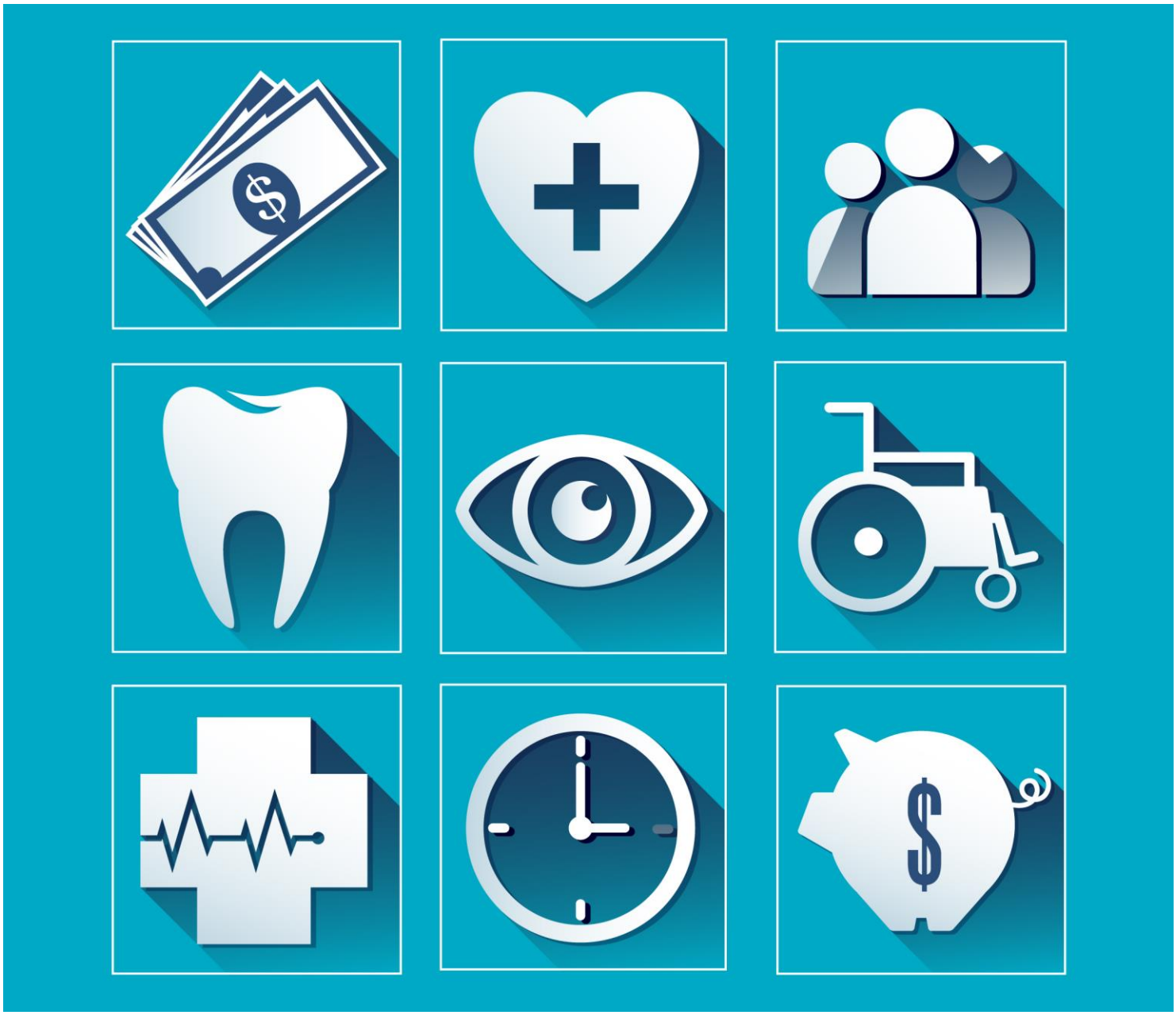
MARSH & McLENNAN AGENCY

Lawrence County Schools Council of Government
District: South Point Local School District

Employee Benefits Enrollment Guide

Plan Year: May 1, 2016 through April 30, 2017



Contact Information

Refer to this list when you need to contact one of your benefit vendors.

MARSH & MCLENNAN AGENCY:

Claims Manager: Thadd Scott - Phone: 513-707-5017; Email: thadd.scott@mma-mw.com

Account Management: Michelle Meyer - Phone: 513-707-5022; Email: michelle.meyer@mma-mw.com

Account Assistant: Kara Valle - Phone: 513-707-5024; Email: kara.valle@mma-mw.com

Toll Free Number: 1-800-949-1167

Address: 6279 Tri-Ridge Blvd., Suite 400, Loveland, OH 45140

MEDICAL PLAN:

Anthem Blue Cross/Blue Shield

Member Services: 1-800-552-9159

Nurse Line: 1-888-249-3820

Claim Address: Anthem, P. O. Box 105187, Atlanta ,GA 30348-5187

Website: www.anthem.com

PRESCRIPTION DRUG PLAN:

Express Scripts

Member Services: 1-855-216-1512

Website: www.Express-Scripts.com

DENTAL:

Guardian Life Insurance Company

Member Services: 1-800-541-7846

Claim Address: Guardian Group Dental Claims, P. O. Box 2459, Spokane , WA 99210-2459

Website: www.guardiananytime.com

VISION:

Guardian / VSP - Choice

Member Services: 1-877-814-8970

Claim Address: Vision Service Plan, P. O. Box 997105, Sacramento, CA 95899-7105

Website: www.vsp.com

LIFE INSURANCE:

Guardian Life Insurance Company

Member Services: 1-800-541-7846

Welcome to Open Enrollment!

Elections you make during open enrollment will become effective May 1, 2016.

Lawrence County Schools Council of Government offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

How to Enroll

The first step is to review your current benefit elections. Decide if you want to make any changes to your current benefit elections. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

If waiving health insurance coverage, please sign waiver form.

When to Enroll

The open enrollment period runs from 4/1/16 through 4/29/16. The benefits you elect during open enrollment will be effective from 5/1/16 through 4/30/17.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence, commencement or termination of adoption proceedings, change in employment status or change in coverage under another employer-sponsored plan. If you experience a status change, please notify your district board office no later than 30 days from such change to the appropriate action may be taken. Failure to notify in a timely manner may result in denial of requested change until the next open enrollment period.

What's New for **2016-17**

- The Anthem out of pocket maximum on the $500 deductible health plan will be increasing by $1000 as of May 1st. The new out of pocket maximum is $3000 per person to a maximum of $5,000 per family.

- On the health plan, dependents will lose coverage as of the last day of the month following their 26th birthday. In 2015, the State of Ohio changed their law to match federal law definition of a dependent, so dependents can no longer be covered up to age 28. If you have a dependent covered over the age of 26, and they are not handicapped, they will lose coverage as of May 1, 2016. All dependents losing coverage will be offered COBRA continuation.

Medical (Anthem) and Prescription Drugs (Express Scripts)

Our Anthem PPO plans allow you the freedom to use providers in and out-of-network, although the chart below only outlines the in network benefits. If you receive services out-of-network, your cost increases significantly. As a reminder, our benefits run on a calendar year basis.

Services	OPTION 1	OPTION 2
Preventive Care	Covered in Full	Covered in Full
Physician Office Visit *PCP includes family practice, general physician, internist, pediatricians, OB/GYNs	$20 copayment Primary Care Physician*; $30 copayment Specialist	$20 copayment Primary Care Physician*; $30 copayment Specialist
Calendar Year Deductible	$500 per person to a maximum of $1,500 per family	$4,000 per person to a maximum of $8,000 per family
Inpatient Hospitalization	80% after Deductible	80% after Deductible
Outpatient Surgery	80% after Deductible	80% after Deductible
Non-Surgical Outpatient Services for diagnostic testing, labs and x-rays (except Advanced Imaging)	Covered in Full	Covered in Full
Advanced Diagnostic Imaging (CT Scan, MRI, Nuclear Medicine, PET Scan, etc.)	80% after Deductible	80% after Deductible
Durable Medical Equipment	80% after Deductible	80% after Deductible
Outpatient Therapies **Calendar Year Visit Limits:** **Cardiac Rehab: 60** **Pulmonary Rehab: 30** **Physical Therapy: 30** **Occupational Therapy: 30** **Manipulation Therapy: 20** **Speech Therapy: 30**	If billed as office visit, then Specialty Physician Office Visit applies. If billed as outpatient facility, 80% after Deductible	If billed as office visit, then Specialty Physician Office Visit applies. If billed as outpatient facility, 80% after Deductible
Urgent Care	$35 copayment	$35 copayment
Emergency Room	$250 copayment (waived if admitted)	$250 copayment (waived if admitted)
Out of Pocket Maximum (includes deductible) Per Calendar Year	$3,000 per person to a maximum of $5,000 per family (INCLUDES COPAYS EXCEPT RX)	$5,000 per person to a maximum of $10,000 per family (INCLUDES COPAYS EXCEPT RX)
Prescription Drugs **Retail Pharmacy (30-days)** **Mail Order (90-days)** **Specialty Rx is Retail Copay**	**Retail Pharmacy** $10 / $25 / $40 **Mail Order** $20 / $50 / $80 **Rx OOP max:** $1,000 single / $2,000 family	**Retail Pharmacy** $10 / $25 / $40 **Mail Order** $20 / $50 / $80 $1,000 single / $2,000 family

Anthem BlueCross BlueShield LiveHealth ONLINE Lawrence County Council of Governments

Visit a doctor without going to a doctor's office.

Sometimes you just need a doctor – whether you're at home in the middle of the night or in the middle of a road trip. Now you can talk to a doctor any time of day, wherever you are. LiveHealth Online lets you have face-to-face conversations with a doctor on your computer or mobile device. It's medical advice the moment you need it. No appointments. No waiting. So simple. And the cost to Lawrence County members is $10 per visit.

Who are the doctors who use Live Health Online?

- U.S. board-certified.
- Average 15 years practicing medicine.
- Mostly primary care physicians.
- Specially trained for online visits.

How it works

Log on to your Anthem.com secure member portal and click on the link to LiveHealth Online. First you need to sign up, which is quick, easy and free to do. Be sure to enter your insurance information since LiveHealth Online is covered at a $10 copay for Lawrence County members. Each time you log in, you'll see doctors who are available in your state. Simply click on a doctor's photo to view his or her star rating, profile and languages spoken. Want to come back later? Bookmarking a doctor's profile is easy. LiveHealth Online even has a preferred provider section where you can store a preferred doctor's information.

It's for everyone

Anyone can use LiveHealth Online, and doctors can help with many different health issues, such as:

- Colds
- Flu
- Allergies
- Sinus infections
- Bronchitis
- Diarrhea
- Pinkeye and other eye infections
- Urinary tract infections
- Rashes
- Psychology – therapists & psychologists offer flexible evening and weekend appointments. In most cases, you can make an appointment to see a therapist within 4 days or less! Call 1-844-784-8409 from 7am to 11pm, 7 days a week, to schedule an appointment. The appointment will be via video on your smartphone, tablet or computer with a webcam.

Please note: LiveHealth Online is not for emergencies. If you're experiencing an emergency, call 911 immediately.

It's fast

Once you select a doctor, click **Connect** and in just a few minutes you'll be talking with him or her – face-to-face! During your session, the doctor can review your health history, answer questions, assess your condition and even prescribe medications if needed. After each session, you can rate your experience and send a record from the LiveHealth Online system to your regular doctor.

Take care of yourself. Use your preventive care benefits.

Anthem. BlueCross BlueShield

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24, with fair skin, about ways to lower their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening[2] when done as part of a preventive care visit

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[3]
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)[4,5]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[5]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[5]
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.

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Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years[6]
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles) for those 60 years and older

A word about pharmacy items

For 100% coverage of over-the-counter (OTC) drugs and other pharmacy items listed below, the person receiving the item(s) must meet the age and other specified criteria. You need to work with your in-network doctor or other health care provider to get a prescription for the item(s) and take the prescription to an in-network pharmacy. Even if the item(s) do not "need" a prescription to purchase them, if you want the item(s) covered at 100%, you have to have the prescription.

Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old
- Fluoride supplements for children from birth through 6 years old
- Iron supplements for children 6-12 months

Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco cessation products including select generic prescription drugs, select brand-name drugs with no generic alternative, and FDA-approved over-the-counter products, for those 18 and older

Women's preventive drugs and other pharmacy items — age appropriate:

- Contraceptives including generic prescription drugs, brand-name drugs with no generic alternative, and over-the-counter items like female condoms or spermicides[5,7]
- Folic acid for women 55 years old or younger
- Vitamin D for women over 65
- Breast cancer risk-reducing medications following the U.S. Preventive Services Task Force criteria (such as tamoxifen and raloxifene)[6]

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Customer Service number on your ID card.
2 Some plans cover additional vision services. Please see your contract or *Certificate of Coverage* for details.
3 Check your medical policy for details.
4 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.
5 This benefit also applies to those younger than 19.
6 You may be required to get prior authorization for these services.
7 A cost share may apply for other prescription contraceptives, based on your drug benefits.

Dental Plan with Guardian

There are no plan changes to your dental benefits as of May 1, 2016. To locate a participating provider, log onto www.guardiananytime.com, or call Guardian at 1-800-541-7846.

	PPO – Dental Guard Preferred Network (for both plans)	
Services	**VALUE PLAN (only select this plan if your dental provider(s) are in the Guardian network)**	**NAP (Network Access) PLAN (select this plan if your dental provider(s) are out of network or if you want the freedom to choose in or out of network)**
Preventive Services	Covered in Full	Covered in Full
Deductible, per Calendar Year	$50 per person to a maximum of $150 per family	$50 per person to a maximum of $150 per family
Basic Services	100% after Deductible	80% after Deductible
Major Services	60% after Deductible	50% after Deductible
Annual Maximum, per person, per Calendar Year	$1,000 (*maximum rollover benefit available)	$1,000 (*maximum rollover benefit available)
Orthodontia (children up to age 19)	50% to $1,000 lifetime	50% to $1,000 lifetime
Dependent Child Age Limit	To age 19 (25 if a full-time student)	To age 19 (25 if a full-time student)

*With maximum rollover, Guardian will roll over a portion of your unused maximum into your personal Maximum Rollover Account (MRA). The MRA can be used in future years, if you reach the plan's regular annual maximum. To qualify, you must have a claim for covered services for which a benefit payment is used, in excess of any deductible, and you must not exceed the claims threshold during the benefit year. You and your insured dependents maintain separate MRAs based on your own claim activity. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Your regular annual maximum is $1,000. The MRA threshold is $500, which means that your claims had to be under that amount for the calendar year. If you used out of network dental providers, your MRA credit would be $250 and if you used in network providers, your MRA credit would be $350. Your MRA account can grow to a maximum of $1,000 over several years, which may be used in a later year after you have depleted your regular annual maximum.

Vision Plan with VSP Choice (Guardian)

There are no plan changes to your vision benefits as of May 1, 2016. To locate a participating VSP Choice provider, please log onto www.vsp.com, or call Member Services at 1-877-814-8970. The chart below outlines the in-network benefits. By seeking care from an in network provider allows you to maximize your plan benefits. Your policy also contains a reimbursement for services received out of network, but the claim needs to be filed by you (the provider will not file the claim). For out of network services, please obtain an itemized receipt from your vision provider, and contact Marsh and McLennan Agency for an out of network vision claim form.

Services	VSP Choice Plan
Eye Exam (every 12 months)	$20 copayment
Lenses (every 12 months) **Single Vision Lenses** **Bifocal Lenses** **Trifocal Lenses** **Ventricular Lenses**	$20 copayment
Frames (every 24 months)	$130 allowance then 20% off remaining balance
Contact Lenses (every 12 months) **Elective** **Medically Necessary**	$130 allowance Covered in Full
Dependent Child Age Limit	To age 19 (25 if a full-time student)

Basic Life Insurance

South Point provides eligible Certified employees with $30,000, Classified employees with $30,000, and Administrators with $50,000 of group life and accidental death and dismemberment (AD&D) insurance, and pays the full cost of this benefit. Contact your board office or Marsh & McLennan Agency to update your beneficiary, as needed.

Voluntary Life Insurance

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions. You can purchase coverage on yourself in $10,000 increments up to a $200,000 maximum, and your spouse (up to age 70) in $10,000 increments up to $50,000 max. You may also purchase coverage on your dependent children up to 10% of your elected amount up to a maximum of $10,000 per child. The dependent child age limit is 23 years of age (or up to 25 years if they are a full time student). The minimum age is 14 days. The death benefit begins to reduce when you reach age 65.

If you waived the Voluntary Life Insurance Coverage when it was initially offered in 2010 (or during your new hire election period), and decide later to apply for this coverage, you will be subject to underwriting approval based on the completion of an Evidence of Insurability form (medical history). Guardian has the right to decline you and/or your dependents based on information disclosed.

The voluntary life coverage is portable up to age 70, or it can be converted to a whole life policy, which builds cash value and has a level premium for the life of the policy (no age limit). If you are interested in continuing your coverage after your employment ends, you will need to contact Guardian within 30 days of your termination date. Guardian can be reached at 1-800-541-7846, or contact Michelle Meyer at Marsh & McLennan Agency for further information.

Questions & Answers

Changes that can be made effective May 1, 2016:

- Change medical plans (i.e., $500 deductible to $4,000 deductible or vice versa)
- Enroll or terminate individual and/or dependent coverage in the medical/dental/vision plans
- Add or make changes to the Voluntary Life and/or Long Term Disability plans (Evidence of Insurability may be required)

Forms to be completed if making changes:

- Anthem Enrollment Form to change medical plans or individual/dependent coverage levels in the medical plan.
- Guardian Enrollment Form to change dental or vision plan elections.
- Guardian Voluntary Life and AD&D Enrollment and/or Medical Underwriting Form.

What Forms MUST be completed?

- If waiving the health insurance plan, you are required to sign a waiver form each year.

Where do I find these forms?

- Contact your district's board office for all forms.

When are the forms due and where do I return them?

- All forms are due by 4/29/16 and must be returned to your district's board office.

Other Information:

- If you do not make changes to your current elections, those elections will remain the same for the plan year May 1, 2016 through April 30, 2017.

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

ANNUAL NOTICES – PLAN YEAR 2016-17

Important required materials – information only no action is required

DEPENDENT COVERAGE TO AGE 26 NOTICE

The Anthem group health insurance plan extends coverage for your dependent children up to the end of the month following the child's 26th birthday. When coverage ends due to reaching age 26, your dependent will be offered COBRA. The following factors do NOT apply when determining your child's eligibility: Financial dependence on the participant or any other person; Residency with the participant or with any other person; Student status; marital status; employment status; or eligibility for other coverage. If your child is not currently enrolled in the group health plan, you may add the child during the open enrollment period, or at a later date, if the child experiences a qualifying life event.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits 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 Anthem group health insurance plan. For more information, please contact Anthem member services at the phone number listed on the back of your ID card.

THE NEWBORNS' AND MOTHERS' HEATH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth. Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PATIENT PROTECTIONS / DESIGNATION OF PRIMARY CARE PHYSICIAN

Cincinnati Christian University's group health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem member services using the phone number on the back of your ID card, or go online to Anthem.com.

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in 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 Anthem member services, using the phone number on the back of your ID card, or go online to Anthem.com.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or

- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have 60 days to request special enrollment in the group health plan coverage.

To request special enrollment or obtain more information, contact your district's board office.

Important Notice from Lawrence County Schools Council of Government About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Express Scripts 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. Lawrence County Schools Council of Government has determined that the prescription drug coverage offered by the Express Scripts 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 15 to December 7.

However, if you lose your current creditable prescription drug coverage through Lawrence County Schools Council of Government, by 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 Express Scripts coverage will not be affected.
If you do decide to join a Medicare drug plan and drop your current Express Scripts coverage, be aware that you and your dependents will be able to get this coverage back at the next open enrollment period.

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 Express Scripts 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 Express Scripts 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:	April 1, 2016
Name of Entity/Sender:	Lawrence County Schools Council of Government
Address:	111 South 4th Street, 3rd Floor, Ironton, OH 45638
Phone Number:	740-532-4223

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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, 2014. You should contact your State for further information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid</td></tr>
<tr><td>IDAHO – Medicaid</td><td>Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
<tr><td>Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588</td><td>MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084</td></tr>
</table>

INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	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	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

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