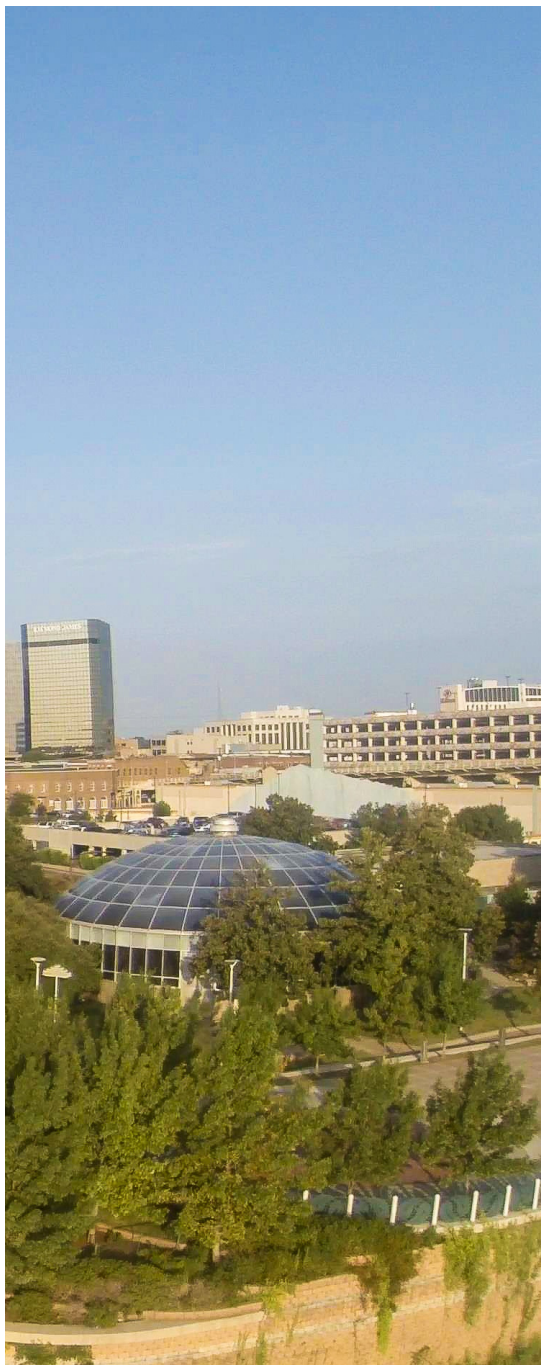
Shreveport

2021 ACTIVE EMPLOYEE BENEFITS GUIDE



YOUR 2021 BENEFITS

Welcome to your 2021 City of Shreveport employee benefits program. We take pride in our city and our employees. Our goal is to provide comprehensive benefits that allow you to live happy, healthy lives.

This guide contains an overview of our plan offerings, including medical, dental, vision, additional coverage options and important resources. Read this guide carefully to decide which options are right for you and your family.

We encourage you to become educated consumers, learn more about your coverage and take advantage of the broad range of benefits that are provided to our most important resource - YOU.

INSIDE THIS GUIDE

eSuite.shreveportla.gov

To activate your account, your email address must be on file. Register with your last name and SSN. If you do not have an active email address on your employee profile, please contact the Help Desk at (318) 673-5770.

Access to the website eSuite.shreveportla.gov allows you access to your accrual time, manage your direct deposit, view your current & historical benefits, view your paychecks, view your current tax withholdings, and more! Just click the activate your account link on Employee Login Page and click My HR Tab for access to these features.

BENEFIT ADVOCATE CENTER

The Benefit Advocate Center (BAC) is your one-stop resource to answer all your employee benefit questions. You have a busy life. With so much going on, it can be difficult to slow down and focus on the small details. Who can you turn to when you need help understanding your employee benefits provided by The City of Shreveport? The BAC is available to answer your questions and address any issues. When you call or email the BAC, a personal advocate will be ready to help you.

Contact the BAC when you have questions regarding:

- Explain your plan options
- Clarify benefits eligibility
- Help you understands your claims
- Covered services
- Provider availability
- Qualifying life events
- Replacement ID cards
- Pharmacy/Prescription problems

CITY OF SHREVEPORT
BENEFIT ADVOCATE CENTER

Phone: 844-304-5008
Email: bac.shreveport@ajg.com
Hours: Monday - Friday, 7 a.m. - 6 p.m. (CST)

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

Full-Time and Part-Time employees that work 20+ hours per week and contribute to a retirement plan qualifies for benefit coverages; once a full month's premium is collected through payroll, then benefits are effective the first day of the month on or after sixty (60) days of employment.

For example, when an employee is hired on March 3rd the effective date will be June 1st.

You may also choose to cover the following dependents:

- Legal spouse
- Children up to age 26, which includes natural children, stepchildren, legally adopted children, children placed for adoption and children with proven legal guardianship

QUALIFYING LIFE EVENTS

The benefits you select typically remain in effect throughout the plan year unless you have a qualifying life event, including:

- Change in your legal marital status (marriage, divorce, or annulment)
- Gain or loss of a dependents due to birth, adoption, court order, death, disability or reaching the dependent child's age limit)
- Change in your dependent's employment status that results in loss or gain of coverage

If you have a qualifying life event, you must notify the Benefits Office within 30 days of the event.

Government Plaza, Suite #620 | 318-673-5420

You will be required to provide documentation, such as a marriage certificate or birth certificate. Any change to your benefit elections must be related to the qualifying life event.

MEDICAL PLAN SURCHARGES

Surcharges are implemented by the City of Shreveport. The cost of your medical plan may vary based on the following:

Tobacco Surcharge

The monthly Tobacco Surcharge may apply to you if:
• You or your spouse use tobacco

To avoid a Tobacco Surcharge:
• You must complete the Tobacco Free Affidavit form.

The Tobacco Free Affidavit form can be obtained from the Benefits Office.

Working Spouse Surcharge

The monthly Spouse Surcharge may apply to you if:
• Your spouse has access to medical coverage with their employer

To avoid the Spouse Surcharge:
• You must complete the Spouse Health Care Coverage Affidavit

The Spouse Health Care Coverage Affidavit can be obtained from the Benefits Office.

Wellness Surcharge

The monthly Wellness Surcharge may apply to you if:
• You do not participate in the Wellness Program for 2021

To avoid the Wellness Surcharge:
• Have a Preventive/Wellness check-up annually from your doctor

Find more information about wellness check-up and physical by visiting www.bcbsla.com.

MEDICAL COVERAGE

Your medical coverage is provided by Blue Cross and Blue Shield of Louisiana (BCBSLA). You have the choice of two plans - the Base Plan or High-Deductible Plan. Both plans provide access to the large PPO network of BCBSLA providers to bring you quality health care when and where you need it.

Use in-network providers to save the most money. In-network doctors have agreed to charge a lower fee for their services, which means you keep more money in your pocket. To find an in-network provider, visit **www.bcbsla.com**.

TERMS TO KNOW

Deductible - The amount of money you pay each year before the plan starts to pay for a portion of covered services for inpatient/outpatient services (does not include copays).

Coinsurance - The percentage of the costs of covered services you pay after you meet your deductible for inpatient/outpatient services. You pay a portion of expenses and the plan pays the rest.

Out-of-Pocket Maximum - The most you pay for covered services in a plan year, includes deductible.

Copay- A fixed dollar amount you pay for a covered service (Primary/Specialist office visits, urgent care, emergency room, and prescription drugs).

Preventive Care - Annual exams and screenings meant to maintain good health and prevent illness. In-network preventive care is 100% covered by your medical plan. Preventative care services can be identified at www.bcbsla.com/wellness/preventive-care-services.

The chart below shows the amount you will pay for the medical service listed.

	BASE PLAN		HIGH-DEDUCTIBLE PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible (Individual/Family)	$750/$1,500	$1,500/$3,000	$2,000/$4,000	$4,000/$8,000
Out-of-Pocket Maximum (Individual/Family)	$4,000/$8,000	$8,000/$16,000	$6,000/$12,000	$12,000/$24,000
Preventive Care	0%	Not Covered	0%	Not Covered
Office Visit (Primary Care/Specialist)	$30/$60 copay	40%*	$30/$75 copay	50%*
Urgent Care	$60 copay	40%*	$75 copay	50%*
Emergency Room	$350 copay	40%*	25%*	50%*
Hospitalization	25%*	40%*	25%*	50%*
Mental/Behavioral Health (Inpatient/Outpatient)	25%* / $30 copay	40%* / 40%*	25%*	40%*
Substance use Disorder (Outpatient Services)	$30 copay	40%*	$30 copay	40%*

*The amount you pay after you reach your deductible, also called coinsurance

PRESCRIPTION DRUG COVERAGE

PRESCRIPTION DRUG COVERAGE

When you enroll in one of the medical plans, you automatically receive prescription drug coverage provided by BCBSLA. You can purchase up to a 30-day supply of prescription drugs at a retail pharmacy or up to a 90-day supply through mail-order pharmacy. **Due to the move to a new Pharmacy Benefit Manager (PBM), Express Scripts, we encourage you to research your medications at this website www.bcbsla.com/find-a-doctor/rx-drug-resources.**
The chart below shows the amount you will pay for the prescription services listed.

	BASE PLAN		HIGH-DEDUCTIBLE PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Retail Pharmacy (30-Day Supply) Generic (Tier 1) Preferred Brand (Tier 2) Non-Preferred Brand (Tier 3) Specialty (Tier 4)	 $10 copay $30 copay* $50 copay* $100 copay*	Not Covered	 $10 copay $50 copay $70 copay $100 copay	Not Covered
Mail-Order Pharmacy (90-Day Supply) Generic (Tier 1) Preferred Brand (Tier 2) Non-Preferred Brand (Tier 3) Specialty (Tier 4)	 $25 copay $75 copay* $125 copay* Not Covered	Not Covered	 $25 copay $125 copay $175 copay Not Covered	Not Covered

*The amount you pay after you reach your $100 deductible for non-generic drugs

TIPS FOR SAVING ON YOUR PRESCRIPTION DRUGS

Choose Generic Medications

Generic medications are FDA-approved with the same high quality, strength, and purity as brand-name drugs. But when it comes to price, there can be a big difference. Generic drugs are considered the lowest cost, or tier, of prescription medications, often costing less than half of the brand-name counterpart. Ask your doctor or pharmacist if a generic medication is right for you.

Compare In-Network Pharmacies

Different in-network pharmacies might charge drastically different prices for the exact same medication. And the pharmacy with the lowest cost for one medication might have higher prices for a different medication compared to other pharmacies. Comparing the prices at several in-network retail pharmacies for each medication is another easy way you can save on your prescription drug costs.

PLEASE NOTE: SPECIALTY DRUGS REQUIRE PRIOR AUTHORIZATION FROM THE ORDERING PHYSICIAN

Mail-Order Medications

Many prescriptions are taken for chronic or ongoing conditions, such as high blood pressure, high cholesterol or diabetes. You can save money on these maintenance medications by using mail-order pharmacy, which delivers a 90-day supply of your medication directly to you. This saves you the cost of transportation and time spent waiting in line at the pharmacy.

DENTAL AND VISION PLANS

DENTAL AND VISION COVERAGE

You have the option to elect dental coverage provided by Blue Cross and Blue Shield of Louisiana (BCBSLA) and/or vision coverage provided by BCBSLA. **The charts below show the amount you will pay for the services listed based on the network.**

DENTAL PLAN	
	IN / OUT-OF-NETWORK[1]
Annual Dental Deductible	$50 per person
Annual Dental Maximum	$2,500
Preventive Services	0%[1]
Basic Services	20%[2]
Major Services	40%[2]
Annual Orthodontia Deductible	$50
Orthodontia	40%[2]
Orthodontia Lifetime Maximum	$2,500

[1] If you visit an out-of-network dentist, you may be balance billed.

[2] The amount you pay after you reach your deductible. Balance billed is the difference between the amounts and the insurance reimburses and the amounts the provider chooses to charge.

Dependent children can be added up to age 3 with no limitation.

Late Entrant Limitation

If an employee applies for dental coverage more than 31 days after the employee or any eligible dependents first become eligible or after participation in the Plan ended because a required contribution was not paid, the employee and any eligible dependents are late entrants.

The benefits for the first 12 months of coverage for late entrants will be limited to Class I Dental services.

The Plan will not pay for any treatment that is started or completed during the late entrant limitation period, but may end

VISION PLAN		
	IN-NETWORK	OUT-OF-NETWORK (REIMBURSEMENT)
Eye Exam (Once Every 12 Months)	$15 copay	Up to $40
Lenses (Once Every 12 Months) Single Bifocal Trifocal Lenticular	 $25 copay $25 copay $25 copay $25 copay	 Up to $40 Up to $60 Up to $80 Up to $100
Frames (Once Every 24 Months)	Up to $130 retail	Up to $50
Contact Lenses (Once Every 12 Months) Necessary Elective	 Covered at 100% $105 allowance	 Up to $225 Up to $105

FIND IN-NETWORK DENTAL PROVIDERS

Dental exams are an important part of your overall health. Remember to use in-network providers for the most savings.

- To find an in-network dental provider near you, visit la.ourdentalcoverage.com/find-a-dentist/#/.

FIND IN-NETWORK VISION PROVIDERS

Vision exams are an important part of your overall health. Remember to use in-network providers for the most savings.

- To find an in-network vision provider near you, visit idoc.davisvision.com/DavisVision.Member/BCBSLouisiana/FindAProvider/Index.

ADDITIONAL BENEFITS

CITY TERM LIFE INSURANCE

Life insurance provides your beneficiary with a lump-sum payment in the event of your death. If you elect this coverage for yourself, you can also add coverage for your spouse and children. If you choose to add coverage after you are first eligible, you will be required to provide Evidence of Insurability. This coverage is available to employees as a new hire and at open enrollment, excluding Civil Service and Deferred Comp employees.

You can elect the following voluntary life insurance amounts for yourself, your spouse and your dependents:

- **Employee** - Life insurance will be 4x your annual earnings or $400,000 max.
- **Spouse** - $5,000
- **Children age 15 days to 6 months** - $1,000
- **Children age 6 months to 26 years** - $2,000

Please note Retirees can purchase up to a maximum of $75,000, not to exceed one times the Retiree's Basic Annual Earnings.

CITY AD&D

Accidental death & dismemberment (AD&D) coverage provides financial protection for your beneficiaries in the event of your accidental death or injury. The benefit amount is 2x your annual earnings or $150,000 and is an automatic coverage for the employee only and provided at no cost to the employee. If hired 1st-15th of the month, effective date is 1st off following month. If hired 16th –end of month, effective date is 1st of the month following 30 days.

CITY LONG-TERM DISABILITY

Long-term disability provides 60% of your covered earnings up to $5,000 per month. Benefits begin after 90 days of disability and discontinue at social security normal retirement age. Conditions treated within 3 months prior to the effective date of coverage are excluded from this coverage for 12 months. Cost deductions for the employee begin after 3 months, the 90 day elimination period. If hired 1st-15th of the month, effective date is 1st off following month. If hired 16th –end of month, effective date is 1st of the month following 30 days. This is a required automatic benefit when the employee contributes to a City pension/retirement plan. (Civil Service Employees Excluded)

SUPPLEMENTAL/VOLUNTARY LIFE INSURANCE (NEW YORK LIFE)

Additional Term and Permanent Life Insurance policies are available by contacting Scott McGuire at 318-752-4526. This coverage is available to employees as a new hire and throughout the year by contacting the agent.

BENEFICIARY DESIGNATION

It is important to select your beneficiary when you enroll and remember to update your designations as needed to ensure the benefit is paid according to your wishes. You are automatically the beneficiary for any spouse or child coverage.

Any beneficiary changes must be made in person at the Benefits Office.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

As an employee, assistance for this program will cover up to 3 visits.
For arrangements, please contact City's HR Department 318-673-5150.

UNIVERSAL LIFE INSURANCE (TRUSTMARK

Permanent life insurance provides your beneficiary with a lump-sum payment in the event of your death. If you elect this coverage for yourself, you can also purchase coverage for your spouse and children. If you choose to add coverage after you are first eligible, you will be required to provide Evidence of Insurability. This coverage can only be elected during open enrollment.

ACCIDENT (TRUSTMARK

Accident insurance is designed to cover unexpected expenses that result from a non-occupational accident, with the freedom to spend the benefit how you choose. Examples of covered benefits include hospital admission, emergency transportation, physical therapy and surgery. This coverage can only be elected during open enrollment.

CRITICAL ILLNESS (TRUSTMARK

Critical illness insurance will pay a specific benefit for the diagno-sis and treatment of certain illnesses, such as cancer, heart attack and stroke. Your selected base benefit amount is the annual maxi-mum that is available each year depending on the diagnosis. This coverage can only be elected during open enrollment.

SHORT-TERM DISABILITY (ALLSTATE

Short-term disability provides 60% of your covered earnings up to $5,000 per week and benefits begin after 14 days of injury or ill-ness, up to a maximum of 12 weeks. Conditions treated within 12 months prior to the effective date of coverage are excluded from this coverage. You must elect this coverage. This coverage can only be elected during open enrollment.

CAFETERIA PLAN / FLEXIBLE SPENDING ACCOUNT

The Flexible Spending Account allows you to pre-pay with pre-taxed dollars your out of pocket medical, dental, vision expenses and dependent care expenses. That money will be reimbursed to you on a tax-free basis. The use it or lose it provision has been modified by the IRS to give you additional 75 days at the end of the year to spend on any balances you may have. That means you will have 75 days beginning January 1, 2022 to spend any balance you may have in your account at the end of December 31, 2021. The reductions you authorize will be effective for the balance of the plan year.

It's not possible to prevent life from happening, but you can do more to be prepared for the unexpected.

Voluntary benefits provide peace of mind knowing that you and your family are protected from financial hardship.

You choose the benefit level that works for you, and your premiums are deducted from your paycheck.

See the schedule of benefits for more information.

*This coverage must be changed to direct bill after you retire.

Mandatory Retirement Program:

Membership in the Retirement System is required for any regular employee of the City with the following exceptions:

◊ Employees of the City's Police and Fire Departments who are members of another retirement system; and

◊ Part-time employees (less than 20 hours are not eligible), crossing guards and temporary or seasonal employees

In addition, the following persons may become members in the system: Those non-City employees employed by the following organizations:

- Caddo Parish Library
- Caddo-Shreveport Sales and Use Tax Commission
- Metropolitan Planning Commission
- Other non– City employees recommended by the Board of Trustees and approved by the city Council.

For more Information, please contact the Pension Office:

Pension Manager *(contact for LTD claims)*	318-673-5427
Administrative Assistant	318-673-5426
Pension Office Fax Number	318-673-5428

Voluntary Retirement Options:

AXA 457b	Bonnie Arbuckle	318-990-2623
AXA 457b	Amy Stroker	318-820-8636
AXA 457b	Wesley Roan	318-458-9999 / 318-564-6074
Nationwide	Terry McGlothern	318-4005-9954
Nationwide	*(Home Office)*	877-803-3924
Mass Mutual	Edna Delphin	318-861-8401
Valic	Melissa McConnell	318-572-8601

Benefit Advocate Center (BAC) for retirees 1-844-304-5008

CONTACT INFORMATION

BENEFIT	PROVIDER	PHONE	WEBSITE/EMAIL
Benefit Advocate Center	Gallagher Benefit Services	844-304-5008	bac.shreveport@ajg.com
Medical/Rx	BCBSLA	800-363-9150	www.bcbsla.com
Dental	BCBSLA	800-363-9150	www.bcbsla.com
Vision	BCBSLA	800-363-9150	www.bcbsla.com
City Term Life Insurance	UHC	888-299-2070	myuhclife.com
City AD&D	UHC	866-615-8727	bac.shreveport@ajg.com
City Long Term Disability	UHC	866-615-8727	FPcustomersupport@uhc.com
To file an LTD claim, contact: Pension Manager / Retirement Office 318-673-5426 | 318-673-5427			
Life Insurance	New York Life	318-752-4526	Newyorklife.com
Accident, Critical Illness, Universal Life	Trustmark	800-918-8877	trustmarksolutions.com
Short-Term Disability	Allstate	800-521-3535	allstatebenefits.com
Employee Assistance Program (EAP)	City of Shreveport	318-673-5150	City of Shreveport HR Department
Flexible Spending Account (FSA)	The Human Resource Group	318-688-4939	Sharon@hrdeptinc.com

Gallagher

Insurance | Risk Management | Consulting

2021 Annual Enrollment Notices & Disclosures

City of Shreveport
January 1, 2021

Arthur J. Gallagher & Co.
www.ajg.com

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Legal Notices & Disclosures — Page

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 8-10 for more details.

WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

If you would like more information on WHCRA benefits, please call your Plan Administrator at 318-673-5420.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	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: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)	NEBRASKA – 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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – 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: kihpp.program@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htmPhone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT – Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
City of Shreveport is committed to the privacy of your health information. The administrators of the Health and Welfare Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting the Benefits Office at 318-673-5420.

HIPAA SPECIAL ENROLLMENT RIGHTS

Health and Welfare Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Health and Welfare Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the Benefits Office at 318-673-5420.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from City of Shreveport

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

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Shreveport coverage will not be affected.

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**January 1, 2021**
Name of Entity/Sender:	**City of Shreveport**
Contact—Position/Office:	**Yvonne Hall**
Office Address:	**505 Travis Street, Ste. 620**
Phone Number:	**Shreveport, LA 71101**
	318-673-5420

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;
- 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: Yvonne Hall, 318-673-5420.

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. Please contact Yvonne Hall, 318-673-5420, for any additional questions regarding COBRA.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Yvonne Hall
318-673-5420

MARKETPLACE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Donna Wise, 318-673-5421.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

•As your employer, we offer a health plan to:

X All eligible employees.
☐ Some employees.

•With respect to dependents:
X We do offer coverage.
☐ We do not offer coverage.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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

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

X **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? 1st of the month following 60 days (mm/dd/yyyy) (Continue)
☐ **No**

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

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

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15. For the lowest cost plan that meets the minimum value standard[3] offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
    a. How much would the employee have to pay in premiums for this plan?
    b. How often? Weekly Every 2 weeks Twice a month **X** Monthy Quarterly Yearly

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

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16. What change will the employer make for the new plan year?
    ☐ Employer won't offer health coverage
    ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
    a. How much would the employee have to pay in premiums for this plan?
    b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

SELF-FUNDED, NON-FEDERAL GOVERNMENTAL PLAN OPT OUT NOTICE

Model Notice to Enrollees in a Self-Funded Nonfederal Governmental Group Health Plan For Plan Years Beginning On or After September 23, 2010

[This notice is appropriate in the case of a collectively bargained plan ratified on or after March 23, 2010.]

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. City of Shreveport has elected to exempt Health and Welfare Plan from all of the following requirements:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.

2. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.

4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for 2021 beginning January 1, 2021 and ending December 31, 2021. The election may be renewed for subsequent plan years.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0702**. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4- 26-05, Baltimore, Maryland 21244-1850.

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Gallagher

Insurance | Risk Management | Consulting

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

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