delta Dental** | Option #2 ($1,500)	
DEDUCTIBLE	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Single/EE+1/Family	$25/$50/$75	$25/$50/$75	$50/$100/$150	$50/$100/$150
MAXIMUM THE CARRIER WILL PAY				
Annual Maximum	$2,000	$2,000	$1,500	$1,500
FREQUENCIES				
Cleaning	Twice per calendar year		Twice per calendar year	
Exam	Twice per calendar year		Twice per calendar year	
DENTAL COVERAGE				
Cleanings	100%	100%	100%	100%
Exams	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%
Sealants	100%	100%	100%	100%
Fillings	80%	80%	80%	80%
Simple Extractions	80%	80%	80%	80%
Root Canal	80%	80%	80%	80%
Periodontal Gum Disease	80%	80%	80%	80%
Oral Surgery	80%	80%	80%	80%
Crowns	60%	60%	50%	50%
Dentures	60%	60%	50%	50%
Bridges	60%	60%	50%	50%
Orthodontia	50%	50%	50%	50%
Orthodontia Lifetime Maximum	$2,000 lifetime maximum		$1,500 lifetime maximum	
Orthodontia Maximum Age	No age limit		No age limit	
OUT OF NETWORK EXPLANATION				
	Your insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist, which may result in a balance bill.		Your insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist, which may result in a balance bill.	
PLAN INFORMATION				
Benefit Year	January 1- December 31		January 1- December 31	
Network Type	PPO & Premier		PPO & Premier	
Network Name	Delta Dental		Delta Dental	
Member Website	www.DeltaDentalTN.com		www.DeltaDentalTN.com	
Customer Service Phone Number	1-800-223-3104		1-800-223-3104	

PREMIUM PER EMPLOYEE PAYCHECK		
Employee Only (EO)	$8.45	$2.27
Employee + 1 (EE+1)	$17.52	$4.75
Family (Fam)	$25.03	$6.79

Plan Explanation

We provide two options for dental insurance through Delta Dental.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Vision Benefits

Davis Vision | Vision Benefits

VISION COVERAGE	IN-NETWORK
Eye Exam	$10
Spectacle Lenses	$20 - (Clear plastic lenses in any single vision bifocal trifocal or lenticular prescription)
Covered Frames	$0 - (Any Fashion or Designer level frame from Davis Vision's Collection. Retail value up to $160)
Frame Allowance	$0 - ($130 toward any frame from provider plus 20% off any balance. No copay required)
Visionworks Frame Allowance	$0 - ($180 allowance plus 20% off any balance toward any frame from a Visionworks family of store locations. No copay required)
Covered in Full Contact Lenses	$20 - (From Davis Vision's Collection after copay up to: Planned Replacement- Two boxes/multi-packs; Disposable- Four boxes/multi-packs)
Contact Lens Allowance	$20 - ($150 allowance toward any contacts from provider's supply plus 15% off balance); Visually Required Contacts: Covered in full with prior approval
FREQUENCIES	
Exam Frequency	Once per plan year
Lens Frequency	Once per plan year
Frame Frequency	Every other plan year
OUT OF NETWORK EXPLANATION	
	While you will receive a reimbursement when you go out of network, the out of network provider may NOT file the claim for you.
PLAN INFORMATION	
Plan Year	July 1- June 30
Network Name	Davis Vision
Member Website	www.davisvision.com
Customer Service Phone Number	1-800-999-5431

PREMIUM PER EMPLOYEE PAYCHECK	
Employee Only (EO)	$3.40
Employee + 1 (EE+1)	$6.50
Family (Fam)	$10.56

DavisVision™

Plan Explanation

Our vision benefits are provided through Davis Vision.

Disclaimer

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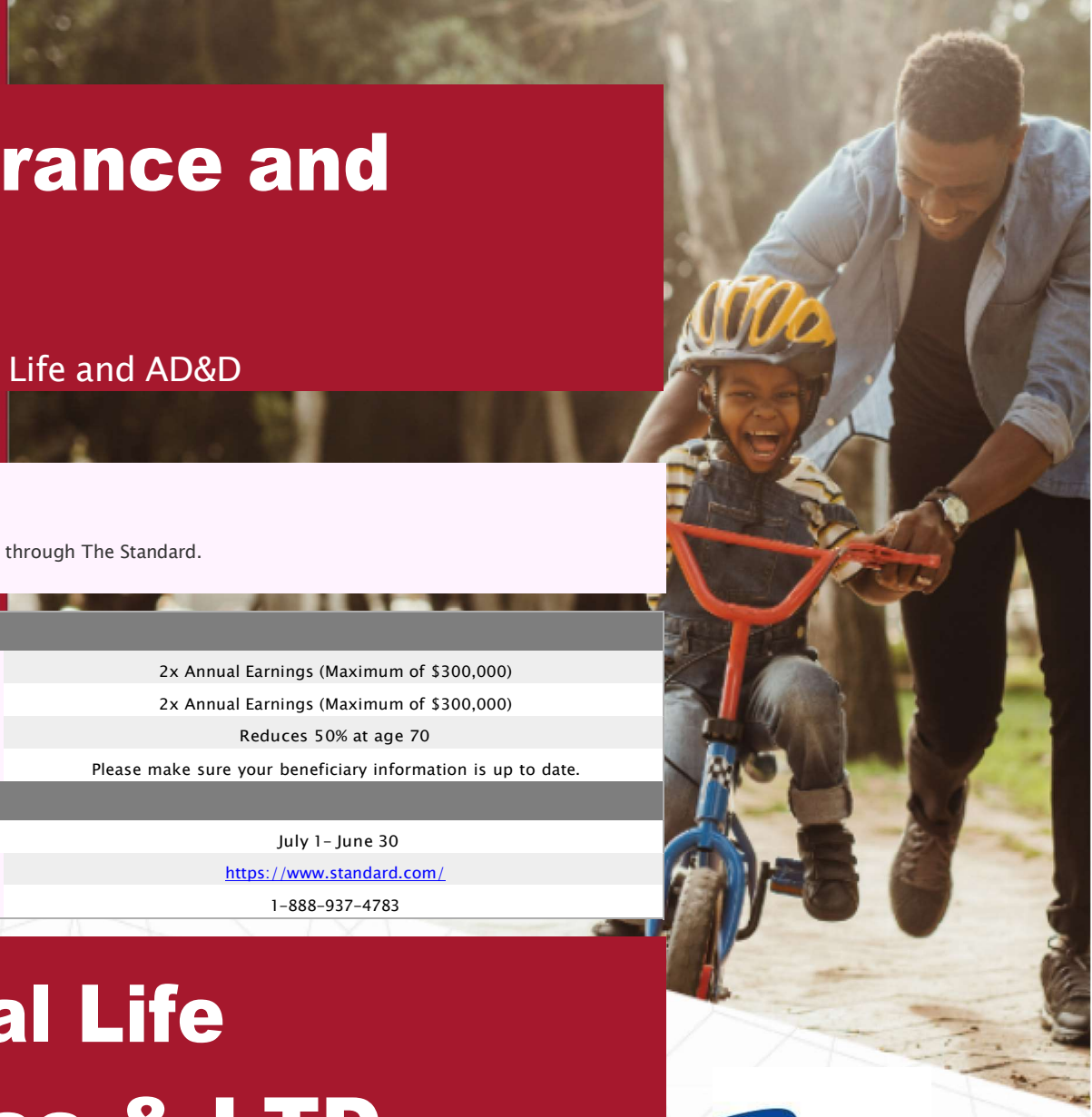
Life Insurance and AD&D

The Standard | Basic Life and AD&D



Plan Explanation

Our life insurance benefits are offered through The Standard.

LIFE INSURANCE BENEFITS	
Life Insurance Coverage	2x Annual Earnings (Maximum of $300,000)
Accidental Death & Dismemberment	2x Annual Earnings (Maximum of $300,000)
Age Reduction Schedule	Reduces 50% at age 70
Beneficiary	Please make sure your beneficiary information is up to date.
PLAN INFORMATION	
Plan Year	July 1- June 30
Member Website	https://www.standard.com/
Customer Service Phone Number	1-888-937-4783

Additional Life Insurance & LTD

LIFE INSURANCE BENEFITS	
Employee Life Insurance Coverage	Multiples of $10,000 up to $500,000; Evidence of insurability may apply
Spouse Life Insurance Coverage	Multiples of $5,000 up to $250,000 (Employee life is required. Spouse life may not exceed 50% of employee additional life); Evidence of insurability may apply
Child(ren) Life Insurance Coverage	$10,000 or $20,000 (Employee life is required)
Accidental Death & Dismemberment	Included in all coverages
Guaranteed Insurability	Employee Life: 3x annual earnings; Spouse Life: $20,000
Beneficiary	Please make sure your beneficiary information is up to date.
LONG TERM DISABILITY (LTD)	
Pays 60% of your pre-disability earnings	Evidence of insurability may apply
PLAN INFORMATION	
Plan Year	July 1- June 30
Member Website	https://www.standard.com/
Customer Service Phone Number	1-888-937-4783

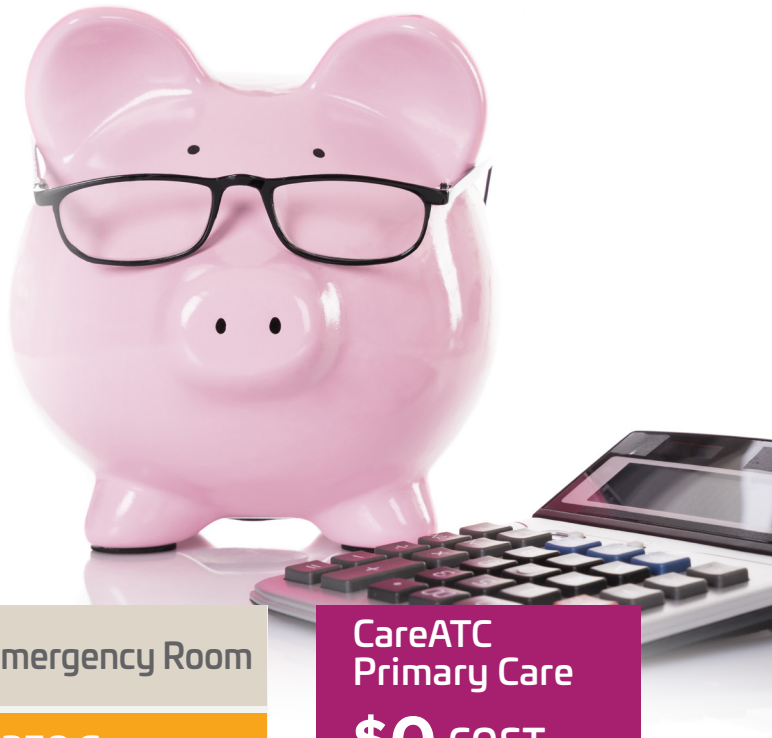
Disclaimer: *This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage*

DID YOU KNOW?

Care4Us™

You can SAVE BIG with CareATC

Great care. **No out of pocket.**



Primary Care through Health Plan	Urgent Care	Emergency Room	CareATC Primary Care
$30 Copay	$50 Copay	$250 Copay	$0 COST
Treat a wide range of health issues, including preventive care and illness. Helps coordinate specialty care and treatment plans.	Medical care for injuries and sicknesses that require immediate attention but are not life-threatening with no appointment needed.	Medical care for injuries and sicknesses that require immediate attention but are not life-threatening with no appointment needed.	Primary care for disease prevention, chronic disease management, and care for illnesses or injury. No cost labs and generic medications provided at time of visit.

Where to go for care.

Where you get your health care may make a big difference in how much you pay for services. Hospitals are the most expensive locations for outpatient diagnostic services and care. Get the same quality of care and pay less by using an independent lab or imaging center, and the CareATC Health & Wellness Center.

CareATC Health & Wellness Center	Urgent Care	Emergency Room
Check ups, illness, and chronic care	Urgent but not life-threatening	Life-threatening, serious or involving severe pain
$0 FREE	$$ Low/Moderate	$$$ Highest

Estimated cost by comparison.

3 Easy Ways to Schedule:

- www.careatc.com/patients
- CareATC app
- 901.625.5767

Show Me The App!

CareATC
THE POWER TO BE WELL.

Employee Clinic System Hours of Operation

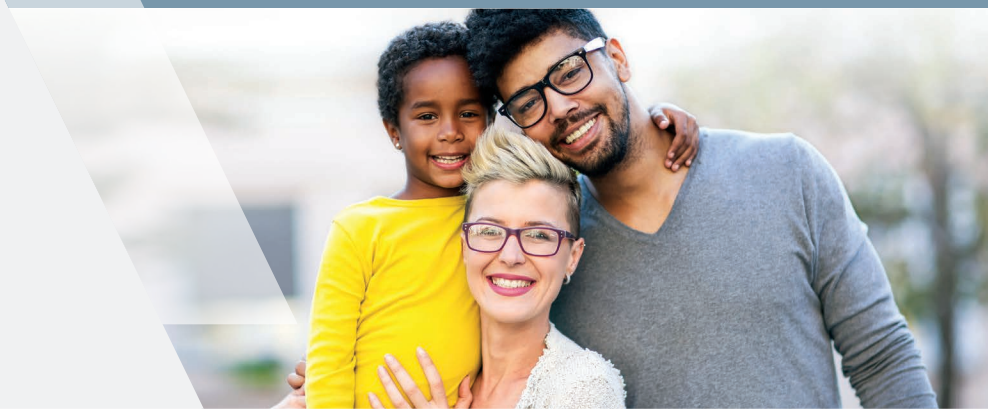
Bartlett Clinic
7665 Hwy 70, Ste 101
Bartlett, TN 38133

Mon / Wed	7am - 5pm
Tue	8am - 5pm
Thu	8am - 6pm
Fri	7am - 11am

Collierville Clinic
777 W. Poplar Ave, Ste 104
Collierville, TN 38017

Mon / Wed	8am - 5pm
Tue	8am - 6pm
Thu	7am - 5pm
Fri	8am - 1pm

City of Bartlett



Your benefits made simple.

To make your enrollment easier, you'll be able to enroll in your major medical insurance and supplemental benefits at the same time. Get all your benefit options and details with less hassle.

Your American Fidelity account manager can answer your questions and help you prepare your plan.

Limited Benefit Accident Only Insurance

- Helps with out-of-pocket expenses for the treatment of covered accidental injuries.
- Provides benefit payments directly to you.
- Some covered accidents include burns, a sprained ankle or spider bites.

Learn more: americanfidelity.com/accident

Limited Benefit Hospital Indemnity Insurance

- Helps pay for out-of-pocket costs associated with a covered inpatient stay or treatment.
- Compatible with Health Savings Accounts allowing for tax benefits and potential savings.
- Benefits are paid directly to you.

Learn more: americanfidelity.com/hospital-indemnity

Limited Benefit Cancer Insurance

- May help protect you financially if you are diagnosed with a covered cancer so you can focus on recovery.
- Provides benefit payments directly to you.
- May cover expenses like travel and lodging, experimental treatments and second opinions.

Learn more: americanfidelity.com/cancer

Limited Benefit Critical Illness Insurance

- Pays a lump sum benefit upon diagnosis of certain covered life-altering illnesses.
- Helps with costs not covered by medical insurance.
- Some eligible conditions include heart attack, organ failure and more.

Learn more: americanfidelity.com/critical-illness

Book your appointment.

enroll.americanfidelity.com/E3E6C3AC

AMERICAN FIDELITY
a different opinion

Whole Life Insurance

- Rates are based on issue age and guaranteed to remain level for the life of the policy to age 121.
- Policy's cash value can be used to pay for loans, premiums or other purposes.
- Provides immediate coverage.

Learn more: **americanfidelity.com/whole-life**

Term 100 Life Insurance

- Provides long-term coverage to age 100.
- Rates are guaranteed for 30 years or to age 85, whichever is first. After, premiums may remain the same, increase, or decrease but won't exceed the guaranteed amount stated in your policy.
- You own your policy, so you can take it with you to a different job or into retirement.

Learn more: **americanfidelity.com/term-100**

Renewing your FSA?

Flexible Spending Accounts do not automatically renew each year. Meet with your American Fidelity account manager to ensure you continue taking advantage of these tax-savings accounts.

americanfidelity.com/fsa

24/7 Access with AFmobile®

Manage your insurance benefits and reimbursement accounts all from the palm of your hand.

- **View** account balances
- **Manage** claims and reimbursements
- **Submit** documentation
- **Receive** alerts
- **Maintain** personal information

Get Started:

Register online at **americanfidelity.com/register**

Download AFmobile at **americanfidelity.com/afmobile**

Please allow one business day after you enroll before registering for an online account.
If you already have an account, your username and password will be the same for AFmobile.

Healthcare Flexible Spending Accounts

Save money on eligible medical expenses.

Healthcare Flexible Spending Accounts (HCFSAs) allow you to save part of your paycheck, before taxes, to pay for eligible medical costs throughout the year.

Features:

- Funds available at the beginning of your plan year
- Reduce your taxable income
- Contribute as much, or as little, as you want (up to the annual limit)

Learn more at
americanfidelity.com/fsa

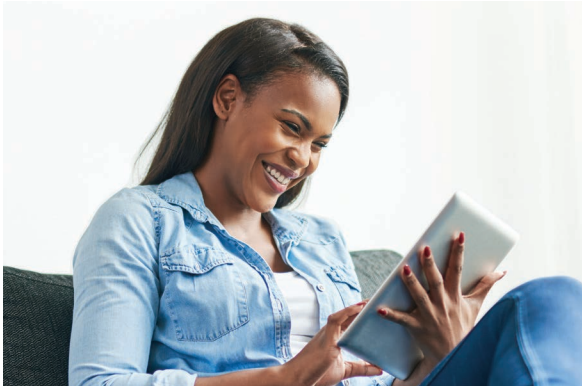
Calculate medical costs
americanfidelity.com/fsa-worksheet

Examples of Eligible Expenses

- Asthma treatments
- Chiropractic care
- Contact lenses
- Copays
- Dental services
- Eye exam/eyeglasses
- Fertility treatments
- Laser eye surgery
- Over-the-counter medications
- First aid kits
- Physical therapy
- Prescriptions
- Prenatal care
- Sunscreen with 15 SPF or higher
- Breast pumps and supplies

americanfidelity.com/eligible-expenses

Notes



File Your Claims Faster

Your online account is convenient, secure and provides faster claim processing than filing by paper.

You can file your claim, upload documentation and track your claims with an online account.

americanfidelity.com/register

These products may contain limitations, exclusions, and waiting periods. The following statements only apply if the product is displayed on this document. ***These products are not appropriate for people who are eligible for Medicaid coverage: Accident Only, Cancer, Critical Illness, Hospital Indemnity, Hospital GAP PLAN® and Hospital GAP Plan Choice® Insurance.*** *HSA contributions are not subject to federal and most states' income tax. State income tax may apply in California and New Jersey. Please consult a tax advisor for your state's specific rules. HRAs are not part of a Section 125 Plan. Contributions made by employer not employee.*

Howard Herlihy
Account Executive
American Fidelity Assurance Company
800-662-1113, Ext. 2595
howard.herlihy@americanfidelity.com

American Fidelity Assurance Company
americanfidelity.com

Cancer Care Close to Home.

MSSC Cancer Care Program

through Baptist Cancer Center

Cancer Screenings

Your MSSC Health Plan offers preventive cancer screenings for members through **Baptist Cancer Center**. Regular screenings help to prevent the onset of cancer or to detect it at its earliest stages, greatly increasing the chances of making a full recovery.

Cancer screenings available through Baptist Cancer Center include, *but are not limited to*:

- **Colonoscopies** (every 10 years for males & females ages 45 & over)
- **Mammographies** (every 2 years for females ages 40 & over)
- **Pap Smears** (Every 3 years for females ages 21-29, every 5 years for ages 30-64)

The preventive cancer screenings above (and wellness exams) are **covered at 100%** under your MSSC plan.

Cancer Treatment

Hopefully, you'll never have a need for cancer treatment. But should the need arise, Baptist Cancer Center offers world-class care.

Better Doctors. Baptist's medical team consists of 40+ providers with over 600 years of combined practice experience in almost every type of cancer.

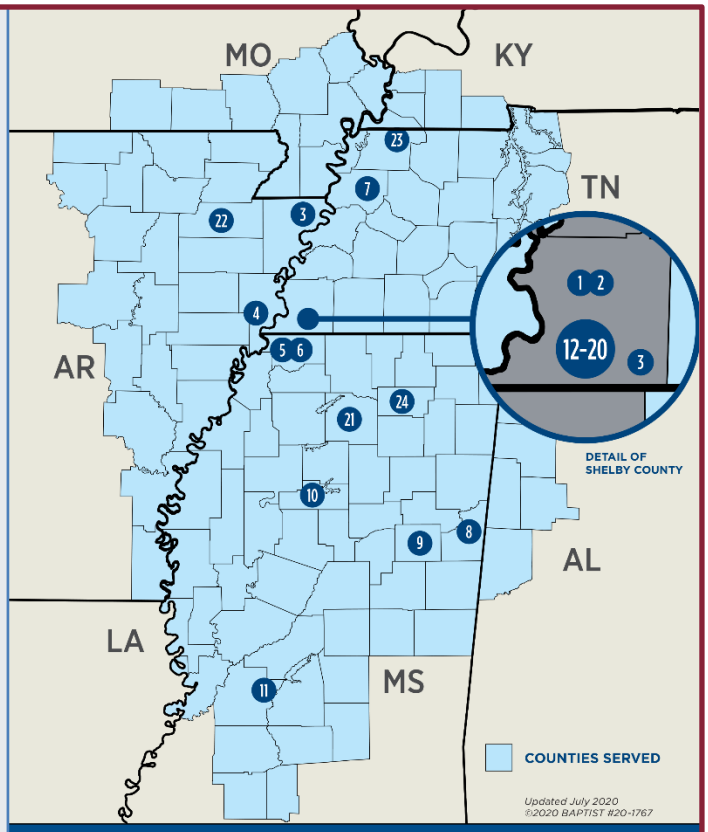
Better Care. Baptist combines the talents and expertise of a team of specialists invested in the patient's well-being. Customized treatment plans include the latest technology, therapies and research.

Better Cost. MSSC Health Plan has contracted directly with Baptist to offer the highest quality cancer care at the lowest possible cost… and you never have to worry about surprise "balance bills."

Better Access. Baptist Cancer Center offers one direct access point for all patients. By calling **901-752-6131**, you can address any patient questions, make or change appointments, and more.

BAPTIST® CANCER CENTER

baptistcancercenter.com



Baptist Cancer Centers are located in 24 locations in Tennessee, Mississippi and Arkansas, and serve patients throughout those states as well as counties in Alabama, Kentucky, Louisiana and Missouri.

1. Bartlett Kate Bond, 1
2. Bartlett Kate Bond, 2
3. Collierville
4. Crittenden
5. DeSoto 391 Southcrest
6. DeSoto 7900 Airways
7. Dyersburg
8. Golden Triangle Columbus
9. Golden Triangle Starkville
10. Grenada
11. Jackson
12. Memphis 80 Humphreys
13. Memphis 6029 Walnut Grove
14. Memphis Breast MultiD
15. Memphis Breast Surgery
16. Memphis Gastro MultiD Clinic
17. Memphis Gynecological Oncology
18. Memphis Radiation Oncology
19. Memphis Stem Cell Clinic
20. Memphis Thoracic MultiD
21. North Mississippi
22. NEA Baptist Fowler Family Center for Cancer Care
23. Union City
24. Union County

Nurse Navigators

Baptist Cancer Center offers a nurse navigator for patients at each location. Any time you schedule a screening, a nurse navigator is with you to provide support and address your questions and concerns.

If you require cancer treatment, nurse navigators offer personalized support and information, from diagnosis through follow-up care. Our experienced nurses specialize in cancer care, and vary their responsibilities based on the needs of the patient.

MedBen® health. benefits.

Your MSSC Health Plan offers low-cost immunization services through

THE SHOT NURSE
IMMUNIZATION & WELLNESS SERVICE

The Shot Nurse is dedicated to the well-being of community members in the Memphis & Mid-South area. Their team of nurses provides immunization services that prevent disease and improve one's quality of life. These services include all immunizations or boosters needed for work, school, travel, and everyday health; lab work; TB Skin tests; Men's Testosterone Replacement; Lipo and Vitamin B12 Shots.

The Shot Nurse Locations are:

Trinity Commons
714 N Germantown Pkwy, Suite 11
Cordova, TN 38018

Poplar Avenue & Perkins
4637 Poplar Avenue
Memphis, TN 38117

Saddle Creek in Germantown
7596 W. Farmington
Germantown, TN 38138

Visit The Shot Nurse website by scanning the QR code below.

Contact MedBen at 800-686-8425 or email medben@medben.com regarding coverage for these services under the health plan.

Your Plan's Preferred Pharmacy!

Zero Copay

On *Most* of Your Medications!

Dr. Rebecca Mitchell
Pharmacist-In-Charge

Care4Us Pharmacy

Call *901-625-DRUG (3784)* to speak to our friendly pharmacy team or email help@care4uspharmacy.com regarding your eligibility for **"Free Delivery"** or any other **"Cost-Saving"** opportunities available only at your Care4Us pharmacy.

Our Benefits

- Proactive personalized pharmacy solution ***exclusive*** to covered MedBen Health Plan members and their families.
- The ***preferred*** member-based pharmacy is built with our members in mind.
- The formulary offers generics and preferred brand medications to keep our members' out-of-pocket costs ***low***.
- Our Pharmacist will evaluate your drugs in real-time, providing quick and ***seamless savings*** opportunities right at the pharmacy counter.

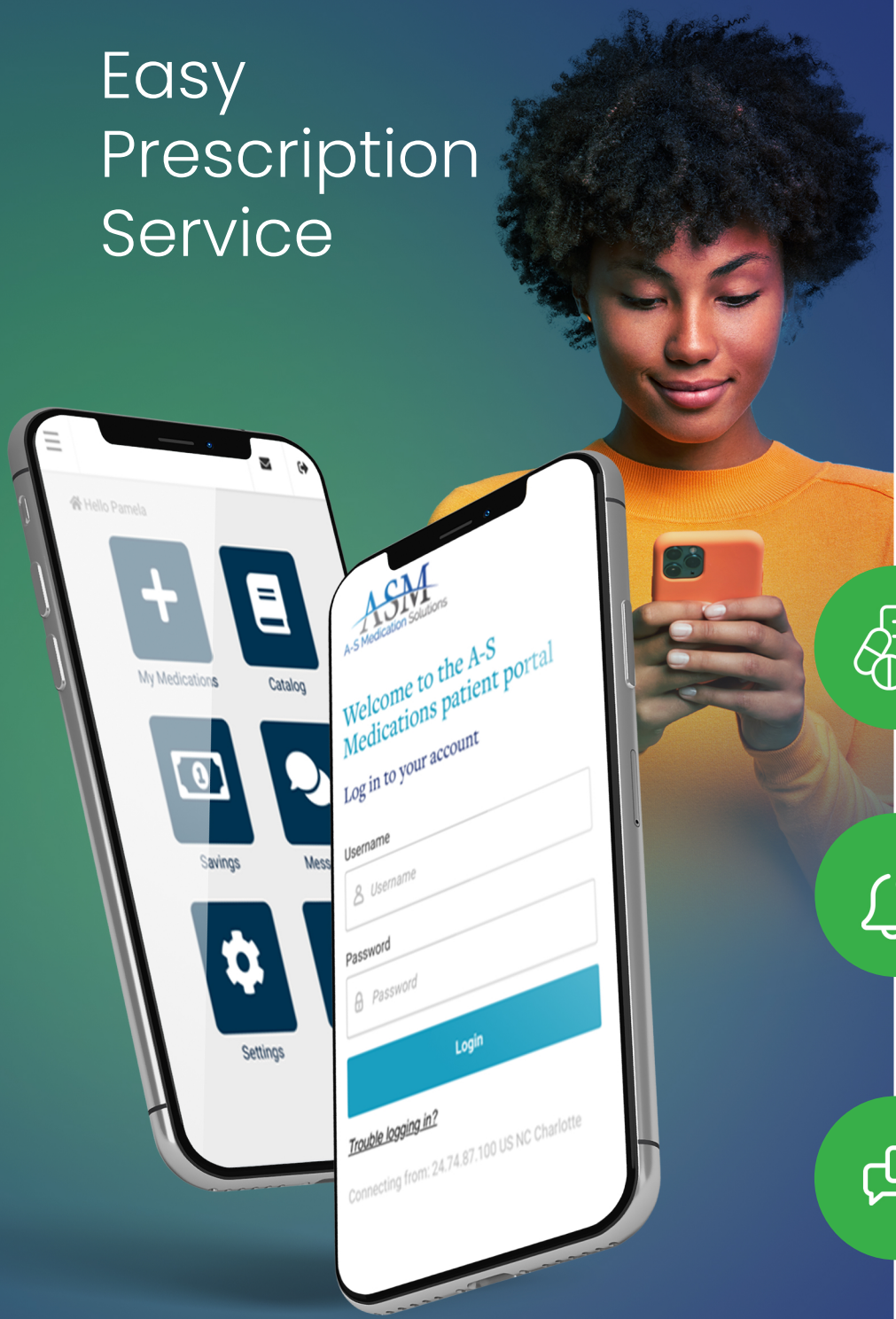
Pharmacy Hours

MONDAY	8:00 AM- 5:00 PM
TUESDAY	8:00 AM- 5:00 PM
WEDNESDAY	8:00 AM- 5:00 PM
THURSDAY	8:00 AM- 5:00 PM
FRIDAY	8:00 AM- 5:00 PM
SATURDAY	CLOSED
SUNDAY	CLOSED

Phone: 901-625-DRUG
Toll-Free: 833-958-4273
Fax: 901-676-6134

Address: 7665 US HWY 70, Suite 102
Bartlett, TN 38133
Website: www.care4uspharmacy.com

Easy Prescription Service



Care4Us Pharmacy

PARTNERED BY

ASM A-S Medication Solutions

Order prescriptions, request a refill your prescription or add a new prescription.

Receive prescription reminders and alerts.

In APP Messaging, text our pharmacist with questions and refill requests.

Using the APP for the first time?

Contact our pharmacy team **at 901-625-DRUG** or email **pharmacist@care4uspharmacy.com** to establish your member account.

Already a member?

Scan Here

Sign up for the Care4Us Pharmacy APP Today!

IMPORTANT NUMBERS

Benefit	Vendor	Customer Service	Website/Email
Medical/Pharmacy	MedBen	Scan To Download the Mobile app (800) 686-8425	MedBen medben@medben.com www.medben.com/mssc
Dental	Delta Dental	(800) 223-3104	www.deltadentaltn.com
Vision	Davis Vision	(800) 999 -5431	www.davisvision.com
Life and LTD	The Standard	(800) 348-3226	
Voluntary Products (Cancer/ Critical Illness/Accident)	American Fidelity	(800) 662-1113	www.americanfidelity.com
Flexible Spending and Dependent Care		(800) 465-2129	
Employee Assistance Program	Concern EAP	(901) 458-4000 www.myconcerneap.com	
Care4Us Clinic Locations	7665 Hwy 70, Ste #101, Bartlett, TN 38133 (901) 625-5767	777 W. Poplar Ave., Ste #104 Collierville, TN 38017 (901) 625-5767 www.careatc.com/patients CareATC app	
Care4Us Pharmacy Bartlett Location	7665 Hwy 70, Ste #102, Bartlett, TN 38133 (901) 625-3784	help@care4uspharmacy.com	
Contacts	City of Bartlett (901) 385-6430 6400 Stage Road Bartlett, TN 38134	Chief HR Officer: Lori Von Bokel-Amin lvonbokel@cityofbartlett.org Active Emp Benefits & Retirees: Natalie Payne npayne@cityofbartlett.org	

Important Items to Remember

NEW HIRE WAITING PERIOD

Employees who start work on the 1st are eligible for benefits on that day. Employees who start any time after the 1st will be eligible for benefits on the 1st of the following month.

TERMINATION OF BENEFITS

Coverage ends on the last day of the month the termination occurs.

ELIGIBLE EMPLOYEES

To be eligible for City of Bartlett benefits, you must be a full time employee working an average of 30 hours per week during the year.

OPEN ENROLLMENT

You can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc.) during this time period each year. Open enrollment occurs 30 days prior to your plan renewal. All changes made during this time period will take effect on the renewal date.

MAKING PLAN CHANGES DURING THE YEAR

If you've had a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc) during the year, you're able to make coverage changes to your plan even though it's outside of the Open Enrollment window. Please turn in all paperwork within 30 days of your Qualifying Event to ensure it will be processed timely and any claims incurred will be paid. PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it once it's available.

STAY IN NETWORK

To obtain the best benefits, The Copay Plan uses direct contracts with hospital networks to reduce costs to the plan. All services are assigned a copay. Balance billing received from non-contracted facilities will be negotiated. Please contact MedBen at (800) 686-8425 (M-F 7:00 am-5:30 pm), if you receive a bill for an amount above what your explanation of benefits (EOB) from MedBen says you owe. You may also email medben@medben.com.

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is (Provider Charge-Network Discount=Negotiated Rate). It also shows whether the service was applied to your deductible or paid as a co-pay. It is NOT A BILL, but merely an explanation of how the insurance carrier paid your claim.

NEED A NEW ID CARD OR ANOTHER ID CARD FOR A DEPENDENT?

You may register by downloading the mobile app found on the Google Play or the Apple App Store (MedBen Mobile). Once registered you may print out temporary ID cards and order new cards, or you can contact MedBen at (800) 686-8425 (M-F 7:00 am-5:30 pm).

HAVE QUESTIONS ABOUT AN INSURANCE CLAIM?

PLEASE HAVE COPIES OF YOUR EXPLANATION OF BENEFITS ALONG WITH A COPY OF YOUR BILL(S) READY & CONTACT: MedBen at (800) 686-8425 (M-F 7:00 am-5:30 pm)

Insurance Terms and Definitions

PPO (PREFERRED PROVIDER ORGANIZATION)

A PPO is a type of insurance network. In this type of network, you may choose to obtain care in or out of your network. If you choose to visit a "Preferred", or "In-Network", provider, your out of pocket expense will be significantly less than if you visit a provider outside your network. The reason for this is the In-Network provider agrees to accept set, contracted rates as payment in full for their services in return for being part of the insurance carrier's Preferred Provider network.

DEDUCTIBLE

The amount you pay before the insurance carrier starts sharing the expense of your dental care except for diagnostic and preventative services.

OUT OF POCKET MAXIMUM

This is the maximum amount you will pay for covered medical expenses during your deductible period.

CO-PAYS

This is a set Dollar amount you pay when you receive medical care from a PCP, Specialist, Urgent Care, Emergency Room, or Pharmacy. It's called a co-pay, because you pay the set dollar amount and your insurance carrier pays the rest of the actual charge from the doctor/facility. Co-pays DO NOT apply to the deductible.

NEGOTIATED RATE (CONTRACTED RATE)

When a Provider (doctor, facility, pharmacy or hospital) contracts with an insurance carrier, they are considered In-Network. Part of the contract states that the provider will accept a lower payment (lower than what they normally charge) from the insurance carrier as payment in full. This lower payment is the Negotiated Rate.

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate). It is NOT A BILL, but merely an explanation of how the insurance carrier paid your claim.

FLEXIBLE SPENDING ACCOUNT (F S A)

This is an account funded by the Employee. The FSA is used to pay for Qualified Medical Expenses (IRS Publication 502) through tax free contributions. The employee chooses the total amount they want in their FSA for the year during open enrollment. That amount is divided up by the number of pay periods per year and is taken out of each paycheck before taxes. With the FSA, you have access to the total amount of funds you selected during open enrollment at the beginning of your plan year. The maximum amount you can contribute to the FSA is $3,300 in 2025. Typically, you can only roll over $660 from year to year.

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.

To request special enrollment or obtain more information, contact Natalie Payne, Senior Coordinator-HR, 901-385-6430, npayne@cityofbartlett.org

Newborn's 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).

WHCRA Enrollment 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. Therefore, the following deductibles and coinsurance apply: $0 deductibles; pays 100% after applicable copayment is met..

If you would like more information on WHCRA benefits, call your plan administrator Natalie Payne, Senior Coordinator-HR, 901-385-6430, npayne@cityofbartlett.org

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call your plan administrator at (901) 385-6430 for more information.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact medben@medben.com; 1-800-686-8425. The federal phone number for information and complaints is: 1-800-985-3059

Visit: www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit: https://www.tn.gov/partnersforhealth/no-surprises-act-transparency-in-coverage.html for more information about your rights under state laws.

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it**. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage MUST PAY for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

RETIREE COVERAGE ONLY:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Retiree coverage only: Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: The City of Bartlett.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA

continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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.

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.

* https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

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

Natalie Payne, Senior Coordinator-HR, 901-385-6430, npayne@cityofbartlett.org

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.02% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your employer via the information provided below.

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. Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2024.
2. An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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 The City of Bartlett		4. Employer identification Number (EIN) 62-6011034
5. Employer Address 6400 Stage Road		6. Employer Phone Number 901-385-6430
7. City Bartlett	8. State Tennnessee	9. Zip Code 38134
10. Who can we contact about employee health coverage at this job? Lori Von Bokel-Amin		
11. Phone number (If different from above)		12. Email address lvonbokel@cityofbartlett.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:

☑ Some Employees, Eligible employees are:

Full time employees who average over the year, a minimum of 30 hours or more a week.

• With respect to dependents:

☑ We do offer coverage, Eligible dependents are:

Children up to age 26 unless deemed handicapped, and spouses who are not eligible through their employer, are retired, unemployed, self-employed, or where their employer pays less than 50% of the total cost of the cheapest medical 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

[X] **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? 07/01/2025 (mm/dd/yyyy) (Continue)

[ ] **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

[X] **Yes** (Go to question 15) [ ] **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $76.00

b. How often ? [ ] Weekly [ ] Every 2 weeks [X] Twice a Month [ ] Monthly [ ] Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

[ ] Employer won't offer health coverage

[ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often ? [ ] Weekly [ ] Every 2 weeks [ ] Twice a Month [ ] Monthly [ ] Quarterly [ ] Yearly

*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.

Important Notice from The City of Bartlett 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 The City of Bartlett and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Bartlett has determined that the prescription drug coverage offered by the MedBen Copay Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The City of Bartlett coverage WILL be affected. .
If you do decide to join a Medicare drug plan and drop your current The City of Bartlett coverage, be aware that you and your dependents WILL be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The City of Bartlett and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The City of Bartlett changes. You also may request a copy of this notice at any time.

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

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call1-877-486-2048.

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

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

Date: 4/23/2025

Name of Entity/Sender: The City of Bartlett

Contact: Lori Von Bokel-Amin, Chief HR Officer, 901-385-6430, lvonbokel@cityofbartlett.org -- Position/Office: Chief HR Officer

Phone Number: 901-385-6430

Address: 6400 Stage Road, Bartlett, TN 38134

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information.

Builds on HIPAA's protections. GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Before the Affordable Care Act, HIPAA prevented a plan or issuer from imposing a preexisting condition exclusion based solely on genetic information. Under the Affordable Care Act, plans are prohibited from excluding coverage or benefits due to any preexisting condition. HIPAA continues to prohibit discrimination in eligibility, benefits, or premiums based on a health factor (including genetic information).

Additional underwriting protections. GINA provides that group health plans cannot adjust premiums or contribution amounts for a plan, or a group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

Prohibits requiring genetic testing. GINA generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer under certain conditions to request (but not require) that a participant or beneficiary undergo a genetic test.

Restricts collection of genetic information. GINA prohibits plans from collecting genetic information (including family medical history) from an individual prior to or in connection with enrollment in the plan, or at any time for underwriting purposes. Thus, under GINA, plans and issuers are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA).

GINA includes an exception for incidental collection of genetic information, provided the information is not used for underwriting purposes. However, the GINA regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

Other protections. GINA also contains individual insurance market provisions, administered by the Department of Health and Human Services' Centers for Medicare & Medicaid Services, privacy and confidentiality provisions, administered by the Department of Health and Human Services' Office for Civil Rights, and employment-related provisions, administered by the Equal Employment Opportunity Commission (EEOC).

For more information, see the Frequently Asked Questions Regarding the Genetic Information Nondiscrimination Act on the EBSA Website.

The City of Bartlett

6400 Stage Road, Bartlett, TN 38134
https://www.cityofbartlett.org/
901-385-6430, npayne@cityofbartlett.org
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing Purposes
- Sale of your Information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Special Notes: We never sell or market your personal information

Greater limits on disclosures: We will never share any substance abuse treatment records without your written permission.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of this notice: 2025-04-24

OHCA notice:

Privacy Official: Lori Von Bokel-Amin, lvonbokel@cityofbartlett.org, 901-385-6430

This Benefit Booklet

Presented by

Sherrill Morgan & Assoc.

www.sherrillmorgan.com

1-859-291-6600

525 W. 5th Street, Ste. 310, Covington, KY 41011