Augusta County Public Schools

2024 Benefits Guide

Prepared by Marsh & McLennan Agency

Welcome to Your 2024 Benefits

We are dedicated to providing you with unique benefits that meet the needs of you and your family. We understand the importance of a well-rounded benefits program, and because of that, we offer a range of plans that help protect you in the case of illness or injury. You can learn about the details of these plan options by reading through this Benefit Guide.

Starting with the basics of how to enroll, followed by the details of each plan, this guide is a go-to resource for all things benefits related. Once you better understand the various options we offer, you can make an informed decision on which plans work best for you and your family.

We encourage you to read through this booklet in its entirety. Included you will find details about:

- Who is eligible to participate
- How to enroll and how to make changes during the year, if applicable
- Each benefit offered and a summary of what is covered under the plan
- The Insurance Companies who administer our benefits and how to contact them if you need assistance
- And much more!

We appreciate the hard work and dedication you bring to our schools. For this and many other reasons, we want to offer you competitive and cost effective benefits. It's one way we can say thank you for your contributions.

If you have any questions about the employee benefits described herein or would like more information, please refer to your plan documents and insurance booklets or contact Anne Hubbard at ahubbard@augusta.k12.va.us.

Sincerely,

Augusta County Public Schools

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 page 19 for more details.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. 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 questions about your benefits, contact Human Resources.

Eligibility & Enrollment

Who is Eligible

If you are a contracted employee or under a letter of agreement working at least 30 hours a week, you are eligible to enroll in the benefits found in this guide. Eligible dependents include your legal spouse, children up to age 26, and/or unmarried children over age 26 who are incapable of self-support.

New Hires

If you are enrolling as a New Hire, and you were hired between the 1st and the 15th of the month, you are eligible for our benefits on the first of the following month. If you were hired between the 16th and the 31st, your benefits begin on the first following the first full month. You have thirty days from your date of hire to submit your benefit elections.

When to Enroll

The open enrollment period is **October 20, 2023 to November 10, 2023**. The benefits you elect during open enrollment will be effective from January 1, 2024 through December 31, 2024.

How to Enroll

This year's open enrollment will be passive (**except for the FSA**), which means if you do not make elections during this open enrollment session, your current benefit choices will carry over for the 2024 plan year. Make any changes to, enroll in, or waive your coverages in Plansource by **November 10th, 2023**.

Use this link to access your benefit enrollment site: http://benefits.plansource.com.

To access your online account for enrollment, use the initial login information below:

User Name:

- First initial of your First Name
- First six letters of your Last Name
- Last four (4) digits of your SSN

Initial Password:

- Your birthdate in YYYYMMDD format
- This will take you to a password reset page

Retain your password for future use.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to your benefit elections until next year's open enrollment period. Life events such as marriage, divorce, birth or adoption of a child, change in child's dependent status, death of qualified dependent, change in employment status or change in coverage under another employer-sponsored plan may qualify you for a special enrollment period. Please notify Anne Hubbard within 30 days of your qualifying event.

Have Questions?

Anne Hubbard
Benefits & Payroll Supervisor
ahubbard@augusta.k12.va.us or payroll@augusta.k12.va.us

Medical Plan

Anthem

The chart below provides an overview of the medical plan through Anthem. Please refer to your plan document for specific details. Networks frequently change and so it is always a good idea to confirm your provider's participation is in-network to avoid additional costs.

	Anthem Low Plan
Services	**In-Network**
Deductible • Individual • Family	Embedded* $1,000 $2,000
Coinsurance • Plan Pays • You Pay	 70% 30%
Out-of-Pocket Max • Individual • Family	 $4,000 $8,000
Preventive Services	Covered at 100%
Primary Care Visit	$25 copay
Specialist Visit	$50 copay
Virtual Visits	See details in the Virtual Care section of this guide
Urgent Care	$75 copay
Emergency Room	30% after deductible
Inpatient	30% after deductible
Vision - Blue View Vision In Network Only • Child • Adult	 No Charge $15 copay
Services	**Out-of-Network**
Deductible • Individual • Family	Embedded $1,000 $2,000
Coinsurance • Plan Pays • You Pay	 60% 40%
Out-of-Pocket Max • Individual • Family	 $4,000 $8,000

**Embedded Deductible – In an embedded plan deductible, after each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan.*

Your Cost

Your monthly payroll deductions are shown below.

Medical Employee Deductions					
	Employee Only	Employee & Child	Employee & Children	Employee & Spouse	Employee & Family
Low Plan	$0.00	$169.50	$331.50	$372.00	$605.00
High Plan Grandfathered Employees Only	$80.00	$294.50	$495.50	$544.00	$838.00

Pharmacy Information

Enrolling in medical coverage provides prescription drug coverage through Anthem. Below highlights information about the prescription drug plan offered!

	Anthem Low Plan	
Rx Deductible	None	
	30-Day Retail	**90-Day Mail Order**
Tier 1 Generic	$10	$20
Tier 2 Preferred Brand	$30	$60
Tier 3 Non-Formulary Brand	$60	$120
Tier 4 Specialty	$60	30 day only - $60

Prescription Drug Benefits

Prescription Drug Benefits are offered through Anthem. Please remember that you must take your Anthem card to a retail pharmacy if you want to fill a prescription. if you are on maintenance prescriptions, you can only fill these at CVS, Walmart, Kroger or at a lower cost by using our Mail Order service, Carelon. See "Mail Order and Specialty Rx section below for more information.

Anthem encourages the use of formulary medications. The most up to date drug lists and drug management program information is located online at www.anthem.com.
If your medication is not listed, ask your doctor about an equivalent medication that is listed on the formulary.

Mail Order & Specialty Rx

If you are currently taking any maintenance medications, take advantage of the cost savings and convenience of our Mail Order Program. Specialty drugs are high cost drugs used to treat certain chronic conditions. Specialty drugs must be obtained directly through our specialty pharmacy: CarelonRx.

CarelonRx will fill and ship your specialty medication right to your home. They have a team of specially trained pharmacists and nurses who can provide you with the personalized care and support you need to manage your therapy – all at no extra cost to you! The service includes easy refills, reminders, text alerts, free shipping, and 24/7 access to your specialty pharmacist team.

Price Comparison Tools

Did you know you can compare drug prices based on your zip code by logging in to our Anthem account at www.anthem.com? You can also review a list of medications that are considered equivalent to the drug you have been prescribed to see if there is a generic or lower cost alternative to discuss with your medical provider.

If you take a high cost medication or a specialty medication, talk to your provider or pharmacist about manufacturer assistance programs. Many drug manufacturers offer copay assistance programs that will limit the out-of-pocket cost on the drug. You can also search for the drug manufacturer online and apply for these programs.

Retail Pharmacy Discount Programs

Pharmacies offer generic medication programs for 30 and 90–day supplies for less than $10. Several popular maintenance medications are offered through these generic programs. In order to take advantage of these programs, take your prescription to one of the participating pharmacies and present to the pharmacist. You will not need to show your Provider ID card. It's that easy to start saving money!

GoodRx

GoodRx is a savings site and app that allows you to shop for the best cost, offers additional savings with a drug discount card, and finds the lowest prices and discounts by comparing prices at different pharmacies. You receive instant access to the lowest prices for prescription drugs at more than 75,000 pharmacies, plus pharmacy hours and locations, pill images, promotions and discounts, and savings tips that can cut your prescription costs!

Virtual Care

Virtual Care doctors can treat cold and flu symptoms, bronchitis and other respiratory infections, sinus and ear infections, pinkeye, allergies, migraines, rashes and other skin irritations, urinary tract infections and much more!

Virtual Care through Sydney Health™			
	Employee Cost	Examples of appropriate care level	
Virtual Primary Care	**Low Plan** Annual Well visit - $0 Condition Management $0	• Annual Well Visits • Annual bloodwork	• Chronic condition management for issues such as high blood pressure, cholesterol, diabetes, etc.
Medical Text Chat*	$0	• Annual Well Visits • Annual bloodwork • Chronic condition mgmt. • Low intensity urgent care issues	• Infections • Cold and flu • Sore or strep throat • Rash
Video Visits • PCP • Specialist	• $0 • $50	• Stress, anxiety, depression • Upper Respiratory Infection • Rash • Sinus Infection • Sore Throat/Strep	• Back Pain • Urinary Tract Infections • Sprains or Strains • Colds and Flu

You can also ask your primary care doctor if they offer telehealth visits.

Virtual Visits with your PCP	Anthem Low Plan
• PCP • Mental Health / Substance Abuse Care • Specialist	$25 copay $25 copay $50 copay

* You will see a $39 hold on your credit card until the vendor confirms insurance information and once they confirm the cost share the hold would be voided.

Anthem's Mobile App

The Sydney Health™ mobile app provides quick access to your health plan information — all in one place. The app's interactive chat feature helps you navigate your benefits with greater ease. Simply type your questions in the app to find answers quickly.

Sydney Health™ can also suggest resources to help you understand your benefits, improve your health, and save money.

You can scan the QR code to download the Sydney Health™ app today.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs.

My Health Dashboard

You can filter providers by what is most important to you such as gender, languages spoken, or location.

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals.

Live Chat

Find answers quickly with the Live Chat tool in Sydney Health. You can use the interactive chat feature or talk to an Anthem representative when you have questions about your benefits or need information.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker, then consult with a doctor through a video visit or text session.

Community Resources

This resource center helps you connect with organizations offering free and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

Use the Sydney Health℠ app for a virtual visit with a doctor 24/7. Video call, text, or chat with a doctor who can help you feel better — no appointment required.

Behavioral Health

Seeking help for depression, stress and other types of mental illness is a big step. Virtual Care makes it easier for you to take that step by providing convenient access to licensed therapists in the privacy of your own home or office. The cost is similar to what you would pay for an office therapy visit.

Psychologists and therapists seen through Virtual Health can help you 7 days a week with many conditions. The conditions include stress, anxiety, depression, grief, panic attacks, relationship or family issues, coping with an illness and more.

Condition Care - Anthem

Managing an ongoing health condition is not easy, and having a little extra help can make all the difference. *Condition Care* is a no-cost health and wellness program with tools, resources and support you and your covered dependents with diagnosis such as Asthma (pediatric or adult). Chronic obstructive pulmonary disease (COPD), Coronary artery disease, Diabetes, types 1 and 2 (pediatric or adult), and Heart failure. You will get 24/7, toll-free phone access to nurses, nurse care managers, dietitians, and other health care professionals who can answer health questions and support in reaching your health goals. Educational guides, electronic newsletter and tools to help you learn more about your condition(s) are also available.

Condition Care does not replace your doctor. Instead, the clinical team members work with your doctor to help you follow your care plan and meet your health goals.

Know Where To Go

If you need immediate medical attention, your first thought may be to go to the Emergency Room. However, if your condition is not serious or life threatening, you may have a less expensive choice. Use the chart below to identify where you should go for care!

Plan	Cost	When to Use
Primary Care	$	Routine, Primary, Preventive Care Regular Health Screenings Non-urgent treatment Chronic disease management
Virtual Visits	$	Cold, flu, fever, sore throat, diarrhea, rash, pink eye, sinus infections, cough, headache, stomach ache or ear ache
Convenience Care	$$	Common infections (ear, pink eye, strep, bronchitis), flu shots, vaccines, rashes, screenings
Urgent Care	$$$	Sprains, small cuts, strains, sore throats, minor infections, mild asthma, back pain or strain, vomiting, flu, fever, sports injuries *After hours care & no appointments necessary*
Emergency Room	$$$$	Heavy bleeding, large open wounds, chest pain, spinal injuries, difficulty breathing, major burns, severe head injuries, seizures, unconsciousness, poisoning *Life threatening emergency*

If you believe you are experiencing a medical emergency, go to your nearest emergency room or call 911, even if your symptoms are not as described here.

Click here to watch a video about Knowing Where To Go.

Supplemental Health Benefits

Aflac Policy Overview

The additional health benefit options below can be used to customize your coverage to complement your medical plan options. If you elect any other the voluntary options below, you will be responsible for the cost of these benefits and directly debited from your bank account or credit card.

Health insurance doesn't cover everything. Aflac pays money directly to you to help cover lost wages, co-pays, deductibles, and any other out of pocket expenses you may have.

For more information on these benefits and rates, please refer to www.aflacgroupinsurance.com/customer-service/.

Accident Insurance

Accident insurance will pay you if you seek treatment for any on the job or off the job injury. Benefits are payable for medexpress/ emergicare, ER, primary doctor, physical therapy, follow up appointments, x-ray, MRI, surgery, hospitalization, and much more. Will also pay each family member $50 each year to have a wellness exam, physical, or any vaccination. Coverage is available for employees, spouse, and children up to age 26.

Critical Illness Insurance

Critical Illness Insurance will pay you a lump sum benefit of your choosing between $5,000 and $50,000 if the following events occur: cancer, heart attack, stroke, kidney failure, major organ transplant, sudden cardiac arrest, bypass surgery, sever burn, paralysis, coma, loss of speech/sight/hearing, benign brain tumor, Alzheimer's Disease, Parkinson's Disease, ALS, sustained Multiple Sclerosis. Will also pay employee and spouse $100 each year to receive an annual physical. Coverage is available for employees, spouse, and children up to age 26.

Aflac Representative:

Michelle Lawson, Bost Benefits
+1434-760-2257

How To Enroll With Aflac

URL: www.memberbenefitlogin.com/acps

- Log in ID: SSN + 740 (Example: 123-45-6789 = 123456789740)
- Initial Password: Date of Birth (MMDDYYYY)
- Complete payment information - Employees are responsible for the full cost of this coverage

Once you have enrolled in the insurance products you wish to have, you will need to complete the process by adding your direct billing information such as a bank account or credit card. This is completed in the Final Steps page and you will be directed to the Paylogix website.

Flexible Spending Accounts (FSA)

Flexible Benefits Administrators

FSAs provide you with an important tax advantage that can help you pay for expenses on a pre-tax basis. By anticipating your family's costs for the next year, you can actually lower your taxable income.

You must enroll in your FSA every year to contribute. Your FSA plan options are shown below.

Dependent Care FSA

- Available to all employees
- Allows employees to use pre-tax dollars toward qualified dependent care such as caring for children under age 13 or caring for elders.
- **The annual contribution maximum is $5,000** (or $2,500 if married and filing separately).
- There is no rollover for dependent care FSA funds.
- All claims for services incurred in 2024 must be submitted by February 28, 2025.

Healthcare FSA

- Allows employees who are not contributing to an HSA to pay for certain IRS-approved medical care expenses with pre-tax dollars.
- **The 2023* annual maximum contribution of $3,050 can be used for eligible health care related expenses, including medical, dental and vision expenses.**
- This plans allows any remaining funds up to $610 to rollover into the next plan year.
- Services must be incurred between January 1 and December 31, 2024.
- All claims for services incurred in 2024 must be submitted by February 28, 2025.

The IRS maintains a complete list of qualified medical and dependent care expenses eligible for FSA reimbursement. See the list at: https://www.irs.gov/publications/p502/index.html.

*The 2024 rates have not been released by the IRS as of the publication of this booklet.

Dental Plans

United Concordia

You have two choices for dental coverage offered by United Concordia. Deductible is waived for preventive care. Although you may use non-participating dentists, you will likely pay more than you would if you are using a provider in the carrier network. **Scan this QR code to access the United Concordia portal for more information about your dental plans.**

SAW Consortium Client Center

	Low Plan	High Plan
Benefits	**In-Network Member Costs**	**In-Network Member Costs**
Annual Deductible (Calendar Year) Individual Family	 $50 $150	 $50 $150
Preventive Services	Covered 100%	Covered 100%
Basic Services	20%	20%
Major Services	N/A	50%
Annual Maximum	$1,000	$1,500
Orthodontia Adults and Children	N/A	50%
Orthodontia Lifetime Maximum	N/A	$1,250
Out-of-Network Overview*		
Reimbursement	100% Preventative 20% Basic United Concordia's non-participating allowance	100% Preventative/20% Basic/ 50% Major United Concordia's non- participating allowance

*Out-of-Network providers can balance bill you the difference between what they charge and the carrier's reasonable and customary amount.

- **United Concordia Mobile Apps**
  - This secure mobile app allows members to check the status of their claims, view plan coverage information, access a virtual ID card and use other features.
  - The Chomper Chums app helps parents encourage their children to learn proper brushing techniques and establish long-lasting, good oral health care habits.
- **Smile for Health® - Wellness**, encouraging proper treatment and maintenance of periodontal health in members with certain qualifying chronic conditions.
- **My Dental Benefits -** United Concordia's *My Dental Benefits* portal offers members secure access to manage your dental benefits information, including covered services, coverage levels, frequency limitations, maximums and deductibles, explanations of benefits (EOBs), claims status and history, and virtual ID cards.

Scan here to download the mobile App

Your Cost

Your payroll deductions are shown below.

Dental Employee Deductions					
	Employee Only	Employee & Child	Employee & Children	Employee & Spouse	Employee & Family
Low Plan	$23	$44	$49	$46	$70
High Plan	$33	$63	$70	$66	$99

Voluntary Vision Plan

Anthem

With the Blue View Vision network you may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com.The chart below provides an overview of your available vision plan through Anthem. Please refer to your plan document for specific details. Using an in-network provider will offer you the lowest service pricing.

	Vision Plan	
In-Network Benefits	**In-Network Member Costs**	**Out-of-Network Member Reimbursements**
Vision Exam	$10 copay	Up to $42
Frames	$130 allowance	Up to $45
Lenses	$20 copay	Up to $40 - $80
Contact Lenses	$130 allowance	Up to $105
Contact Lens Fit & Follow-Up Standard Premium	 $0 copay 10% off retail, then $55 allowance	 Up to $35 Up to $35
Benefit Frequency		
Exams	Once every 12 months	Once every 12 months
Lenses (or Contacts)	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months

** Using a provider that is out of the network shown above, you may experience higher costs.*

To Find an in-Network Provider

To locate a participating network eye care doctor or location:

- » Use your Sydney Health app.
- » Log in at anthem.com, click on the *Find Care* button.
  - Choose either the “Use Member ID for Basic Search” or “Basic Search as a guest” options.
  - Complete the steps to find a provider under your Blue View Vision network.

Your Cost

Your payroll deductions are shown below.

Monthly Vision Employee Deductions				
Employee Only	**Employee & Spouse**	**Employee & Child**	**Employee & Children**	**Employee & Family**
$7.36	$14.70	$12.66	$18.56	$25.88

Important Terms

Use the terms below to understand your benefits better!

Coinsurance	A percentage of a health care cost that the covered employee pays after meeting the deductible.
Copayment (Copay)	A fixed dollar amount for each doctor visit that the covered employee pays for a health care service, usually when the service is received. For example, a primary care doctor may charge a nominal copay per visit.
Deductible	A fixed dollar amount that the covered employee must pay out-of-pocket each calendar year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits for individual and other coverage tiers.
Explanation of Benefits (EOB)	A record of a person's past and current health events. A "detailed receipt." Ask for this whenever you have a medical service performed for your records. FSAs, HSAs and HRAs will sometimes need this additional verification.
Evidence of Insurability (EOI)	A record of a person's past and current health events. It is used by insurance companies to verify whether a person meets the definition of good health.
Guarantee Issue (GI)	A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, GI doesn't limit how much you can be charged if you enroll.
In-Network	Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.
Out-of-Network	A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than in-network providers.
Out-of-Pocket Maximum	The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including copayments and coinsurance.
Preventive Care	Most health plans must cover a set of preventive services – like shots and screening tests – at no cost to you. Visit https://www.healthcare.gov/coverage/preventive-care-benefits/ to view free preventive services for all adults, women and children.
Premium	The amount the employee pays for your health insurance.

Employee Resources

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

Benefit	Whom To Call	Phone Number	Website
Medical	Anthem	+1800-451-1527	www.anthem.com
Pharmacy	Anthem	+1800-451-1527	www.anthem.com
Virtual Care	Use your Sydney Health℠ App		
Dental	United Concordia	+1800-332-0366	www.unitedconcordia.com
Vision	Anthem	+1866-723-0515	www.anthem.com
Flexible Spending Accounts	Flexible Benefits Administrators	+1800-437-3539	flexdivision@flex-admin.com
Accident	Aflac	+1800-433-3036	www.aflacgroupinsurance.com/customer-service/
Critical Illness	Aflac	+1800-433-3036	www.aflacgroupinsurance.com/customer-service/

Educational Videos

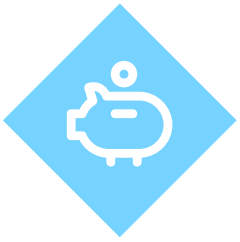
Click on the videos below to learn more about how the benefit works.

PPOs & HDHPs

In & Out-of-Network

Dental

Vision



Health FSA

Dependent Care FSA

Health and Welfare Benefits Annual Notices

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law for the 2024 plan year.

Enclosures:

- Medicare Part D Creditable Coverage Notice
- HIPAA Special Enrollment Rights Notice
- HIPAA Notice of Privacy Practices
- Children's Health Insurance Program (CHIP) Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice
- Newborns' Mothers Health Protection Act (NMHPA) Notice
- General Notice of COBRA Continuation Rights
- Health insurance marketplace coverage options and your health coverage – new hire only

Augusta County Schools will herein be referred to as "Employer"

Anthem will herein be referred to as "Medical Plan(s)"

Anne Hubbard will herein be referred to as "Plan Administrator"

You can contact your Plan Administrator at Anne Hubbard at ahubbard@augusta.k12.va.us

The attached legal notices packet includes certain legal notices applicable to most employers that offer health and welfare benefit plans. We have prepared this packet for you based on our knowledge of your benefits as our client and our understanding of the notices requirements as a broker in the insurance industry and not as legal or tax advice. These notices may require certain modifications to fit your exact circumstances in order to fulfill your legal obligations. There may also be other legal notices applicable to you that are not included within this packet. We recommend you review these notices with your legal counsel prior to distributing them to your employees and plan participants, and we are happy to assist you and/or your legal counsel with this review process.

IMPORTANT NOTICES

IMPORTANT NOTICE FROM YOUR EMPLOYER 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 your Employer 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. Your employer has determined that the prescription drug coverage offered by the Medical Plan(s) 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 while enrolled in the Employer's coverage as an active employee, please note that your Employer coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in your Employer's coverage as a former employee.

You may also choose to drop your Employer's coverage. If you do decide to join a Medicare drug plan and drop your current Employer's coverage, be aware that you and your dependents may not be able to get this coverage back.

IMPORTANT NOTICES

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 your Employer 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 your Employer 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).

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:	10/20/23
Name of Entity/Sender:	Augusta County Schools
Contact--Position/Office:	Anne Hubbard/Benefits & Finance Supervisor
Address:	ahubbard@augusta.k12.va.us
Phone Number:	+1540-245-5126

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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)	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+)	**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

IMPORTANT NOTICES

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: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	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: (617) 886-8102
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

IMPORTANT NOTICES

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: +1919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: +1888-549-0820	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: +1800-432-5924
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 July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

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

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Anne Hubbard +1540-245-5126.

WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), 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?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 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).

HIPAA NOTICE OF PRIVACY PRACTICES

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.

The Employer sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Employer, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by they Employer, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Employer's HIPAA Privacy Officer:

Augusta County Schools
Attention: HIPAA Privacy Officer
Anne Hubbard
Benefits & Finance Supervisor
ahubbard@augusta.k12.va.us

Effective Date

This Notice as revised is effective October 20, 2023

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether

the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical

information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

IMPORTANT NOTICES

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

IMPORTANT NOTICES

Model 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."

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: FBA COBRA Administrator

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**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

IMPORTANT NOTICES

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/agencies/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
Contact Anne Hubbard at +1540-245-5126 or ahubbard@augusta.k12.va.us.

IMPORTANT NOTICES

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE - NEW HIRE ONLY

Part A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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.

** 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.*

How Can I get More Information?

For more information about the 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 HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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 ordered to correspond to the Marketplace application.

Name of Entity/Sender:	Augusta County Schools
Contact--Position/Office:	Anne Hubbard, Benefits & Finance Supervisor
Address:street, city, state	ahubbard@augusta.k12.va.us
Phone Number:	+1540-245-5126

Your employer offers a health plan to eligible employees and dependents. See the Plan Information section of the SPD for details. 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

**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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).*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