Cherokee County

1831

GEORGIA

2023 Benefit Guide

Cherokee County Board of Commissioners

Cherokee County

1831

GEORGIA

We are happy to provide you with this Benefit Guide to summarize your employee benefits for the 2023 plan year. Cherokee County recognizes that benefits are an important part of your life as an employee.

Our benefits program will help you choose what works best for your needs and your budget. But this document is not just an enrollment guide; it is a resource for you and your family to use throughout the year. Inside you will find a summary of each benefit plan and helpful tips you may have not known about in the past. This guide is designed to break down the insurance rates to help you make an informed decision regarding the selection and management of the services and benefits provided to you as an employee of Cherokee County.

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The information in this Enrollment Guide is presented for illustrative purposes. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this guide or if you need a copy of the plan documents please contact Human Resources.

Eligibility & Enrollment

Employee Eligibility

All full time employees working an average of 30 hours per week are eligible to enroll in benefits. For specific details, please refer to the plan documents. New full time employees' benefits eligibility for all lines of coverage will begin on the 1st of the month following the first full month of full time employment.

Sample of Savings Using Pre-tax Deductions

INCOME FACTORS	PRE-TAX CONTRIBUTIONS	POST-TAX CONTRIBUTIONS
Employee Gross Pay	$35,000	$35,000
Pre-Tax Premium	$417	-
Taxable Income	$34,583	$35,000
Assumed Tax Rate[1]	25.65%	25.65%
Net Pay	$25,712	$26,023
After Tax Premium		$417
Take Home Pay	$25,712	$25,605

[1]Assumed Tax Rate of 18% Federal Income Tax and 7.65% FICA (Social Security and Medicare)

Dependent Eligibility – Medical Plan

Legislation regulates eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible dependents include:

- Legal Spouse
- Dependent children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

* To verify if a dependent is eligible for coverage please contact the Human Resources Department

Dependent Verification of Eligibility

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

- **Spouse Verification Documentation:** Marriage Certificate
- **Child Verification Documentation:** Birth Certificate, court document awarding custody or requiring coverage

Mid-year Enrollment Changes

Section 125 Cafeteria Plan

Employees may take advantage of, at no cost to them, the tax benefits of a 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

Current IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event. Changes must be reported within 30 days of the actual event.

Some common qualifying events may include:

- Marriage, Divorce or Death of Spouse
- Birth, Adoption or change in legal custody
- Loss of other coverage
- Enrollment in the Marketplace Exchange
- Change in Medicare or Medicaid entitlement
- Military Leave

To determine if any of these apply to you, please check with your Human Resources representative.

Please Note: The IRS does not consider financial hardship a qualifying even to drop coverage.

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How to Enroll

Cherokee County BOC will continue to use the online benefit enrollment system. To enroll, please visit:

www.benselect.com/Enroll/Login.aspx

Log in instructions:

- Enter your SSN or Employee Number
- Your PIN is the last 4 digits of your SSN followed by the last 2 digits of your birth year
- Contact **humanresources@cherokeega.com** if you experience login issues

Quick Links to Your Providers

Medical Benefits: *Cigna Plan*

Cigna

Cigna Provider Search:
www.cigna.com

Dental Benefits: *Delta Dental*

DELTA DENTAL

Dental Provider Search:
www.deltadental.com

Medical Benefits: *Northside Plan*

NORTHSIDE HEALTH NETWORK

Children's Healthcare of Atlanta

Northside and CHOA Provider Search:
www.nhnmanager.com

Vision Benefits: *National Vision Administrators, LLC*

NVA
National Vision Administrators, L.L.C.

Vision Plan Provider Search:
www.e-nva.com

NHN Mental Health and Out of Area:

First Health Network

First Health Provider Search:
providerlocator.firsthealth.com

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Medical Insurance

Medical coverage is important for you and your family. You can choose between two (2) different medical plan options. Trustmark is the TPA for both options.

Below is a snapshot summary of your medical benefits and is not intended to replace your Summary of Benefits or Coverage.

Trustmark
Phone: *1-877-279-5285*
Website: *www.mytrustmark.com*

IN NETWORK BENEFITS	PLAN OPTIONS	
	NHN	Cigna PPO
Deductible - (Individual / Family)	$750/$2,250	$750/$2,250
Is Deductible Calendar Year or Policy Year?	Calendar Year	Calendar Year
Is Deductible Embedded or Non Embedded?	Embedded	Embedded
Out of Pocket Maximum - (Individual / Family)	$2,000/$6,000	$2,000/$6,000
Coinsurance	20%	20%
Prescription Drugs	$10/$35/$80	$10/$35/$80
Mail Order Drugs (90 Day Supply)	$25/$50/$50	$25/$50/$50
International Pharmacy Program	Brand Only - $0	Brand Only - $0
Specialty Rx	20% Coinsurance to a max of $200 per prescription	20% Coinsurance to a max of $200 per prescription
PHYSICIANS OFFICE VISITS		
Primary Care Physician	$25	$25
Teladoc (Virtual Visit)	$0	$0
Urgent Care Center	$30	$30
Retail Clinic	Not covered	$25
Specialist	$30	$30
Referral Needed for Specialist?	No	No
NO COST CARE		
Routine Adult Physical Exams Well Child & Well Woman Exams Routine Mammograms and Colonoscopy ***Level 1 Imaging	Covered 100%	Covered 100%
DIAGNOSTIC LABORATORY & IMAGING		
Diagnostic Imaging Level 2 and Lab Services	Deductible then 20%	Deductible then 20%
HOSPITALIZATION / OUTPATIENT SERVICES		
Inpatient Hospitalization (Facility)	Deductible then 20%	$500 per admission plus deductible then 20%
Outpatient Surgical Care (Hospital Facility)	Deductible then 20%	Deductible then 20%
Emergency Room	$250	$250
OUT OF NETWORK BENEFITS		
Deductible - (Individual / Family)	Not Applicable	$6,000/$18,000
Out of Pocket Maximum - (Individual / Family)	Not Applicable	$9,000/$27,000
Coinsurance	Not Applicable	40%
EMPLOYEES BI-WEEKLY PAYROLL DEDUCTIONS		
Employee Only	$39.33	$49.16
Employee + 1 Dependent	$92.09	$115.11
Employee + Family	$137.51	$171.89

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Cigna Payer Solutions

Stay in control of your health.

You've got a lot on your plate, but taking the time to get a preventive care screening and flu shot now can save the time and hassle of dealing with bigger health problems later.

Certain underlying conditions show no outward symptoms — including high cholesterol, which increases the risk for heart disease and stroke[1].

Annual screenings can help identify medical conditions early, so it's important to get screened regularly as part of your overall wellness routine. Plus, preventive care services are 100% covered[2] by most health insurance plans.

It's more than a physical.

Your annual check-up is about the whole you, both body and mind. If you're feeling anxious or lonely or are having trouble balancing home and work, be sure to let your provider know.

Preventive care keeps you informed.

Get a clearer picture of your health numbers and risk factors so you can make informed diet, exercise and lifestyle decisions.

Common lab tests and screenings include[3]:

- Blood pressure
- Cholesterol
- Cancer screenings
- Body mass index (BMI)

Do your part by getting a flu shot.

The Centers for Disease Control and Prevention (CDC) recommends that everyone six months and older get an annual flu vaccination[4]. Protect yourself and your family by helping to slow the spread this flu season.

Contact your primary care provider to schedule your annual check-up and flu shot.

Log in to **myCigna.com** or use the **myCigna® app** to find a local provider in your plan's network.

Together, all the way.®

Cigna.

1. CDC, "Cholesterol." February 21, 2020. https://www.cdc.gov/cholesterol/index.htm.
2. Not all preventive care services are covered, and different plans may cover different things. For example, immunizations for travel are usually not covered. See your plan materials for a complete list of covered preventive care services.
3. This information is for educational purposes only. It's not medical advice. Always ask your doctor for appropriate examinations, treatment, testing, and care recommendations.
4. CDC, "Who Needs a Flu Vaccine and When." August 20, 2020. https://www.cdc.gov/flu/prevent/vaccinations.htm.

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SurgeryPlus

SurgeryPlus is a supplemental benefit at NO ADDITIONAL COST that offers higher-quality, a great experience and lower costs for non-emergent surgical procedures.

*Must schedule through SurgeryPlus to qualify.

SurgeryPlus has Located the Nation's Top-Quality Surgeons

SurgeryPlus has already located and rigorously screened the area's top-quality surgeons for the best possible care. Our highly qualified surgeons chose to be part of the SurgeryPlus network for a number of reasons, including quick and easy claims payments, no denials, direct referrals of surgery-ready patients and the opportunity to participate in an elite network setting them apart from other under-performing surgeons.

	Other Network	SurgeryPlus
Board Certification	Optional	Mandatory
Specialty Training Requirement Procedure	Optional	Mandatory
Volume Requirements		✓
State Sanction Check		✓
Medical Malpractice Claims Review		✓
Criminal Background Checks		✓
CMS Quality Requirements (Hospital Only)		✓
Monthly Network Monitoring		✓

You Can Save Money

Cherokee County will waive your coinsurance and deductible when you use SurgeryPlus, reducing financial burden.

Care Advocates Manage the Entire Process

A dedicated Care Advocate will manage the entire procedure process for you, including locating a surgeon, scheduling appointments, transferring medical records and arranging all logistics. You'll work with the same Care Advocate throughout the entire process so they'll know all the details of your case and ensure your top-satisfaction.

Hundreds of Procedures are Covered

Hundreds of procedures are covered. Below is a list of the main categories; however, call SurgeryPlus to inquire about a specific procedure and a Care Advocate will assist you with your needs and questions.

- Spine
- Cardiac
- General Surgery
- Genitourinary
- Orthopedic
- Ear, Nose, and Throat
- Pain Management

You Do Not Need to Enroll in SurgeryPlus

If you are covered under Cherokee County's medical plan, you have been automatically enrolled in this extra benefit at no additional cost. If you are planning a procedure call SurgeryPlus as you could save thousands of dollars.

To learn more about SurgeryPlus call (855) 715-1683

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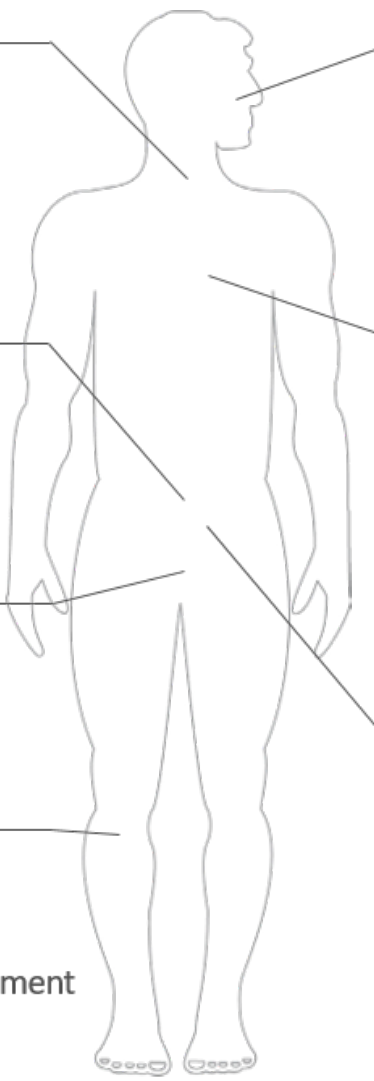
SurgeryPlus

SurgeryPlus covers hundreds of planned surgeries including, but not limited to:



Spine
Fusions
Disk Repair/Replacement
Laminectomy
Laminotomy

General Surgery
Gallbladder Removal
Hernia Repair
Thyroidectomy

Genitourinary
Hysterectomy
Bladder Repair

Orthopedic
Knee Replacement Hip Replacement Shoulder Replacement
Ankle/Wrist/Elbow Replacement
Arthroscopy
Rotator Cuff Repair
Tendon Repair
Carpal Tunnel
Bunionectomy

Ear, Nose & Throat Septoplasty
Sinuplasty Eustachian Tubes

Cardiac
Cardiac Valve Surgery
Cardiac Defibrillator Implant

GI
Colonoscopy
Endoscopy

Pain Management
Cervical Epidural Lumbar Epidural Steroid Stellate Ganglion Block

Not all covered procedures are listed. If you don't see a procedure listed, speak to a Care Advocate at **(855) 715-1683**

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SCRIPTSOURCING PROVIDES A UNIQUE OPPORTUNITY TO HELP EMPLOYEES SAVE MONEY ON NAME BRAND MEDICATIONS.

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Know the Costs®

For Cigna Participants Only

MRI | CT | Ultrasound | X-Ray | Nuclear Medicine | PET | Bone Density | Sleep Studies

Know the Costs ® (KTC) is a radiology benefit service that allows you to obtain certain outpatient radiology imaging and **NO COST** to you.

How to make the most of your benefit:

- If your doctor orders imaging, be sure to tell them you have the KTC radiology benefit.
- Contact us prior to imaging appointments to ensure you're scheduled at a KTC facility or locate a participating KTC facility.
- Don't present your health insurance card, only your KTC card with group number.
- When completing registration paper work, list KTC as your primary insurance.
- Sleep studies available at Coosa Medical Group.
- If the imaging provider bills your insurance, we may be unable to reverse the filing.

How to Reach us:

info@KnowTheCosts.com

833-KTC-4YOU

Members

Call *Know the Costs*® before Scheduling Outpatient Imaging

NHN Participants

Participants who are enrolled in the NHS (Northside Health Network) should use Northside & CHOA Imaging Centers.

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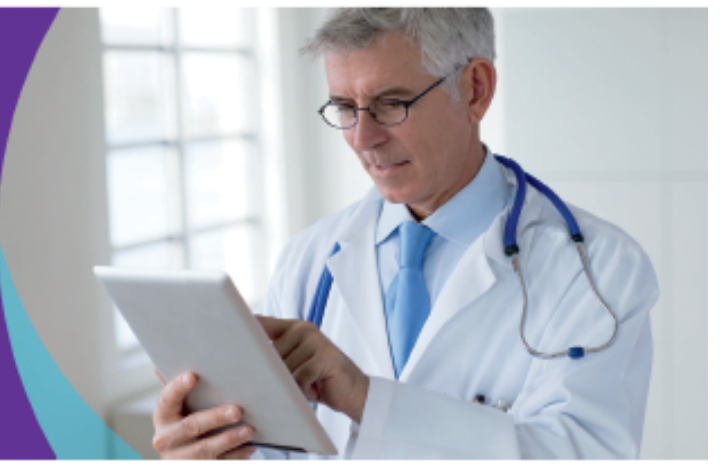
TELADOC.

Trustmark
benefits beyond benefits

So many reasons to use Teladoc®



Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits.
It's an affordable option for quality medical care.

1. Talk to a doctor anytime, anywhere you happen to be
2. Receive quality care via phone, video or mobile app
3. Prompt treatment, talk to a doctor in minutes
4. A network of doctors that can treat every member of the family
5. Prescriptions sent to pharmacy of choice if medically necessary
6. Teladoc is less expensive than the ER or urgent care

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink Eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician

Talk to a doctor anytime!

Teladoc.com
1-800-TELADOC (835-2362)

Available on the iPhone App Store
Google play

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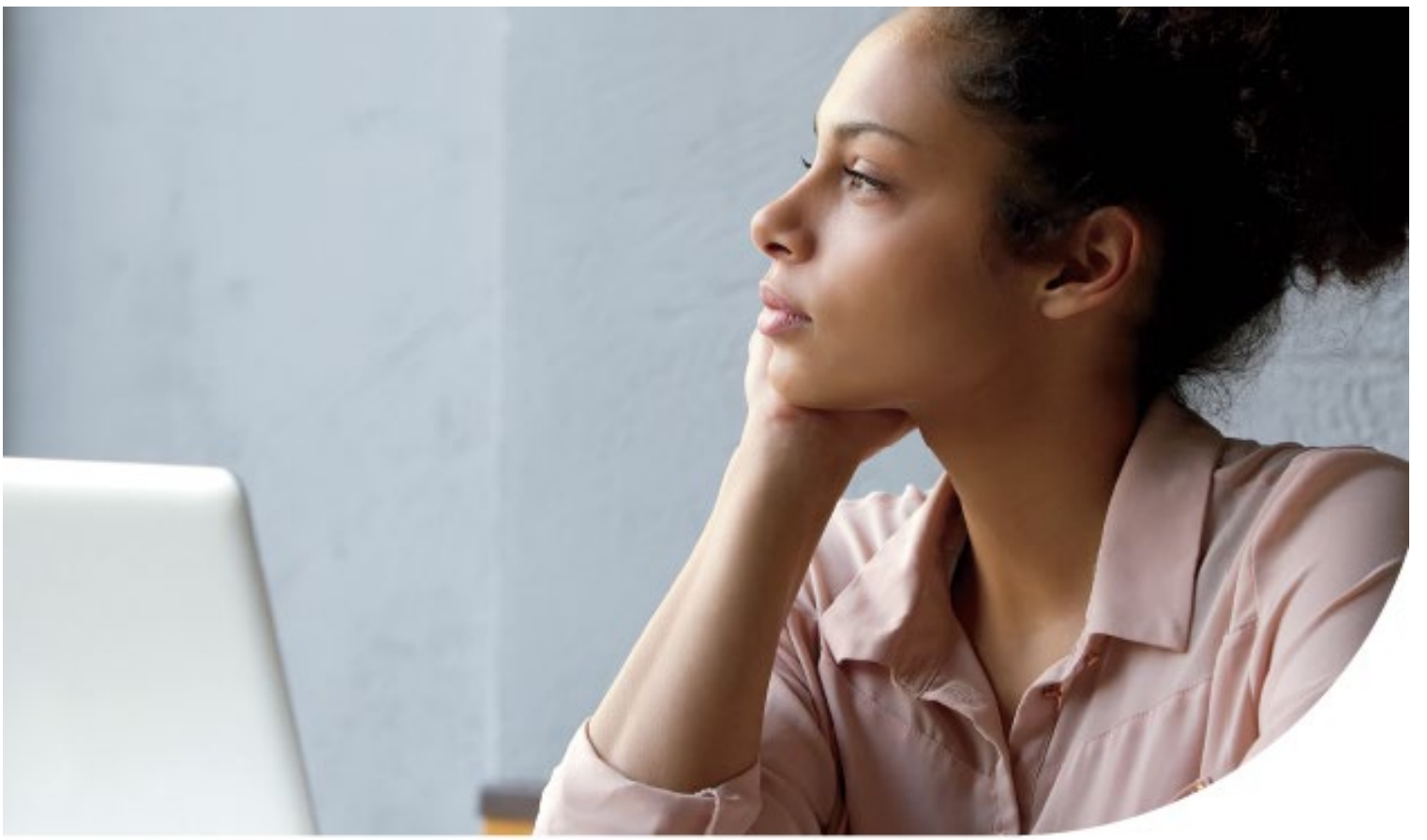

A **calm mind** is a tap away

How is your emotional well-being?

If something is weighing you down, talking to someone can help. Teladoc's licensed therapists are available seven days a week. Choose your therapist, pick a time that is convenient for you, and then talk to the therapist from the privacy of home or anywhere you feel comfortable.

Teladoc therapists can treat:

- Anxiety
- Depression
- Stress/PTSD
- Panic disorder
- Family and marriage issues
- And more

Get confidential therapy quickly and conveniently

Schedule a session today

Teladoc.com | Download the app |

TELADOC.

Made available by
Cherokee County BOC

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Employee Assistance Program (EAP)

ComPsych®
GuidanceResources® Worldwide

An Overview of Your GuidanceResources® Program

No matter what's going on in your life, GuidanceResources® is here to help.

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges. This flyer explains how GuidanceResources can help you.

Confidential Counseling on Personal Issues

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service, staffed by experienced clinicians, is available by phone 24 hours a day, seven days a week. A GuidanceConsultant℠ is available to listen to your concerns and refer you to a local provider for in-person counseling or to resources in your community. Call any time with personal concerns, including:

- Depression
- Marital and family conflicts
- Job pressures
- Stress and anxiety
- Alcohol and drug abuse
- Grief and loss

Online Information, Tools & Services

GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to www.guidanceresources.com. Each time you return to the site, you will find personalized, relevant information based on your individual life needs. You can:

- Review in-depth HelpSheets℠ on topics you select
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools

Financial Information, Resources, & Tools

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Getting out of debt
- Retirement planning
- Tax questions
- Estate planning

Legal Information, Resources, & Consultation

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

- Divorce and family law
- Debt obligations
- Landlords and tenants issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

We Are Available 24 Hours a Day/ 7 Days a Week

Call: 800.311.4327

TDD: 800.697.0353

Online: guidanceresources.com

Your company Web ID: GEN311

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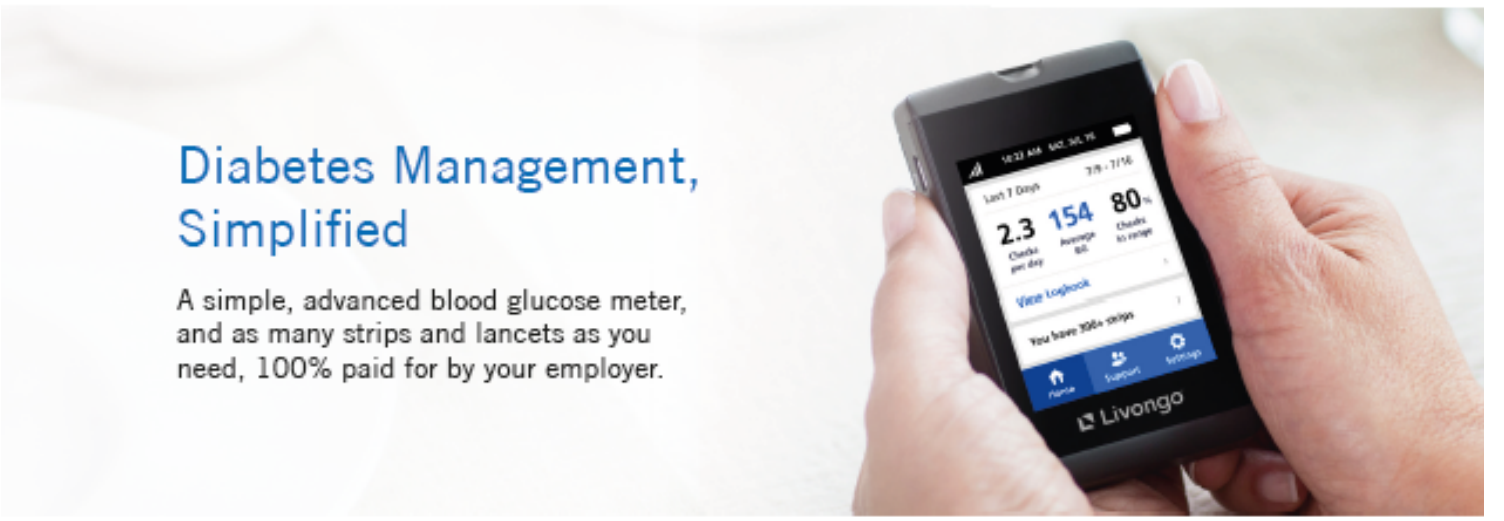
Diabetes Management

Trustmark
benefits beyond benefits

Livongo

Livongo is available to members who have been diagnosed with Type 1 or Type 2 diabetes.



It's all in the meter and on the house.

- Personalized tips with each blood glucose check
- Real-time support when you're out of range
- Strip reordering, right from your meter
- Optional family alerts keep everyone in the loop
- Send a health summary report directly from your meter
- Automatic uploads mean no more paper logbooks

Unlimited strips.
Unlimited lancets.
It's all free for you.

Join today at **join.livongo.com/TRUSTMARK/register** or call **(800) 945-4355**

Use registration code: **TRUSTMARK**

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Dental Insurance

Your Dental plan is provided through Delta Dental. Find a dentist at www.deltadentalins.com. Your Plan pays **$1,200 per person** total per Benefit Year on all services, except oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services.

If you choose to go Out-of-Network, the reimbursement level will be based on the reasonable and customary charges from dentists in the same area.

Delta Dental

Phone: *1-800-521-2651*

Website: *www.deltadentalins.com*

SUMMARY OF BENEFITS		
Annual Deductible - (Individual/Family)	$50/$150	
Annual Benefit Maximum	$1,500	
Orthodontia Lifetime Maximum	$1,000	
Network	PPO & PREMIER Network	
	In Network	**Out of Network**
TYPE A - DIAGNOSTIC AND PREVENTIVE SERVICES (DEDUCTIBLE IS WAIVED)		
Oral Evaluations	Covered 100%	Covered 100%
Prophylaxis: Cleanings		
Fluoride Treatment (child only)		
Bitewing X-rays, Full Mouth X-rays		
Sealants		
Space Maintainers		
TYPE B - BASIC SERVICES		
Fillings	Covered 80%	Covered 80%
Endodontics		
Simple Extractions		
Palliatative Emergency Treatment		
Occlusal Guards (one per year)		
TYPE C - MAJOR SERVICES		
Periodontal Services	Covered 50%	Covered 50%
Inlays/Crowns/Bridges		
Oral Surgery		
Dentures		
ORTHODONTIA SERVICES		
Diagnostics and Treatments	Covered 50%	Covered 50%
EMPLOYEES BI-WEEKLY PAYROLL DEDUCTIONS		
Employee Only	$6.50	
Employee + Spouse	$18.25	
Employee + Child(ren)	$17.22	
Employee + Family	$26.11	

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Vision Insurance

The National Vision Administrators plan is a full service plan that offers choice, flexibility, and value. Find a provider at www.e-nva.com.

National Vision Administrators (NVA)

Phone: *1-800-672-7723*
Website: *www.e-nva.com*

SUMMARY OF BENEFITS	IN NETWORK	OUT OF NETWORK	FREQUENCY
Routine Eye Examination*	$10 copay	$21 allowance	12 months
Eyeglass Frames	$150 allowance then 20% discounted remaining balance	$75 allowance	12 months
STANDARD EYEGLASS LENSES			
Single Vision	$10 copay	$18 allowance	12 months
Bifocal		$32 allowance	
Trifocal		$56 allowance	
CONTACT LENSES			
Conventional Contact Lenses	$120 allowance then 15% discount off remaining balance	$72 allowance	12 months
Disposable Contact Lenses	$120 allowance	$72 allowance	
Medically Necessary Contact Lenses	Covered in full	$200 allowance	
EMPLOYEES BI-WEEKLY PAYROLL DEDUCTIONS			
Employee Only		$3.40	
Employee + Spouse		$6.78	
Employee + Child(ren)		$6.40	
Employee + Family		$9.80	

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Basic Life and AD&D Insurance

Cherokee County Board of Commissioners pays 100% of the premium for your Basic Life/AD&D coverage as an Active employee. Once you retire, you can elect to continue $25,000 but you will pay the full cost.

Prudential

Phone: *1-800-534-0542*

Website: *www.prudential.com*

BENEFIT SUMMARY	
Life Benefit	
Amount	Class 1: Active Employees: 1 times annual salary (from $25,000 to a maximum of $200,000)
AD&D Benefit	
Amount	Class 1: Active Employees: 1 times annual salary (from $25,000 to a maximum of $200,000)
Benefit Reduction	
Benefits will reduce:	65% of the original amount at age 65

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Voluntary Life and AD&D Insurance

Prudential

Phone: *1-800-534-0542*

Website: *www.prudential.com*

BENEFIT SUMMARY	
Employee Life Benefit	
Amount	$50,000 increments to a maximum of $250,000
Guarantee Issue	$150,000 when first eligible
Spouse Life Benefit	
Amount	$25,000, $50,000, or $100,000
Guarantee Issue	$25,000 when first eligible
Child Life Benefit	
Amount	$10,000
Guarantee Issue	$10,000
AD&D Benefit	
Amount	Employee Amount: $50,000 increments to a maximum of $250,000 Spouse Amount: $25,000 increments to a maximum of $100,000 Child Amount: $10,000
Benefit Reduction	
Benefits will reduce	At age 65: 65% of the original amount

How to Calculate Your Voluntary Life Premium:

Premium is based on coverage units of $1,000 Formula:
(Benefit Volume x Rate)/1,000 = Monthly Premium

Example:

- 40 year old employee elects $200,000 in coverage
- Monthly Premium = ($200,000 x $0.194)/1,000= $38.80
- Payroll Deduction = ($38.80 x 12)/26 = $17.90 per bi-weekly paycheck

Coverage	Age	Employee Monthly Tobacco Rate	Employee Monthly Non-Tocacco Rate	Spouse Rates (Based on SP DOB)
		Per $1,000	Per $1,000	Per $1,000
Optional Life Employee and Spouse (based on Employee age)	Under 25	$0.163	$0.091	$0.102
	25-29	$0.163	$0.091	$0.102
	30-34	$0.225	$0.104	$0.112
	35-39	$0.318	$0.138	$0.142
	40-44	$0.475	$0.194	$0.224
	45-49	$0.797	$0.318	$0.400
	50-54	$1.285	$0.535	$0.656
	55-59	$1.795	$0.817	$0.948
	60-64	$2.210	$1.106	$1.454
	65-69	$3.901	$2.173	$2.684
	70-74	$6.483	$4.057	$4.672
	75+	$6.489	$4.057	$4.672
Optional AD&D		$0.04/$1,000		
Optional Dependent Child(ren)		$0.27 per $1,000 (covers all dependent children)		

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Short Term Disability Insurance

Cherokee County Board of Commissioners pays 100% of the premium for your coverage as an Active employee.

Prudential
Phone: *1-800-842-1718*
Website: *www.prudential.com*

BENEFIT SUMMARY	
Benefit	
Elimination Period	Accident: 7 days Illness: 7 days
Weekly Benefit	60%
Maximum Benefit Period	12 weeks
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	$25
Definitions	
Definition of Disability	Partial disability with zero day residual benefits

Long Term Disability Insurance

Cherokee County Board of Commissioners pays 100% of the premium for your coverage as an Active employee.

Prudential
Phone: *1-800-842-1718*
Website: *www.prudential.com*

BENEFIT SUMMARY	
Benefit	
Elimination Period	90 days
Weekly Benefit	60%
Maximum Benefit Period	To age 65
Maximum Weekly Benefit	$6,000
Minimum Weekly Benefit	10% or $100, whichever is greater
Definitions	
Definition of Disability	24 month own occupation

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Prudential Travel Accident Insurance

Prudential

Phone: *1-800-842-1718*

Website: *www.prudential.com*

All full-time employees are covered by Worldwide emergency travel assistance through Prudential. When traveling for business or pleasure, in a foreign country or just 100 miles or more away from home, you and your family can count on getting help in the event of a medical emergency.

- Hospital admission guarantee
- Emergency medical evaluation
- Medically supervised transportation home
- Transportation for a friend or family member to join hospitalized patient
- Prescription replacement assistance
- Multilingual crisis management professionals
- Medical referrals to western-trained English speaking medical providers
- Care and transport of unattended minor children

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Voluntary Supplemental Insurance

Voluntary Supplemental Plans

You have the opportunity to apply for payroll deducted personal insurance products! These benefits are designed to enhance your current benefits portfolio and can be customized to fit your individual needs!

- Premiums paid through payroll deduction
- Cash benefits paid directly to you
- Benefits paid regardless of other in-force coverage

Colonial Life

Phone: *1-800-325-4368*

Website: *www.colonialLife.com*

Colonial Group Medical Bridge (GMB7000) Plan 2:

The plan provides a lump-sum benefit for a covered hospital confinement. Also included is an outpatient surgery benefit of $1,000 for Tier 1 surgeries or $1,500 for Tier II surgeries, a $100 Daily Hospital Confinement benefit, a $100 per day Rehabilitation Unit Confinement benefit and a $50 standard Wellbeing Assistance benefit.

Group Medical Bridge 7000 - Plan 2 Hospital Confinement Benefit $500/$1,000 Outpatient Surgical Benefit (CY Max $1,500) $100 Daily Hospital Confinement Benefit $100 Rehabilitation Unit Benefit $50 Wellbeing Assistance Benefit Standard		
Hospital Confinement Benefit	**$1,000**	**$1,500**
Employee	$12.21	$14.72
Employee & Spouse	$26.49	$31.89
Employee & Child(ren)	$17.33	$20.77
Family	$31.62	$37.94

Colonial Group Cancer Insurance:

Helps offset the out-of-pocket medical and non-medical expenses related to cancer, such as hospital confinement, cancer treatments (chemotherapy, radiation, experimental treatment, bone marrow, and peripheral stem cell transplant), surgical procedures, transportation and lodging. Also included is a $75 benefit for cancer screening tests, a $5,000 Initial Diagnosis Cancer benefit rider and a Specified Disease benefit rider.

Group Cancer with Additional Benefits	
Plan	**Level 3 with $5,000 Initial Diagnosis Benefit Rider and Specified Disease Benefit Rider**
Employee	$10.73
Family	$17.82

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Voluntary Supplemental Insurance

Colonial Group Critical Insurance:

Complements your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect costs related to a covered critical illness, which can often be expensive and lengthy. You have the choice of benefit from a minimum of $5,000 up to a maximum benefit payment of $50,000. Payment for Subsequent Diagnosis of a different Specified Critical Illness and Subsequent Diagnosis for the same specified illness and a $50 Health Screening Benefit are included.

Bi-Weekly Rates

GROUP CRITICAL CARE 1.0 - NON-HSA COMPLIANT
FULL CI BENEFITS w/SUBSEQUENT DIAGNOSIS plus A $50 HEALTH SCREENING BENEFIT

Non-Tobacco Employee Only							Tobacco Employee Only						
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
17-29	1.85	2.35	2.86	3.37	3.88	4.38	17-29	2.35	3.37	4.38	5.4	6.42	7.43
30-39	2.22	3.09	3.97	4.85	5.72	6.6	30-39	3.12	4.89	6.67	8.45	10.22	12
40-49	3.07	4.8	6.53	8.26	9.99	11.72	40-49	4.8	8.26	11.72	15.18	18.65	22.11
50-59	4.41	7.48	10.55	13.62	16.68	19.75	50-59	7.48	13.62	19.75	25.89	32.03	38.17
60-74	6.32	0.31	16.29	21.28	26.26	31.25	60-74	11.31	21.28	31.25	41.22	51.18	61.1
Non-Tobacco Employee & Spouse							Non-Tobacco Employee & Spouse						
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
17-29	2.84	3.6	4.36	5.12	5.88	6.65	17-29	3.6	5.12	6.65	8.17	9.69	11.22
30-39	3.39	4.71	6.02	7.34	8.65	9.97	30-39	4.71	7.34	9.97	12.6	15.23	17.86
40-49	4.66	7.25	9.83	12.42	15	17.58	40-49	7.25	12.42	17.58	22.75	27.92	33.09
50-59	6.85	11.63	16.41	21.18	25.96	30.74	50-59	11.63	21.18	30.74	40.29	49.85	59.4
60-74	9.81	17.54	25.27	33	40.73	48.46	60-74	17.54	33	48.46	63.92	79.38	94.85
Non-Tobacco 1 Parent Family							Tobacco 1 Parent Family						
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
17-29	1.92	2.49	3.07	3.65	4.22	4.8	17-29	2.42	3.51	4.59	5.68	6.76	7.85
30-39	2.28	3.23	4.18	5.12	6.07	7.02	30-39	3.16	4.98	6.81	8.63	10.45	12.28
40-49	3.12	4.89	6.67	8.45	10.22	12	40-49	4.85	8.35	11.86	15.37	18.88	22.38
50-59	4.45	7.57	10.68	13.8	16.92	20.03	50-59	7.52	13.71	19.89	26.08	32.26	38.45
60-74	6.39	11.45	16.5	21.55	26.61	31.66	60-74	11.38	21.42	31.45	41.49	51.53	61.57
Non-Tobacco Family							Tobacco Family						
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
17-29	2.88	3.69	4.5	5.31	6.12	6.92	17-29	3.65	5.22	6.78	8.35	9.92	11.49
30-39	3.44	4.8	6.16	7.52	8.88	10.25	30-39	4.75	7.43	10.11	12.78	15.46	18.14
40-49	4.71	7.34	9.97	12.6	15.23	17.86	40-49	7.29	12.51	17.72	22.94	28.15	33.37
50-59	6.9	11.72	16.55	21.37	26.19	31.02	50-59	11.68	21.28	30.88	40.48	50.08	59.68
60-74	9.85	17.63	25.41	33.18	40.96	48.74	60-74	17.58	33.09	48.6	64.11	79.62	95.12

Colonial Group Accident Preferred:

Offsets unexpected medical expenses resulting from fractures, dislocations, burns, etc. Provides for initial care and treatment and follow up care.

Bi-Weekly Rates

Employee Only	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
$7.28	$11.90	$12.94	$17.56

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Voluntary Supplemental Insurance

Trustmark Universal Life Events Insurance:

Plan is permanent life insurance that helps shield your family from financial hardship if you or your spouse are suddenly out of the picture. Includes Long-Term Care Benefit of 4%. You can apply for coverage for your spouse, children and grandchildren even if you choose not to participate.

Bi-Weekly Rates

	Age	Benefit Amount
$20/Bi-Weekly Non-Tobacco with LTC Rider	27	$100,229.00
	37	$65,492.00
	47	$36,924.00
	57	$20,224.00
	Guaranteed Cash Value at Age 65	
	27	$4,930.00
	37	$3,190.00
	47	$2,130.00
	57	$60.00

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Flexible Spending Account (FSA)

Ameriflex

Phone: *1-888-868-3539*

Website: *www.myameriflex.com*

Flexible Spending Accounts (FSAs) have become a popular vehicle for reducing rising health care costs. By contributing pre-tax dollars into an FSA, you can save an average of 20% on eligible expenses every year.

If you had funds remaining from 2022 and enroll for 2023, you can rollover up to $550 for your Dependent Care Flexible Spending Account and $570 for your Flexible Spending Account into your 2023 accounts.

You may participate in the following Flexible Spending Accounts:

Health Care Flexible Spending Account

Employees use pre-tax dollars to pay for insurance deductibles, co-payments, glasses and contact lenses, orthodontia, covered over-the-counter medications, and hundreds of other health care-related expenses not covered by their insurance plans. The maximum contribution amount for period 01/01/2023 through 12/31/2023 is $3,050.

Dependent Care Flexible Spending Account

Employees use pre-tax dollars to be reimbursed for work-related day care expenses for their children or dependent adults. The maximum contribution amount for period 01/01/2023 through 12/31/2023 is $5,000 if you are married and filing a joint return or if you are a single parent. If you are married but filing separately, the annual maximum contribution is $2,500.

The following table offers an example of the savings experienced by participating in an FSA:

	FSA Participant	FSA Non Participant
Annual Gross Income	$31,000	$31,000
FSA Deposit for Reoccurring Expenses	-$2,500	-$0.00
Taxable Gross Income	=$28,500	=$31,000
Federal & Social Security Tax	-$6,455.25	-$7,021.50
Annual Net Income	=$22,044.75	=$23,978.50
Cost of recurring Expenses	-$0.00	-$2,500.00
Spendable Income	=$22,044.75	=$21,478.50

For a complete list of Eligible Expenses reimbursable with an FSA account, as well as a complete list of Ineligible Expenses, please visit the following IRS link: www.irs.gov/publications/p502/ar02.html#en_US_publink100017894

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Cherokee County Defined Benefit Plan

What is a Defined Benefit Plan?
A defined benefit plan is the most popular type of primary plan offered by local governments in Georgia. This type of plan is called a "defined benefit" plan because the retirement benefits you will receive are set, or "defined" by the terms of the plan. Typically, the benefit amount is based on a formula that takes into account your salary and years of service in the organization. The plan provides a fixed monthly benefit payment for life, or you may choose from several other payment options that will determine the amount of your monthly benefit.

Participation in the DB plan is mandatory for all Full-Time employees. Employees are automatically enrolled at time of hire.

Please visit our website and register at www.accgretirement.org or by going to mypension.accgretirement.org to view your account.

ACCG Retirement Services

Phone: *770-952-5225*
1-800-736-7166

Website: *www.accgretirement.org*

Regional Client Manager
Robert Kim
(470) 352-1222
rkim@accg.org

Cherokee County Defined Contribution Plan

What is a Defined Contribution Plan?
A defined contribution plan is a retirement plan in which the employee contributes money that they can then invest. This type of plan is called a "defined contribution" plan because you decide how much you want to contribute to your account, and your payout at retirement depends on the performance of your chosen investments. You choose how you want your money invested. Since the Cherokee County BOC plan is a 457(b) plan, you can withdraw you benefits after separation of employment before age 59 ½ without the 10% early withdrawal penalty. Since your contributions are pre-tax, the money is taxed at withdrawal.

Participation in the DC plan is voluntary for all FT Employees. Employees can enroll in this plan at any time.

To Enroll in the 457(b) plan, go to:

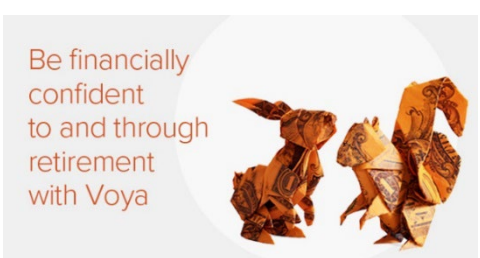
- Enrollment website: enroll.voya.com
- Plan#: 664562
- Verification Code: 005-054

To access your account, update beneficiaries, change contribution percentage or investments, visit https://voyaretirement.voya.com

VOYA Financial

Phone: *678-360-9677, Ext.1*

Website:*https://voyaretirement.voya.com*



Joe D Friend III, CRPC®
Financial Advisor
Voya Financial Advisors, Inc.
3482 Keith Bridge Road,
STE 348
Cumming,GA30041
Phone: 678.360.9677, Ext. 1
Fax:888.958.0721

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Terms To Know

SCAN OR CLICK THE QR CODE TO WATCH A SHORT VIDEO ON THE TERM YOU WOULD LIKE TO KNOW

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

ELIMINATION PERIOD: This is the time period between injury or illness and the receipt of benefit payments.

EMBEDDED DEDUCTIBLE: An embedded deductible is a system that combines individual and family deductibles in a family health insurance policy. When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible in order for after-deductible benefits to kick in, each individual only needs to meet the individual deductible in order for after- deductible benefits to kick in.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EVIDENCE OF INSURABILITY (EOI):
This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

IN NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

NON-EMBEDDED DEDUCTIBLE: A non-embedded deductible is also referred to as an aggregate deductible. Under an aggregate deductible, the total family deductible must be paid out-of-pocket before after-deductible benefits kick in for the health care services incurred by any family member.

OUT OF NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out- of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of- network, but will pay higher out-of-pocket costs.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

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Carrier Contact Information

LINE OF COVERAGE	CARRIER	CUSTOMER SERVICE NUMBER	WEBSITE/NETWORK
Medical	TPA - Trustmark Cigna Network NHN - Network CHOA First Health Teladoc SurgeryPlus	877.279.5285 800.667.1654 877.279.5285 877.279.5285 877.279.5285 800.835.2362 855.715.1683	www.mytrustmark.com www.cigna.com www.nhnmanager.com www.nhnmanager.com providerlocator.firsthealth.com www.teladoc.com www.cherokeecounty.surgeryplus.com
Rx **International Pharmacy Program** **Manufacturers Assistance Program**	US RX Care ScriptSourcing Scriptsourcing	877.200.5533 866.488.7874 866.488.7874	www.us-rxcare.com www.scriptsourcing.com www.scriptsourcing.com
Dental	Delta Dental	800.521.2651	www.deltadentalins.com
Vision	NVA	800.672.7723	www.e-nva.com
Basic & Voluntary Life/AD&D	Prudential	800.534.0542	www.prudential.com/gi
Short Term & Long Term Disability	Prudential	800.842.1718	www.prudential.com/gi
Travel Accident Insurance	Prudential	800.842.1718	www.prudential.com/gi
Employee Assistance Program	Compsych	800.311.4327	www.guidanceresources.com
Flexible Spending Accounts	Ameriflex	888.868.3539	www.myameriflex.com
Voluntary Benefits	Colonial Trustmark	800.325.4368 800.918.8877	www.coloniallife.com www.trustmarksolutions.com

Cherokee County Contact Information

For Benefits and Claims Questions	For Pension and Voya 457(b) Questions
Amy Cleveland Direct Line: 678-493-6014 Email: ancleveland@cherokeega.com	Lewis Williams Direct Line: 678-493-6020 Email: clwilliams@cherokeega.com

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Mandatory Notices

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 27 and 28 for more details.

IMPORTANT NOTICE: MEDICARE D CREDITABLE COVERAGE DISCLOSURE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cherokee County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Cherokee County has determined that the prescription drug coverage offered by the Trustmark 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 group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and the group plan will be your primary coverage and Medicare will be your secondary coverage.

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your reenrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be cancelled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage under the group plan 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.

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Mandatory Notices

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact your Human Resources 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 the group plan coverage 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 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).

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

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.

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.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact Human Resources.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

MODEL GENERAL OF NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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."

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Mandatory Notices

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** 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."

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;
- 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: Human Resources.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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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

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

Plan and COBRA continuation coverage can be obtained on request:
Amy Cleveland
Direct Line: 678-493-6014
Email: ancleveland@cherokeega.com

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

STATE CONTINUATION OF COVERAGE

Due to size, your group plan does not fall under Federal COBRA guidelines. However, you may have a state continuation option available to you. Contact your insurance carrier or Human Resources for more information. Additional information can be found on your state's department of insurance website.

WELLNESS PLAN NOTICE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. We will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Contact Human Resources for more information.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is 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.

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.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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.

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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 percent (as adjusted each year after 2014) 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. (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.)

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.

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

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 (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 deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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, 2022. Contact your State for more information on eligibility –

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ALABAMA – Medicaid

Website: http://myalhipp.com/ | Phone: 1-855-692-5447

ALASKA – Medicaid

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

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program
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+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurancebuy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid

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)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

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

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: (617) 886-8102

MINNESOTA – 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

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 | Omaha: (402) 595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY - Medicaid and CHIP
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
NEW YORK - Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
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
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2023)

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