KNOX COUNTY
TENNESSEE

2024 Benefits Guide

About Us

KNOX COUNTY TENNESSEE

Our Mission and Vision

Knox County's mission is to provide superior public service and support in an efficient and fiscally responsible way so that all residents can improve their quality of life while enjoying the benefits of a vibrant community. We believe that if we focus on transparency, invest in education and partner with our stakeholders, we will be able to create a pervasive culture of community vitality that guides us to becoming the workforce development center of East Tennessee.

The County will...

- Operate in a manner that is worthy of public trust;
- Embrace collaborations, innovation and diversity; and
- Make decisions with economic and workforce development in mind.

What's Inside

Summary Plan Description

This guide is designed to provide a general overview of benefits provided through Knox County Government. It is not a contract or an official interpretation of the benefit plans. For more detailed information, please refer to the plan documents. Important legal notices related to your coverage start on Page 18. They include: HIPAA Special Enrollment Rights, HIPAA Privacy Notice, Wellness Program Disclosure, Section 125 Plan Premium Conversion, Women's Health and Cancer Rights Act, Newborns' and Mothers' Health Protection Act, and Medicare Prescription Creditable Coverage / Part D Notice. Copies of the plan documents and important notices are available at www.knoxcounty.org/benefits or by contacting the Benefits Department (free paper copies available upon request). Should any questions or conflicts arise, the plan documents will be the final authority in determining your benefits. Knox County Government reserves the right to modify or discontinue the plans at any time. This document was prepared exclusively for teammates eligible for benefits provided through Knox County Government and their dependents.

Enrollment Changes

Changes to your enrollment may be made annually during open enrollment each year. Mid-year changes may be made for the following qualifying events such as marriage/divorce, birth/adoption, death, change in job status of yourself or your spouse, and or change in Medicaid/CHIP eligibility.

However, all changes must be made within 30 days (with the exception of Medicaid/CHIP which gives you up to 60 days) of your qualifying event. You must notify Benefits immediately when you experience a qualifying event.

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 Annual Notices section for more details.

Healthcare at Your Fingertips

Download these apps to help give you faster access to the care you need!

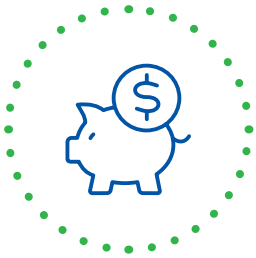
BlueCross BlueShield of Tennessee – Access your digital Member ID card and find a doctor, pharmacy and urgent care. You can review your claims, health plan details and more. Also, access doctors anytime by phone or online video for help with non-emergency issues.

Delta Dental – Check insurance information and easily access tools to keep your smile healthy, anytime, anywhere.

EyeMed – EyeMed gives you access to your benefit information on-the-go. Check your benefit details for eye exams, eyeglass frames, contacts, and lenses directly from your phone.

GoodRx – Stop overpaying for your prescriptions! Compare prescription drug prices and find coupons to save up to 80%, even with insurance.

Key Terms to Know



Copay

A fixed dollar amount that you pay for certain covered services. Typically, your copay is due up front at the time of service.

Deductible

The amount that you must pay each year for certain covered health services before the insurance plan will begin to pay.

Coinsurance

After you meet your deductible, you may pay a coinsurance, which is your share of the costs of a covered service.

Out-of-Pocket Maximum

Includes copays, deductibles and coinsurance. Once you meet this amount, the plan will pay 100% of covered services the rest of the year.

Important Dates and Deadlines

2024 Open Enrollment I October 23, 2023 - November 17, 2023

New Hires

- **New teammates who are benefits eligible must complete benefits selections within 30 days of their hire date.**
- Benefits are effective the first of the month following 28 days of employment. If the new hire starts work on the first regular business day of the month, benefits are effective the first of the following month.
- Employer-sponsored basic life insurance and AD&D coverage start automatically on the date of hire.

Qualifying Life Events/Coverage Changes

- **Children up to age 26** may be covered on your medical insurance plan, regardless of dependent status on your taxes. At the end of the month the dependent turns 26, they will automatically be dropped from the insurance plan and offered COBRA coverage.
- **Coverage and Payment.** In most cases, coverage changes will be effective on the date of the qualifying event, but the payment for your election changes will be collected retroactively. A member of the Benefits team will reach out once your new elections have been processed in order to schedule a repayment plan or process any refunds owed due to the changes.

Enrollment Details

Review this guide and the plan documents found at www.knoxcounty.org/benefits to determine which benefits you want to select or decline.

- Full-time teammates who regularly works 30 hours or more per week are eligible for all benefits listed in this guide. Full-time teammates are required to re-enroll in their benefits each year during open enrollment (except YMCA memberships).
- Part-time teammates who regularly works 18.5 hours or more per week are eligible for life insurance benefits and gym discounts. Part-time teammates are required to re-enroll in their benefits each year during open enrollment (except YMCA memberships).

Visit www.knoxcounty.org/benefits and click “Employee Self Service.”

- Username/Password: Your Username is your legalfirstname.lastname (john.smith) or legalfirstnamefirstinitial.lastname (johnj.smith). Password information will be emailed to you.

Medical Benefits

Knox County's medical benefits are provided through **BlueCross BlueShield of Tennessee** ("BCBST").

Knox County offers plan options in the **BCBST S and P Networks (BlueCardPPO - outside of Tennessee)**. In these networks, you have the flexibility to go to any provider that you choose. **Network P** includes all local hospital facilities. Tennova North Medical Center in Powell and Turkey Creek Medical Center are currently the only local hospitals that are **not** in **Network S**. If you experience a true emergency, you will still be able to visit the emergency room at the nearest facility (including Tennova) and have those services billed at in-network rates.

To find an in-network provider near you, go to www.bcbst.com/knoxcounty. Please be sure to consult either the online directory or the BCBST customer service department to confirm that your provider participates in the network. If you select an out-of-network physician or facility, you will be subject to higher deductibles and out-of-pocket maximums. But anytime you select an in-network physician or facility, you will see significant discounts and savings.

Medical Benefits	Option 1 - HDHP* *Network S*	Option 2 / Option P *Network S / Network P*
Plan Basics		
Deductible: Individual / Family	$1,600 / $3,200*	$1,500 / $3,000
Out-of-Pocket Maximum: Individual / Family	$4,000 / $8,000*	$4,000 / $8,000
Coinsurance	20% after deductible	20% after deductible
Covered Services Overview		
Preventive Care	Covered 100%	Covered 100%
Office Visit – Primary Care Physician	20% after deductible	$30 Copay
Office Visit – Specialists	20% after deductible	$40 Copay
Emergency Room	20% after deductible	$200 Copay + 20% after deductible
Most Other Services	20% after deductible	20% after deductible
Physical Therapy		
Short-Term Rehabilitation	20% after deductible	$30 Copay
Imaging Services		
Non-hospital, Independent Facility Advanced Imaging / Diagnostics (such as MRI, CAT, PET)	20% after deductible	$100 Copay
Hospital Outpatient Advanced Imaging / Diagnostics (such as MRI, CAT, PET)	20% after deductible	$125 Copay + 20% after deductible

***Option 1: If you cover any dependents, the full family deductible must be met before the plan begins to pay. The full family out-of-pocket maximum must be met before the plan pays 100%.**

Bi-Weekly Premiums (26 pay periods)	Option 1 - HDHP	Option 2	Option P
Employee Only	$17.00	$38.00	$48.00
Employee + Spouse	$87.00	$128.00	$160.00
Employee + Child(ren)	$76.00	$107.00	$133.00
Employee + Family	$122.00	$178.00	$222.00

Money Saving Tip

Urgent care clinics and telemedicine calls are lower cost alternatives to emergency rooms for same day, non-life-threatening care.

Prescription Benefits

Knox County's pharmacy benefits are provided through **EpiphanyRx**. To find the list of covered drugs go to www.epiphanyrx.com, register for access, click on "Resources" then "EpiphanyRx Formulary."

To find an in-network pharmacy near you, go to www.epiphanyrx.com, click on "Resources" then "Members" and then "Pharmacy Locator." Allow the site to use your location, and the pharmacies near you will populate.

If you are taking a *specialty medication*, **Lumicera** will be your specialty pharmacy. If you have questions, call Lumicera at 1-855-847-3553.

Money Saving Tip: Ask your doctor or pharmacist about generics or medications at lower-cost tiers that are safe and effective for your needs.

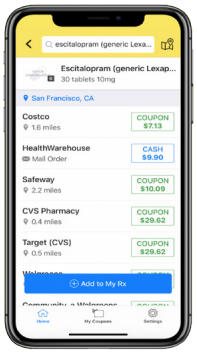
Preventive RX	Option 1 - HDHP *Network S*	Option 2 / Option P *Network S / Network P*
Deductible (Integrated with Medical)	**Not subject to plan deductible**	**Not subject to plan deductible**
ACA Preventive Drug List	$0	$0
Preventive - HSA List		
Tier 1	$5	$5
Tier 2	$20	$40
Tier 3	$40	$80
90 Day Supply	2x ($10, $40, $80)	2x ($10, $80, $160)

Specialty RX	Option 1 - HDHP	Option 2 / Option P
Deductible (Integrated with Medical)	**$1,600 Individual / $3,200 Family**	**$100 individual / $200 family**
	20% after deductible	20%; Minimum: $100, Maximum: $300

All Other Covered Medications	Option 1 - HDHP	Option 2 / Option P
Deductible (Integrated with Medical)	**$1,600 Individual / $3,200 Family**	**$100 individual / $200 family***
Tier 1	20% after deductible	$5*
Tier 2	20% after deductible	$40
Tier 3	20% after deductible	$80
90 Day Supply	20% after deductible	2x ($10*, $80, $160)

***All Tier 1 medications and all medications on the EpiphanyRx Maintenance Drug List are not subject to the plan deductible on Option 2 / Option P.**

Some retailers, pharmacies, and drug manufacturers have discount programs or coupons that may help you save money. Talk to your pharmacy or provider for more information, or you can use services like **GoodRx** to check your prescribed medications for options like this.



How do I find discounts for my prescription?

It's easy. Just go to www.goodrx.com, type in your drug's name in the search field, and click the "Find the Lowest Price" button. It will even help you spell the name of your prescription. You can also download and use the GoodRx app! GoodRx is 100% free. No personal information is required.

Health Savings Account

If you are enrolled in the High Deductible Health Plan, you are eligible to participate in a Health Savings Account (HSA) through TASC.

An HSA allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or as a retirement savings tool. This plan offers more tax savings than a traditional 401(k) or Roth IRA, making it a powerful option for diversifying your retirement portfolio.

2024 Annual Maximum Contributions to your HSA

Employee:	**$4,150**
Family:	**$8,300**
Catch-Up Contribution for those 55+:	**$1,000**

The IRS allows you to contribute the maximum annual contribution as long as you remain eligible through December 31 of the following year. If you are concerned that you may not remain eligible for the entire period, you may wish to prorate contributions based on the number of months you are HSA eligible.

Knox County requires a $100 minimum annual employee contribution to enroll in an HSA. In addition to the contribution you make, Knox County will also contribute to your HSA the first year you enroll. The first contribution will take place at initial enrollment and the second contribution will take place at the end of the plan year. The total employer contribution amounts are listed in the chart below. ***Please note: Employer and Employee contributions count towards the total contribution limit and must not exceed the IRS maximum contribution limits for 2024. Additionally, only Knox County teammates who enroll in Option 1 medical plan will be eligible to enroll in an HSA.***

Total Employer Contribution	
Employee Only	$300
Employee + Dependents	$600

How It Works

It's yours

Think of your HSA as a personal savings account. Any unspent money in your HSA remains yours, allowing you to grow your balance over time.

Easy to use

Swipe your benefits debit card at the point of purchase. There is no requirement to verify all of your purchases. We recommend keeping any receipts in case of an IRS audit.

Smart savings

An HSA's unique, triple-tax savings means the money you contribute, earnings from investments and withdrawals for eligible expenses are all tax-free, making it a savvy savings and retirement tool.

Please note: If you can't claim a child as a dependent on your tax returns, then you may not spend HSA dollars on services provided to that child.

Health Savings Account

Understanding the High Deductible Health Plan

On a high deductible health plan (HDHP), when you need care, you pay for most services out of your pocket until you reach your deductible. One exception is in-network preventive care covered under the ACA which is covered at 100% on a HDHP. The out-of-pocket maximum is the most you'll pay in a plan year for services covered by your plan. Once this limit is reached, the plan pays 100% for covered services for the rest of the year.

Is the HDHP Right for Me?

Consider the following when choosing a health plan:

- If you're healthy and usually go to the doctor once a year, a lower monthly premium may be a good choice for you.
- If you often visit your primary care provider or specialist(s) during the plan year, you must decide if savings from low premiums are greater than the cost of regular care or medication.

By participating in the HDHP, you are also eligible to contribute to a Health Savings Account (HSA). An HSA allows you to set aside pre-tax money each paycheck in order to pay for medical care.

What Does It Cover?

You can use your HSA to pay for thousands of HSA-eligible items, such as:

- Medical services (copays, coinsurance, fees and expenses charged by health care providers)
- Dental treatment (including fillings, extractions, braces and x-rays)
- Eye examinations, glasses, contact lenses and surgery
- Prescription medicines
- Certain over-the-counter medication and supplies

For a complete list of IRS qualified healthcare expenses, visit www.irs.gov/publications/p502

What's the Difference Between an HSA and an FSA?

A Health Savings Account (HSA) and a Medical Flexible Spending Account (FSA) are both used to set aside pre-tax dollars in order to pay for qualified medical expenses. You can save money with either, but they have many differences. Here is a brief outline:

	HSA (Option 1)	FSA (Option 2 / Option P)
Owner	Employee-owned	Employer-owned
Eligibility	Must be enrolled in a high deductible health plan (HDHP)	Anyone is eligible, although you can't be enrolled in an HSA and a Medical FSA
Carryover	All funds carryover from year to year	Unused funds do not carry over from year to year*
Portability	The HSA is portable, so the funds in the account stay with you wherever you go	FSAs are employer-owned accounts, so the funds are forfeited if your employment ends
Investment Options	You can invest HSA funds	You can't invest FSA funds
Documentation	It's not required, but you'll want to keep all documentation in case you're ever the subject of an IRS audit	The IRS requires documentation for some FSA expenses to show the eligibility of the expense
Availability of Funds	Only the funds that have been contributed are available to cover expenses	All funds for the plan year are available on January 1

*Except for the amount the IRS allows.

Flexible Spending Accounts

Teammates have the option to defer money on a pre-tax basis for use on approved medical and dependent care expenses. You can set money aside from your gross income, pre-tax for expenses that you anticipate for the plan year.

Medical Flexible Spending Account

You may elect to set aside $250 to $3,050* from your paycheck-tax into your FSA. You save on taxes and take home more spendable income!

The full medical FSA annual election will be available in January (current teammates) or the first of the month when your elections go into effect (new hires). Each year, funds are added to the existing debit cards. TASC will mail debit cards to new enrollees. Keep your receipts! You may be asked to verify your claim.

2023 Annual Maximum Contribution	
Medical FSA:	$3,050*

A minimum of $25 and maximum of $610* of unused medical flexible spending funds may be rolled over to the following plan year. For expenses from 2024, you can submit receipts until 90 days past January 1, 2025. Visit the TASC website or www.knoxcounty.org/benefits for more information about medical FSA or a list of eligible medical expenses.

Dependent Care Flexible Spending Account

The maximum annual contribution is $5,000* for single or married filing jointly ($2,500* if you are married and file separately).

Dependent care FSA elections are dispersed into your account as they are deducted from your paycheck. Each year, funds are added to the existing debit cards. TASC will mail debit cards to new enrollees. Keep your receipts! You may be asked to verify your claim.

2023 Annual Maximum Contribution	
Dependent Care FSA:	$5,000*

Only elect what you expect to spend by the end of the year, as there is no rollover option for dependent care FSAs and unused funds are lost at the end of the run out period. If the cost of your dependent care changes, you can make changes to this deduction during the year, without a qualifying event, to avoid having unused funds at the end of the year. For expenses from 2024, you can submit receipts until 90 days past January 1, 2025. Visit the TASC website or www.knoxcounty.org/benefits for more information about dependent care FSA.

***2023 IRS limits**

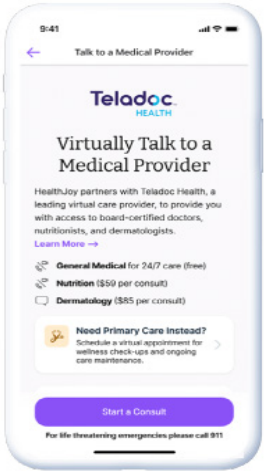
Money Saving Tip

Flexible Spending Accounts (FSAs) allow you to put money aside from each paycheck before you pay federal income taxes. This means FSAs help you keep more of your money and help you set aside money to prepare for important medical expenses.

You do not need to be enrolled in the County's health insurance plan in order to participate.

Telemedicine & Mental Health

Use HealthJoy's telemedicine as a cost-effective, convenient alternative to the emergency room, urgent care facility or in-office doctor's appointment for most non-emergency conditions. Available to all benefits-eligible teammates and their dependents (even if you are not covered on the Knox County health plan).



Use HealthJoy telemedicine for:

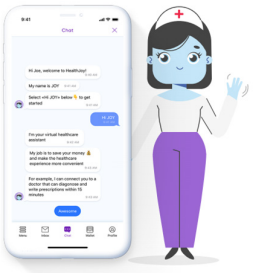
- **Free Sick Visits** (Earache, Urinary tract infection, Aches and pains, Medical question, Medication refill, Sore throat, Cough, Sinus infection, Skin rash, Eye infection)
- **Free Behavioral Health Support**
  - For members ages 13+, choose a therapist or psychologist who fits your needs For members ages 18+, you can consult a psychiatrist for additional support
  - Conveniently schedule visits using our mobile app
  - In-between sessions with our high-quality providers, use self-guided sessions to help build resiliency
  - Anywhere, anytime access allows you to connect and build ongoing relationships with trusted mental health professionals
- **Dermatology - $85 per consult**
- **Nutrition Counseling - $59 per consult**

How Can HealthJoy Help You?

- HealthJoy quickly familiarizes you with your benefits through the **digital benefits wallet**
- Navigate to **the best healthcare providers** using Find Care, or start a provider search
- Access your **digital medical ID cards**
- Get **at-a-glance medical plan copay & coinsurance details** under your profile
- Rely on HealthJoy **Rx Savings Review** to find the lowest price on your family's prescriptions
- Use HealthJoy to spot errors in your **medical bills**

Meet JOY – Your HealthJoy Guide

When you first log into the HealthJoy app, JOY will greet you. She will guide you through how to set up your account and help you find the suite of services HealthJoy offers.



Get Ready for HealthJoy

If you haven't activated your account, keep a lookout for an activation email from groups@healthjoy.com.

You will need the unique activation link inside that email to set up your account. And, don't forget, JOY will be there to help you along the way!

Activate your HealthJoy account here: https://mygroups.healthjoy.com/membership

Mental Health Resources

HealthJoy

When should I choose Mental Health Services?
If you're overwhelmed or struggling with your mental health, therapy can help you understand feelings and behaviors and equip you with valuable coping skills. Mental Health services allow you to schedule a visit with a licensed therapist or an appointment with a board-certified psychiatrist to help manage medications or more serious diagnoses. Therapists and psychiatrists are available for appointments seven days a week from 7 a.m. to 9 p.m. Visits can take place wherever you are most comfortable, by phone or video. Therapist visits only last as long as you feel you need them.

What should I expect during my visit?
You will have a conversation with the mental health professional just as if you were at their office. They want to make you feel comfortable and heard.

Can I talk to the same therapist/psychiatrist every time?
Yes. You can see the same specialist throughout your treatment.

BlueCross BlueShield (In-Network Providers)

To find an in-network provider near you, go to www.bcbst.com/knoxcounty. Please be sure to consult either the online directory or the BCBST customer service department to confirm that your provider participates in the network. If you select an out-of-network physician or facility, you will be subject to higher deductibles and out-of-pocket maximums. But anytime you select an in-network physician or facility, you will see significant discounts and savings.

Mental Health & Substance Abuse	Option 1 - HDHP	Option 2 / Option P
Outpatient, Individual & Group Therapy	Subject to the deductible, no coinsurance	$10 Copay
Inpatient Services	Subject to the deductible, no coinsurance	Subject to the deductible, no coinsurance

EAP (ComPsych)

The EAP offers free, short-term solutions focused counseling. You may be approved for up to 10 free sessions. If short-term solutions focused counseling is not appropriate for your needs, the EAP will help you find a specialist who is in-network with your insurance coverage.

When might my family or I consider using the EAP?
There are many reasons to use EAP services. You may wish to contact the EAP if you:

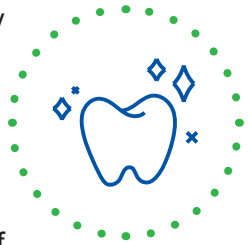
- Are feeling overwhelmed by the demands or balancing work and family
- Are experiencing stress, anxiety, or depression
- Are dealing with grief or loss
- Need assistance with child or elder care concerns
- Have legal or financial questions
- Have concerns about substance abuse for yourself or a dependent

Mental Resources Guide

Additional information for mental health support is available at https://knoxcounty.org/benefits/ on our Mental Health Resource Guide.

Dental Benefits

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.



To find a provider in the network, visit www.deltadentaltn.com.

Certificate of Coverage: The information below is only intended to provide a brief description of your benefits. Please refer to your certificate and summary for a complete description of benefits, exclusions and limitations. They are available at www.knoxcounty.org/benefits and upon request from the Benefits Department.

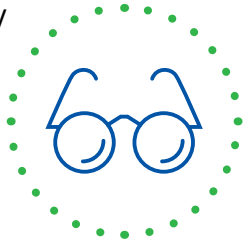
Dental Plan Features	Standard Plan		High Plan	
	PPO Dentist	Premier Dentist	PPO Dentist	Premier Dentist
Plan Basics				
Deductible (Aggregate) Individual / Family *(Basic and Major Services Only)*	$25 / $75	$100 / $300	$50 / $150	$50 / $150
Calendar Year Maximum	$1,500	$500	$1,500	$1,500
Lifetime Maximum (Orthodontics, cephalometric films, photos, diagnostic casts)	$1,000	$500	$1,500	$1,500
Benefits Paid by the Plan				
Preventive Care Services include: exams, cleanings (2 per year), X-rays	100%	80%	100%	100%
Basic Services include: fillings, sealants	80%	60%	Periodontic services, root canals 90%	80%
Major Services include: crowns, dentures, bridges, anesthesia	Periodontic services, root canals 50%	30%	60%	50%
Orthodontic Services (No age limit)	50%	50%	50%	50%

Bi-Weekly Premiums (24 pay periods)	Standard	High
Employee Only	$7.80	$16.97
Employee + 1	$20.09	$32.28
Family	$31.25	$60.27

Money Saving Tip

Ask your dentist for "predetermination of benefits" from Delta Dental prior to performing any non-emergency extensive treatment. An estimate created by your dentist may not accurately reflect your cost for care.

Vision Benefits



Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision plan is provided by **EyeMed**. When using in-network providers, this PPO plan covers most exams, eyeglass and medically necessary contacts in full. Discounts are available for upgrades on covered frames and lenses as well.

To find an in-network provider or surgery center, go to www.eyemed.com.

Should you choose to see an out-of-network provider, EyeMed will reimburse you up to a specified amount. Please see the plan document for the out-of-network reimbursement schedule.

Vision Plan Features	Network: Insight
Vision Exam*	$10 Copay
Prescription Glasses	
Frames*	$150 Allowance; 80% Coinsurance after allowance
Lenses* (Single, Bifocal, Trifocals, Lenticular)	$25 Copay
Contact Lenses	
Medically Necessary*	Covered in full
Conventional*	$0 Copay; $125 Allowance; 85% Coinsurance after allowance
Disposable*	$0 Copay; $125 Allowance; plus balance over allowance
*Once every calendar year.	
Laser Vision Correction (Lasik or PRK from U.S. Laser Network)	15% off the retail price or 5% off the promotional price

Bi-Weekly Premiums (24 pay periods)	
Employee Only	$2.96
Employee + 1	$5.42
Family	$8.31

Money Saving Tip

The Blue365 discount program through BlueCross provides discounts on vision and hearing products and services. Discounts typically cannot be used in combination with EyeMed vision insurance to pay for the same product or service.

You need to be covered by health insurance to have access to the Blue365 discount program, but you do not need to be covered by EyeMed vision insurance. Visit the BlueCross website for more information. The availability of this discount is subject to change or termination without notice.

Basic and Voluntary Life

Group Basic Life and Accidental Death & Dismemberment (AD&D)

Knox County's Basic Life and AD&D Insurance is provided for free to all full-time and part-time team members that work at least 18.5 hours per week. Basic life pays 1.5x your annual salary, up to a maximum of $50,000. AD&D coverage pays up to 2x your annual salary, with a maximum of $100,000.

Important for 2024

1. You must name your beneficiaries in Munis.

2. You must re-elect supplemental life insurance to continue coverage in 2024.

3. During open enrollment, you can increase coverage by one step without answering medical questions (EOI).

Supplemental Term Life Insurance

New hires can select any coverage step as long as it is no more than 7x your salary. During open enrollment, current team members can enroll in the minimum $15,000 coverage without an EOI medical form. Generally, changes greater than one coverage step require submission of an EOI form and approval by the carrier. If you decline coverage during open enrollment, want to make changes to your coverage, or experience a life event in 2024, check with the Benefits team on enrollment options.

	Age										
Coverage	**<30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$15,000	$0.53	$0.70	$0.79	$0.87	$1.31	$2.01	$3.76	$5.76	$11.10	$17.99	$25.34
$30,000	$1.05	$1.40	$1.58	$1.74	$2.61	$4.02	$7.52	$11.52	$22.20	$35.99	$50.67
$45,000	$1.58	$2.09	$2.36	$2.61	$3.92	$6.03	$11.27	$17.28	$33.30	$53.98	$76.01
$60,000	$2.10	$2.79	$3.15	$3.48	$5.22	$8.04	$15.03	$23.04	$44.40	$71.97	$101.34
$75,000	$2.63	$3.49	$3.94	$4.35	$6.53	$10.05	$18.79	$28.80	$55.50	$89.96	$126.68
$90,000	$3.15	$4.19	$4.73	$5.22	$7.83	$12.06	$22.55	$34.56	$66.60	$107.96	$152.01
$105,000	$3.68	$4.88	$5.51	$6.09	$9.14	$14.07	$26.30	$40.32	$77.70	$125.95	$177.35
$120,000	$4.20	$5.58	$6.30	$6.96	$10.44	$16.08	$30.06	$46.08	$88.80	$143.94	$202.68
$135,000	$4.73	$6.28	$7.09	$7.83	$11.75	$18.09	$33.82	$51.84	$99.90	$161.93	$228.02
$150,000	$5.25	$6.98	$7.88	$8.70	$13.05	$20.10	$37.58	$57.60	$111.00	$179.93	$253.35
$165,000	$5.78	$7.67	$8.66	$9.57	$14.36	$22.11	$41.33	$63.36	$122.10	$197.92	$278.69
$180,000	$6.30	$8.37	$9.45	$10.44	$15.66	$24.12	$45.09	$69.12	$133.20	$215.91	$304.02
$195,000	$6.83	$9.07	$10.24	$11.31	$16.97	$26.13	$48.85	$74.88	$144.30	$233.90	$329.36
$210,000	$7.35	$9.77	$11.03	$12.18	$18.27	$28.14	$52.61	$80.64	$155.40	$251.90	$354.69
$225,000	$7.88	$10.46	$11.81	$13.05	$19.58	$30.15	$56.36	$86.40	$166.50	$269.89	$380.03
$240,000	$8.40	$11.16	$12.60	$13.92	$20.88	$32.16	$60.12	$92.16	$177.60	$287.88	$405.36
$255,000	$8.93	$11.86	$13.39	$14.79	$22.19	$34.17	$63.88	$97.92	$188.70	$305.87	$430.70
$270,000	$9.45	$12.56	$14.18	$15.66	$23.49	$36.18	$67.64	$103.68	$199.80	$323.87	$456.03
$285,000	$9.98	$13.25	$14.96	$16.53	$24.80	$38.19	$71.39	$109.44	$210.90	$341.86	$481.37
$300,000	$10.50	$13.95	$15.75	$17.40	$26.10	$40.20	$75.15	$115.20	$222.00	$359.85	$506.70

Spousal Coverage

Coverage is also available for your spouse in the following amounts:

Spousal Coverage	$10,000	$20,000	$30,000
Semi-Monthly Cost	$1.75	$3.50	$5.25

Child Coverage

You can cover one or more children from age 14 days to 26 years old for the flat premium of $0.55 per pay period.

Child Coverage	$5,000
Semi-Monthly Cost	$0.55

Wellness & Work-Life Balance

YMCA of East Tennessee

Knox County teammates may join any local YMCA without signing a contract. To enroll, visit any local YMCA with your Knox County ID badge or a recent pay stub, complete the membership application and fill out a pall roll deduction form. The YMCA will send your form to the Benefits Department to start your membership. Your membership and payroll deduction can be ended at any time by visiting a YMCA location and completing a payroll termination form.

YMCA of East Tennessee	Bi-Weekly Premiums (24 pay periods)
Employee Only	$14.00
Employee + 1 (Spouse or Child < 26 years)	$17.00
Family (Spouse + Children < 26 years)	$19.50

National Fitness Center

Current teammates may only join during benefits open enrollment or upon approval by NFC following the termination of another gym contract. New hires may enroll within 30 days of their date of hire. Contracts run from January 1 - December 31 and cannot be terminated early unless you leave employment.

National Fitness Center	Bi-Weekly Premiums (24 pay periods)
Employee Only	$22.48
Employee + 1 (Spouse or Child < 26 years)	$27.48
Family (Spouse + Children < 26 years)	$44.98

Fitness Your Way - Part of the Blue365 discounts from BlueCross

Teammates and their covered dependents (age 18 and older) can pay one-time enrollment fee of $19 with gym packages starting at $19 per individual per month membership fee for unlimited access to a national network of more than 10,000 fitness locations. No long-term contract is required beyond an initial three-month commitment. Visit www.bcbst.com/knoxcounty for more information about the Blue365 discount program. **(Membership fees are not paid through payroll deduction.)**

SMART TRIPS

Smart Trips is a program that promotes alternatives to driving alone. You can earn rewards if you walk, bike, ride the bus, ride an electric scooter, carpool or vanpool, work from home, or work a flexible schedule and log your trips! Sign up today at https://mysmarttrips.org/ to improve your quality of life, reduce traffic congestion, and improve air quality.

Employee Assistance Program

Tel: 833.485.4246 | Web: www.guidanceresources.com | Web ID: KnoxEAP

It's more than mental health support.....

Legal and Financial Guidance, Counseling, Work-Life Balance, Professional Development, and Online Resources

Getting the most out of life is easier when you have support. Our EAP offers counseling, self-improvement tools and solutions for everyday issues to help you be your best, at home and at work. These services are free, confidential and available all day, every day to you, your dependents and the members of your household.

You can call the resources line anytime, day or night. A master's or PhD level counselor will collect some general information about you and will talk with you about your needs.

The EAP offers free, short-term solutions focused counseling. You may be approved for up to 10 free sessions. If short-term solutions focused counseling is not appropriate for your needs, the EAP will help you find a specialist who is in-network with your insurance coverage.

When might my family or I consider using the EAP?

There are many reasons to use EAP services. You may wish to contact the EAP if you:

- Are feeling overwhelmed by the demands or balancing work and family
- Are experiencing stress, anxiety, or depression
- Are dealing with grief or loss
- Need assistance with child or elder care concerns
- Have legal or financial questions
- Have concerns about substance abuse for yourself or a dependent

Chronic Disease Management

Knox County is now offering three **Livongo** programs at **no cost to you**: Healthy Living & Diabetes Prevention, Blood Pressure Management, and Diabetes Management. Starting **January 1, 2024**, teammates* and family members* who meet certain eligibility criteria and have coverage through Knox County's medical insurance plan may be eligible to enroll in these programs. Eligible participants will have access to advanced health devices, convenient tracking through an easy-to-use app, a personalized action plan to help you reach your goals, and friendly expert health coaches who can offer guidance on managing blood sugar, blood pressure, healthy eating, exercise, and more.

To get started **(on or after January 1, 2024)**, sign up using one of the following options: Text "GO BCBST-HEALTH" to 85240, visit www.livongo.com, or call 800-945-4355 and use registration code: BCBST-HEALTH

**To enroll in Livongo, you must be enrolled in a Knox County medical insurance plan. You must also meet the health criteria for each program you wish to enroll in. Only Livongo programs offered by Knox County will be eligible for enrollment.*

Notices

SECTION 125 PLAN PREMIUM CONVERSION

Section 125 Premium Conversion Plan lets you exclude your Medical, Dental and Vision premiums from your taxable income, meaning your premiums will come out of your income pre-tax. This lowers your taxable income. By default, your premiums will be deducted pre-tax, increasing your take-home pay anywhere from a couple hundred dollars to a thousand or more annually.

SUMMARY OF BENEFIT COVERAGE The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is provided by your Medical carrier. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual open enrollment period, upon plan renewal and upon request at no charge to you.

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).

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

Alabama	855-692-5447
Alaska	866-251-4861
Arkansas	855-692-7447
California	916-445-8322
Colorado	800-221-3943
Florida	877-357-3268
Georgia	678-564-1162
Indiana	877-438-4479
Iowa	888-346-9562
Kansas	800-792-4884
Kentucky	855-459-6328
Louisiana	855-618-5488
Maine	800-442-6003
Massachusetts	800-862-4840
Minnesota	800-657-3739
Missouri	573-751-2005
Montana	800-694-3084
Nebraska	855-632-7633
Nevada	800-992-0900
New Hampshire	603-271-5218
New Jersey	800-701-0710
New York	800-541-2831
North Carolina	919-855-4100
North Dakota	844-854-4825
Oklahoma	888-365-3742
Oregon	800-699-9075
Pennsylvania	800-692-7462
Rhode Island	855-697-4347
South Carolina	888-549-0820
South Dakota	888-828-0059
Texas	800-440-0493
Utah	877-543-7669
Vermont	800-250-8427
Virginia	800-432-5924
Washington	800-562-3022
West Virginia	855-699-8447
Wisconsin	800-362-3002
Wyoming	800-251-1269

For a listing of State websites, visit: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

For states not listed:
877-543-7669
www.insurekidsnow.gov

OMB Control Number 1210-0137
Expires 1/31/2026

NOTICE OF PATIENT PROTECTIONS Your medical plan may require the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. Until you make this designation, the medical plan may designate one for you. For information on how to select a PCP, and for a list of the participating providers, contact your carrier.

If you must select a PCP for your child(ren), you may designate a pediatrician as such.

You do not need prior authorization from your carrier or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our 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 your carrier.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Introduction. The Consolidated Appropriations Act of 2021 was enacted on December 27, 2020, and contains many provisions to help protect consumers from surprise bills, including the No Surprises Act under title I and Transparency under title II.

Your Rights and Protections Against Surprise Medical Bills. When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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.

You are protected from balance billing for:

Emergency service. 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 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 are 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 (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 Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

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

HIPAA– PRIVACY ACT LEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract providers.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

SECTION 111 OF JANUARY 1, 2009 Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including Social Security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine if the Employer plan or Medicare/Medicaid/SCHIP is primary for those employees covered under a government plan and an employer sponsored plan.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

MICHELLE'S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC), this law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38. The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the USERRA. See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides employees with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans' Preference.

HIPAA SPECIAL ENROLLMENT

SPECIAL ENROLLMENT NOTICE This notice is being provided to make certain that you

understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage If you are declining 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).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

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

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage. For More Information or Assistance To request special enrollment or obtain more information, please contact:

Benefits Department
400 Main Street, Suite 360
Knoxville, TN 37902
865-215-3800

Note: If you or your dependents enroll during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the "Health Information Technology for Economic and Clinical Health (HITECH) Act." The HITECH Act supports the concept of meaningful use (MU) of electronic health records (EHR), an effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

RESCISSIONS The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

PREVENTIVE CARE Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

WELLNESS PROGRAM DISCLOSURE Our company's Wellness Program is a voluntary wellness program available to all employees. 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 may also be asked to complete a biometric screening, which may include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

The above Wellness Program notice is only applicable if your plan administrator or medical plan provides a wellness program.

HIPAA PRIVACY NOTICE HIPAA requires Knox County to notify you that a privacy notice is available by obtaining a copy from the Benefits Department. Please contact the Benefits Department if you have any questions.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

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 to sign up for Medicare Part A or B, beginning on the earlier of

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you, or https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes. To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Benefits Department
400 Main Street, Suite 360
Knoxville, TN 37902
865-215-3800

Important Notice from Our Company 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 Our Company 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. Our Company has determined that the prescription drug coverage offered by the medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current employee coverage will not be affected. You can keep this coverage if you elect part D and the Medical Carrier plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Our Company's coverage, be aware that you and your dependents may 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 Our Company 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.

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	October 23, 2023
Name of Entity	Knox County Government
Contact	Benefits Department
Address	400 Main Street, Suite 360 Knoxville, TN 37902
Phone	865-215-3800

Benefit Contacts

Coverage & Carrier	Contact Information
Medical: BlueCross BlueShield Group # 130462	800-565-9140 | www.bcbst.com/knoxcounty App: MyBlueTN
Pharmacy: EpiphanyRx Group # E0134	844-820-3260 | www.epiphanyrx.com
Specialty Pharmacy: Lumicera	1-855-847-3553 | www.lumicera.com
Flex Spending Account: TASC	800-422-4661 | www.tasconline.com
Health Savings Account: TASC	800-422-4661 | www.tasconline.com
Telehealth: HealthJoy	877-500-3212 | https://mygroups.healthjoy.com/membership App: HealthJoy
Dental: Delta Dental Group # Standard Plan: 7453-2001 I High Plan: 7453-2002	800-223-3104 | www.deltadentaltn.com
Vision: EyeMed Group # 9854837	866-299-1358 | www.eyemed.com
Basic and Voluntary Life: Symetra Policy # 01 020046 00	800-796-3872 | www.symetra.com
Gym Membership: YMCA	www.ymcaknoxville.org
Gym Membership: National Fitness Center	https://nfc1.com/
Employee Assistance Program: ComPsych	833-485-4246 | www.guidanceresources.com Web ID: KnoxEAP
Chronic Disease Management: Livongo by Teladoc Health	800-945-4355 | www.livongo.com Text “GO BCBST-HEALTH”: 85240
Knox County Benefits Dept.	865-215-3800 | www.knoxcounty.org/benefits benefits@knoxcounty.org
Knox County Retirement Dept.	865-215-2323 | www.knoxcounty.org/retirement retirement@knoxcounty.org
Online Enrollment: Employee Self Service	https://selfservice.knoxapps.org/ess/