LEGAL NOTICES 2024

Pinellas County Government provides benefit plan participants with certain legal notices each year. This document does not require you to act, unless you wish to exercise one or more of the rights explained in this document.

Please read this information carefully and keep it where you can find it. If you have any questions regarding these legal notices, please contact Employee Benefits at employee.benefits@pinellas.gov or (727) 464-3367, option 1.

The notices are hyperlinked for your convenience:

- Patient Protection and Affordable Care Act and the Reconciliation Act
- Insurance Marketplace Exchange Notice
- COBRA Continuation Coverage
- Patient Protection Notice
- Your Right to Change Certain Benefit Elections During the Year
- Qualified Medical Child Support Orders (QMCSOS)
- Notice of Privacy and Special Enrollment Rights Under HIPAA
- Uniformed Services Employment and Reemployment Rights Act (USERRA)
- Genetic Information Nondiscrimination Act (GINA)
- Medicare Part D Prescription Drug Benefits
- Newborns' and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- CHIP (Children's Health Insurance Program)
- Wellness Program
- Summary of Benefits and Coverage
- Surprise Medical Bills (Balance Billing)
- Machine Readable Files

Human Resources
Helping U Succeed

Patient Protection and Affordable Care Act and Reconciliation Act

The Plan shall comply with the provisions of the Patient Protection and Affordable Care Act, the Reconciliation Act (hereinafter both are collectively referred to as "PPACA") and certain other provisions of applicable law and the applicable regulations that are generally effective after December 31, 2009 ("Applicable Law"). The Plan intends good faith compliance with the requirements of the PPACA and Applicable Law and is to be construed in accordance with same.

Insurance Marketplace Exchange Notice
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income (Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -

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

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an

employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Pinellas County Human Resources Employee Benefits at (727) 464-3367, option 1.

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.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Notice of Right to Elect COBRA Coverage Continuation Coverage

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under the continuation coverage provisions of the law. You and your family should take the time to read this notice carefully.

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.

Qualifying Events

If you are an ***employee*** of Pinellas County Government and are covered under the County’s Group Health and/or Dental Plan you have a right to choose continuation coverage if you lose your group health and/or dental coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the ***spouse*** of an employee covered by the Plan you have the right to choose continuation coverage for yourself if you lose group health and/or dental coverage under the Plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becomes entitled to Medicare.

In the case of a ***dependent child*** of an employee covered by the Plan, he or she has the right to continuation coverage if group health and/or dental coverage is lost for any of the following reasons:

1. The death of the parent-employee;
2. A termination of the parent-employee’s employment (for reasons other than gross misconduct) or reduction in the parent-employee’s hours of employment;
3. The parent-employee’s divorce or legal separation;
4. The parent-employee becomes entitled to Medicare prior to his/her qualifying event;
5. The dependent child ceases to be a “dependent child” under the terms of the Plan.

Children born to or adopted by a covered employee during the continuation coverage period may also elect continuation coverage, provided that the covered employee has elected COBRA coverage for himself or herself. The coverage period will be determined according to the date of the qualifying event that resulted in the covered employee's COBRA coverage

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

Coverage Provided
Under the law, the employee or a family member has the obligation to inform Pinellas County Employee Benefits of a divorce**,** legal separation, or a child losing dependent status under the Group Health Plan within 60 days after either (1) the date of the qualifying event or (2) the date on which coverage would be lost as a result of the qualifying event.

If notification is not made within 60 days after the applicable qualifying event occurs or if you do not timely provide any additional documentation or information (if requested) in a timely manner, your notification will be rejected and COBRA coverage will not be offered.

Employee Benefits has the responsibility to notify the County’s COBRA Administrator of the employee’s death, termination, reduction in hours of employment or Medicare entitlement.

After Employee Benefits is notified that one of these events has happened, the County’s COBRA Administrator will in turn notify you that you have the right to choose continuation coverage. COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA coverage within 60 days from the later of the date coverage is lost under the plan or the date of notification to elect COBRA coverage. Covered employees may elect COBRA coverage on behalf of their spouse, and parents may elect COBRA coverage on behalf of their eligible dependent children. If you do not choose continuation coverage on a timely basis, your group health and/or dental insurance coverage will end.

Period of Coverage
If you choose continuation coverage, the County is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health and/or dental coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, or Medicare entitlement) occur during that 18-month period.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may be

extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage or before COBRA coverage began and is still disabled at the end of the original maximum continuation period of coverage (generally 18 months). To benefit from this extension, a qualified beneficiary must notify the County's COBRA Administrator of that determination within 60 days of the later of (1) the date the qualified beneficiary is determined to be disabled by the Social Security Administration; (2) the date of the qualifying event; and (3) the date on which the qualified beneficiary would lose coverage because of the qualifying event, and before the end of the original 18-month period.

If the above notification is not made within 60 days of the date of the disability determination made by the Social Security Administration and before the end of the 18-month period of COBRA/continuation coverage, or if you do not provide the additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA/continuation coverage beyond the original 18-month period will not be offered. The affected individual must also notify the County's COBRA Administrator within 30 days of any final determination that the individual is no longer disabled.

Second Qualifying Event Extension
If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

1. Divorce or legal separation of former employee
2. Former employee dies
3. Former employee becomes entitled to Medicare benefits
4. Dependent child ceasing to be an eligible dependent under the Plan

You will be required to have certain information available about your qualifying event, including: the type of qualifying event (divorce, legal separation, losing dependent coverage); the date of the divorce, legal separation or dependent losing coverage; the name and Social Security number of the covered employee; and the name, address and Social Security number of the covered spouse or dependent who is losing coverage.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and eligible dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA coverage can be extended.

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying

event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the Pinellas County Board of County Commissioners Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA. If COBRA coverage is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, benefits and cost will be modified as regular changes are made to the plan. Once you make your election, you will have up to 45 days to pay your first COBRA coverage premium, which will include any make-up premiums you missed. COBRA coverage will be effective the day after the qualifying event or the last day of active coverage, whichever is later. Premiums will be equal to the entire cost of the coverage, with an additional two percent to cover administrative expenses.

If the above notification is not made within 60 days after the second qualifying event occurs or if you do not provide any additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA coverage beyond the original 18- (or 29-) month period will not be offered.

However, the law also provides that continuation coverage may be cut short for any of the following reasons:

1. The County no longer provides group health and/or dental coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered – after the date he or she elects COBRA coverage – under another group health and/or dental plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Special Rule for Health FSAs

COBRA coverage under the Pinellas County Board of County Commissioners Health FSA will be offered only to qualified beneficiaries losing coverage that have under-spent accounts. A qualified beneficiary has an under-spent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Pinellas County Board of County Commissioners Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Pinellas County Board of County Commissioners Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year.

Unless otherwise elected, all qualified beneficiaries who were covered under the Pinellas County Board of County Commissioners Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA

annual limit and a separate premium. If you are interested in this alternative, contact the COBRA Administrator for more information.

Special Rule for Employees in the Uniformed Services
If you are an employee and your coverage under the plan terminates due to your service in the uniformed services, you may elect special continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) for yourself and your covered spouse and covered dependents. This special continuation of coverage may extend for up to 24 months beginning from the date your plan coverage would otherwise terminate due to your service in the uniformed services. Service in the uniformed services includes your performance of duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service. If you believe this special continuation of coverage rule applies to you, please contact your human resources contact at your employer.

Alternate Recipients Under QMCSOs
A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Pinellas County Board of County Commissioners during the covered employee's period of employment with Pinellas County Board of County Commissioners is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA’s other coverage cut-off rule with these new limits as follows.

If you become covered by another group health and/or dental plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan’s pre-existing condition rule does not apply to you by reason of HIPAA’s restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the County’s COBRA Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

Please notify Pinellas County Employee Benefits if you have a change in address, marital or dependent status.

If you have any questions about COBRA, please contact Employee Benefits at (727) 464-3367, option 1.

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

Your Right to Change Certain Benefit Elections During the Year

Generally, the decisions you make with regard to your health care plans and the flexible spending accounts remain in effect throughout the plan year. If you experience what the IRS refers to as a "qualified change in status," however, you may make certain changes to these benefits in accordance with Pinellas County Section 125 Cafeteria plan. **If you experience a qualified event, you have 31 days from the date of the qualifying event to submit the Qualifying Event Status Change Form along with supporting documentation to Pinellas County Employee Benefits, unless the qualifying event is the birth or adoption of a child, in which case you have 60 days to submit the form and documentation.**

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Notice of Privacy Practices of the Group Health Plans

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.

This Notice applies to the Group Health Plans (each a "Plan" and collectively, the "Plans") maintained by the Plans' sponsor, Pinellas County ("County"), including the medical plans, the prescription plan, the employee assistance program and managed mental health plan, the vision plan, and the dental plans. This Notice applies to all of the Plans because the County coordinates the operations of the Plans to better serve you and the other participants and beneficiaries of the Plans. As a result, the Plans have entered into an arrangement to abide by the terms of this Notice. References to "we" and "us" throughout this Notice mean the Plans. Each of the Plans will use and disclose your health information as described in this Notice and each is obligated to comply with the terms of this Notice. The Plans may provide benefits through a health insurance issuer, health maintenance organization ("HMO"), or Third Party Administrator (TPA). The health insurance issuer, HMO, or TPA may have its own policies and notice regarding your health information and you should review those notices for information about how the insurance issuer, HMO, or TPA will handle your medical information that is in its possession.

We Are Legally Required to Safeguard Your Protected Health Information
We are required by law to:

- Maintain the privacy of your health information, also known as "protected health information" or "PHI;"
- Provide you with this Notice,
- Comply with this Notice,
- Notify affected individuals following a breach of unsecured PHI

Future Changes to Our Practices and This Notice
We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting the HIPAA Privacy Officer at (727) 464-3367, option 1. We will also make any revised Notice available on our website at www.pinellas.gov/benefits.

How We May Use and Disclose Your Protected Health Information
The law permits us to use and disclose your PHI for certain purposes without obtaining your written authorization. This Section gives examples of each of these circumstances.

Uses and Disclosures for Treatment, Payment and Health Care Operations.

- We may use or disclose your PHI for purposes of your treatment. For example, we may **disclose your PHI to physicians, nurses, and other health care professionals who are involved in your care**. We may also use and disclose your PHI to tell you about treatment alternatives or health- related benefits or services that may interest you. In addition, we may provide you with disease management services and we may use and disclose your PHI as necessary for the nurses, pharmacists and other professionals to provide you with these services.

- We may also use or disclose your PHI to **provide payment for the treatment you receive** under a Plan. For example, we may use and disclose your PHI to obtain our premiums, to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may also use and disclose your PHI to determine your eligibility or coverage for health benefits, to evaluate medical necessity or the appropriateness of care or charges. In addition, we may use and disclose your PHI as necessary to precertify and preauthorize services to you and to review the services provided to you. We may also use and disclose your PHI to obtain payment under a contract for reinsurance, including stop-loss insurance. We may further use and disclose your PHI to adjudicate your claims. Also, we may disclose your PHI to **other healthcare providers or entities** who need your PHI in order to obtain or provide payment for your treatment.

- In addition, we may use or disclose your PHI **for our health care operations.** For example, we may use your PHI to evaluate the quality of the health care you received from providers in participating networks or preferred providers. We may use or disclose your PHI to conduct audits, for purposes of underwriting and ratemaking, as well as for purposes of risk management. In addition, we may use or disclose your PHI in order to manage our data and information systems. We may use or disclose your PHI to provide you with customer service activities or to develop programs. We may also provide your PHI to our attorneys, accountants and other consultants who assist us in performing our functions and to make sure we are complying with the laws that affect us. In addition, we may disclose your PHI to **other health care providers or entities for certain of their health care operations activities**, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your PHI to these entities if they have or have had a relationship with you and your PHI pertains to that relationship.

Sharing of PHI Among the Plans

In addition to the uses and disclosures of your PHI for purposes of treatment, payment and health care operations discussed above, **the Plans may share your PHI with each other**. As discussed at the beginning of this Notice, the Plans have entered into an arrangement to coordinate their operations. To do so, the Plans may need to share PHI with each other to manage their operations. However, the Plans will only share your PHI with each other as necessary for treatment, payment or health care operations of the Plans and their common operation.

Disclosures to the Sponsor of the Plans

We may disclose your PHI to the County, the sponsor of the Plans. As the sponsor of the Plans, the County assigns certain of its personnel to administer the Plans so that the Plans can operate and provide you with your health benefits. The County will only use and disclose your PHI as necessary to administer the Plans. The law only permits the Plans to disclose your PHI to the County, in its role as the Plans' sponsor, if the County certifies, among other things, that it will only use and disclose your PHI as permitted by the Plans, will restrict access to your PHI to those County employees whose job it is to administer the Plans and will not use PHI for any employment-related actions or decisions.

Uses and Disclosures That Require Us to Give You the Opportunity to Object.
Unless you object, we may provide relevant portions of your PHI **to a family member, friend or other person you indicate** is involved in your health care or in helping you get payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose PHI as we determine is in your best interest, but will tell you about it later, after the emergency, and give you the opportunity to object to future disclosures to family and friends.

Other Uses and Disclosures
The law allows us to disclose PHI without your prior authorization in the following circumstances:

- When Required by Law. We disclose PHI when we are required to do so by federal, state or local law.
- For Public Health Activities. For example, we disclose PHI when we report to a public health authority for purposes such as public health surveillance or public health investigations, or to report suspected child abuse.
- For Reports About Victims of Abuse, Neglect or Domestic Violence. We will disclose your PHI in these reports only if we are required or authorized by law to do so, or if you otherwise agree.
- To Health Oversight Agencies. We will provide PHI as requested to government agencies that have authority to audit or investigate our operations.
- For Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or to obtain a court order that will protect the PHI requested.
- To Law Enforcement. We may release PHI if asked to do so by a law enforcement official, in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement; (d) about a death we believe may be due to criminal conduct; (e) about criminal conduct; and (f) in emergency circumstances, to report a crime, its location or victims, or the identity, description or location of the person who committed the crime.
- To Coroners, Medical Examiners and Funeral Directors. We may disclose PHI to facilitate the duties of these individuals.
- To Organ Procurement Organizations. We may disclose PHI to facilitate organ donation and transplantation.
- For Medical Research. We may disclose your PHI without your consent to medical researchers who request it for approved medical research projects; however, with very limited exceptions such disclosures must be cleared through a special approval process before any PHI is disclosed to the researchers, who will be required to safeguard the PHI they receive.
- To Avert a Serious Threat to Health or Safety. We may disclose your PHI to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the public.
- For Specialized Government Functions. For example, we may disclose your PHI to authorized federal officials for intelligence and national security activities that are

authorized by law, or so that they may provide protective services to the President or foreign heads of state or conduct special investigations authorized by law.

- To Workers' Compensation or Similar Programs. We may provide your PHI to these programs in order for you to obtain benefits for work-related injuries or illness.

Uses and Disclosures Requiring Your Authorization

Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose your PHI for the purposes specified in the written authorization, except that we are unable to take back any disclosures we have already made with your permission. In addition, we can use or disclose your PHI after you have revoked your authorization for actions we have already taken in reliance on your authorization, or if your authorization was obtained as a condition to your obtaining insurance coverage and the law permits us to contest a claim or the policy.

Your Rights Related to Your Protected Health Information

You have the following rights:

The Right to Choose How We Communicate With You. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). We must agree to your request as long as it would not be disruptive to our operations to do so. You must make any such request in writing, addressed to Employee Benefits Manager, Human Resources Department, 400 South Fort Harrison, Clearwater, FL 33756.

The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and copy your PHI if you ask in writing to do so. Any such request must be addressed to Employee Benefits Manager, Human Resources Department, 400 South Fort Harrison, Clearwater, FL 33756, which will respond to your request within 30 days (or 60 days if extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed.

If you ask us to copy your PHI, we will charge you a reasonable fee to cover our costs in making the copies. Alternatively, we may provide you with a summary or explanation of your PHI, as long as you agree to that and to the cost, in advance.

The Right to Correct or Update Your PHI. If you believe that the PHI we have about you is incomplete or incorrect, you may ask us to amend it. Any such request must be made in writing and must be addressed to Employee Benefits Manager, Human Resources Department, 400 South Fort Harrison, Clearwater, FL 33756, and must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties that we know have your PHI of the amendment. If

we agree to make the amendment, we will also ask you whom else you would like us to notify of the amendment.

We may deny your request if you ask us to amend information that:
- was not created by us, unless the person who created the information is no longer available to make the amendment;
- is not part of the PHI we keep about you;
- is not part of the PHI that you would be allowed to see or copy; or
- is determined by us to be accurate and complete.

If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint, or to request inclusion of your original amendment request in your PHI.

The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include disclosures we have made for treatment, payment and health care operations purposes, those made directly to you or under an authorization that you provided, or those made to your family or friends. Neither will the list include disclosures we have made for national security purposes or to law enforcement personnel, or disclosures made more than six years prior to the request.

Your request for a list of disclosures must be made in writing and be addressed to Human Resources Director, Human Resources Department, 400 South Fort Harrison, Clearwater, FL 33756. We will respond to your request within 60 days (or 90 days if extra time is needed). The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period.

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit how we use and disclose your PHI. Any such request must be submitted in writing to our Privacy Officer. We are not obligated to grant your request unless required by law.

The Right to Get a Paper Copy of This Notice. Even if you have agreed to receive this Notice by e-mail, you have the right to request a paper copy as well. You may obtain a paper copy of this Notice by contacting HIPAA Privacy Officer at (727) 464-3367, option 1. The Notice is also available on our website at www.pinellas.gov/hr.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the federal Department of Health and Human Services. To file a complaint with us, put your complaint in writing and address it to our HIPAA Privacy Officer, Human Resources Department, 400 South Fort Harrison, Clearwater, FL 33756. **We will not retaliate against you for filing a complaint.** You may also contact our Privacy Officer at (727) 464-3367, option 1 if you have questions or comments about our privacy practices.

Effective Date: January 2, 2024

Your Privacy and Special Enrollment Rights Under HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) includes provisions that protect the privacy of health plan participants and their "Protected Health Information" (PHI). These provisions govern how covered entities, such as health insurance companies and plan administrators, medical professionals and the plan sponsor (Pinellas County Government) must handle PHI. If you participate in any Pinellas County Government health plan, you can review the complete HIPAA Privacy Statement by contacting Employee Benefits to obtain a copy.

Be aware that you may receive a form requesting that you authorize use of your PHI for another purpose. When you grant this authorization, your PHI is still protected from use and disclosure by any party— unless you grant use and disclosure of your PHI in writing, in which case your PHI will only be disclosed in the manner you specifically authorize.

HIPAA Special Enrollment Rights

There are several circumstances under which you or a family member will qualify for HIPAA special enrollment rights:

You acquire a new dependent. If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your new dependent (and your spouse, in the case of birth or adoption of a child) in the Plan. If you are already enrolled for coverage when you acquire a new dependent, you may enroll your dependent. To exercise your special enrollment rights, you must enroll yourself and/or your dependents no more than 31 days after the date you acquire the new dependent. If you acquire a dependent child through birth, adoption or placement for adoption, you have 60 days to enroll the new child. The new election will be effective on the date the dependent child was acquired. If you acquire a dependent through marriage, the new election will be effective on your date of marriage.

If you don't enroll within the applicable 31 or 60 day special enrollment period, you will not be permitted to enroll until the next Open Enrollment period unless you experience a qualifying life event or another special enrollment right.

You or a dependent loses other coverage. If you waived health coverage because you or your dependent had other medical coverage (including coverage under COBRA), you may enroll yourself and your dependents in the Plan if:

- You or your dependents subsequently lose eligibility for that other coverage (or exhaust your COBRA coverage), or
- Employer contributions for that coverage are terminated.

For this purpose, "loss of eligibility" includes, but is not limited to:

- A loss of coverage that results from termination of employment, reduction in hours of employment, legal separation or divorce, death, or cessation of dependent status (e.g., reaching the maximum age to be eligible as a dependent under a plan)
- A situation in which a plan no longer offers any benefits to the class of individuals of which that individual is a part

You will be asked to provide documentation regarding the date the other health plan coverage ended. Loss of eligibility for other coverage does not include a loss due to the failure to pay premiums on a timely basis or termination of coverage for cause, such as fraud.

To exercise your special enrollment rights, you must enroll yourself and/or your dependents no more than 31 days after the date the other coverage ends (or employer contributions terminate). If you don't enroll within 31 days, you will not be permitted to enroll until the next Open Enrollment period.

Children's Health Insurance Program or Medicaid

You will also have a HIPAA Special Enrollment Right if you or your dependent child:

- Loses eligibility under a state-run Children's Health Insurance Program or a Medicaid program, or
- Becomes eligible for premium assistance under a state-run Children's Health Insurance Program or Medicaid.

To exercise this special enrollment right, you must enroll yourself and/or your dependent no more than 60 days after the date of termination of CHIP or Medicaid coverage or the date of eligibility for CHIP or Medicaid assistance. If you don't enroll within 60 days, you will not be permitted to enroll until the next Open Enrollment period.

For more information, see Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) section.

Military Service and Your Pinellas County Benefits

In accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), Pinellas County Government employees who must leave their jobs to perform military service can continue their health care benefits.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular employee contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's absence from work; or
- The day after the date on which the Participant fails to timely apply for, or return to, a position of employment after performing military service.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service. You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Genetic Information Nondiscrimination Act (GINA)

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

GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA prevents a plan from imposing a pre-existing condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information).

GINA provides that group health plans cannot base premiums for an employer or a group of similarly situated individuals on genetic information. However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.

GINA generally prohibits plans from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. In addition, genetic testing information may be requested to determine payment of a claim for benefits. However, the plan may request only the minimum amount of information necessary in order to determine payment. There is a research exception that permits a plan to request (but not require) that a participant or beneficiary undergo a genetic test.

GINA also prohibits a plan from collecting genetic information (including family medical history) before or in connection with enrollment, or for underwriting purposes. Plans are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a health risk assessment. There is an exception for incidental collection, provided the information is not used for underwriting. The incidental collection exception is not available if it is reasonable for the plan to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided

Important Notice from Pinellas County Government 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 Pinellas County Government 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. Pinellas County Government has determined that the prescription drug coverage offered by the Express Scripts 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 15 to December 7.

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 coverage will not be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at www.cms.hhs.gov/CreditableCoverage which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Pinellas County Government coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Pinellas County Government 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 Express Scripts 866-544-9221 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 Pinellas County Government 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 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).

Pinellas County Government Employee Benefits
400 S. Fort Harrison Ave
Clearwater, FL 33756
727-464-3367, option 1

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740, TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA– Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA–Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT – Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium - assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since 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

Notice Regarding Wellness Program

Pinellas County offers a voluntary wellness program available to all employees and spouses/domestic partners on the County's medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include items such as blood pressure, height, and weight. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a premium discount of $500 in the following year. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the premium discount.

Employees who choose to participate in certain eligible health-related activities are eligible to receive wellness incentives.

If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request, and your doctor may recommend, a reasonable accommodation or an alternative standard by contacting the Wellness team at wellness@pinellas.gov.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Pinellas County Government may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing

you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the Health Coach employed by the third-party plan administrator in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Pinellas County Employee Wellness team at wellness@pinellas.gov.

Summary of Benefits and Coverage (SBC)

The Summary of Benefits and Coverage (SBC) document is designed to help you better understand your coverage and allows you to easily compare different coverage options. It summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. You are legally required to receive this summary when enrolling in coverage and within seven business days of requesting a copy from your group health plan.

Linked below are the SBCs of your Cigna medical plans:

- Open Access Plus (OAP) Plan
- Choice Fund Open Access Plus Health Savings Account (HSA) Plan

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

You are protected from balance billing for:

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

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

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Centers for Medicare & Medicaid Services No Surprises Help Desk at 1-800-985-3059 or Cigna at 1-800-862-3557.

Visit the Department of Labor's website (www.dol.gov/ebsa) or call the Employee Benefits Security Administration (EBSA) toll-free hotline at 1-866-444-EBSA (3272) for more information about your rights under federal law.

Machine-Readable Files

View machine-readable files made available in response to the federal Transparency in Coverage Rule which include Cigna's negotiated service rates and out-of-network allowed amounts between health plans and healthcare providers. The files are formatted to allow researchers, regulators, and application developers to more easily access and analyze data.