



**FORT OGLETHORPE
GEORGIA**

2024

Employee Benefits Guide

What's Inside

Summary Plan Description

Please note this guide is designed to provide an overview of the coverages available. Your employer reserves the right to amend or change benefit offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations. If any discrepancy exists between this guide and the official documents, the official documents will prevail. If you would like a printed copy of the materials, please contact your employer.

Please contact Human Resources if you have any questions regarding your benefits plan.

Enrollment Changes

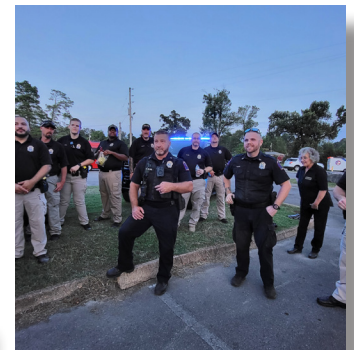
Changes to your enrollment may be made annually during open enrollment each year. Mid-year changes may be made for the following qualifying events such as marriage/divorce, birth/adoption, death, change in job status of yourself or your spouse, and or change in Medicaid/CHIP eligibility.

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

Section 125 Plan Premium Conversion

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

Benefit Contacts	3
Medical Benefits	4
Telemedicine	5
Employee Health Clinic.....	6
Dental and Vision Benefits	7
Basic and Voluntary Life	8
Disability Products	8
Employee Assistance Program.....	9
How to Enroll	9
Annual Notices	11-19



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

Benefit Contacts

Benefit	Carrier	Group Number	Phone Number	Website/Email
Medical Benefits	Cigna	0613940	1-866-494-2111	www.myCigna.com
Telemedicine	Cigna - MDLIVE	N/A	1-888-726-3171	www.myCigna.com
Employee Health Clinic	One-to-One Health	N/A	423-402-8176	www.catoosa.com/clinic
Dental Benefits	Cigna	0613940	1-866-494-2111	www.myCigna.com
Vision Benefits	Cigna	0613940	1-866-494-2111	www.myCigna.com
Basic and Voluntary Life and AD&D	Mutual of Omaha	G000AV2V	1-800-877-5176	www.mutualofomaha.com
Disability Plans	Mutual of Omaha	G000AV2V	1-800-877-5176	www.mutualofomaha.com
Employee Assistance Program (EAP)	Cigna	0613940	1-866-494-2111	www.myCigna.com
	Mutual of Omaha	N/A	1-800-316-2796	www.mutualofomaha.com/eap
Online Enrollment	Employee Navigator	Company ID: FOCITY	N/A	https://employeenavigator.com/benefits/Account/Login
Benefits Department	Cindy Marchant	N/A	706-866-2544, ext. 1940	cmarchant@fortoglethorpega.gov



Medical Benefits



City of Fort Oglethorpe medical benefits are provided through **Cigna**.

City of Fort Oglethorpe offers plan options in the Cigna Open Access Plus Network. In this network, you have the flexibility to go to any provider that you choose.

If you select an out-of-network physician or facility, you will be subject to higher deductibles and out-of-pocket maximums. But anytime you select an in-network physician or facility, you will see significant discounts and savings.

To find an in-network provider near you, go to www.myCigna.com and click on “Find A Doctor.” Please be sure to consult either the online directory or the Cigna customer service department to confirm that your provider participates in the network.

Per Pay Period Premiums	Open Access Plus Plan
Employee Only	\$69.66
Employee + One	\$144.21
Employee + Family	\$209.01

Medical Benefits*	Open Access Plus Plan
Deductible: Individual / Family	\$750 / \$1,500
Out-of-Pocket Maximum: Individual / Family	\$4,500 / \$9,000
Covered Services Overview	
Preventive Care	100%*
Office Visit - Primary Care Physicians	\$30 Copay
Office Visit - Specialists	\$60 Copay
Physical, Occupational, Speech, Audiology and Cognitive Therapy	\$30 Copay
Outpatient and Group Therapy	\$60 Copay
Cigna Telehealth - MDLive	\$30 Copay
Urgent Care	\$75 Copay
Emergency Room	\$250 Copay
Durable Medical Equipment and Supplies	20% After Deductible
Most Other Services	20% After Deductible
Pharmacy - Retail Network	
Tier 1 - Generics (30 Days / 90 Days)	\$10 Copay / \$25 Copay
Tier 2 - Preferred (30 Days / 90 Days)	\$35 Copay / \$88 Copay
Tier 3 - Non-Preferred (30 Days / 90 Days)	\$60 Copay / \$150 Copay

*Review plan documents for out-of-network rates, prior authorization requirements, limits on the number of visits per year and service restrictions.

Cigna has partnered with **MDLIVE** to offer a comprehensive suite of convenient virtual care options - available by phone or video, whenever it's most convenient for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of 10 years of experience and provide personalized care for hundreds of medical and behavioral health needs. MDLIVE doctors are friendly, caring, compassionate, and experts in conducting virtual medical consultations.

Your MDLIVE virtual care options include:

Primary Care

Preventive care, routine care and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology

Fast, customized care for skin, hair and nail conditions - no appointment required

- Board-certified dermatologies review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

3 Easy Steps to Connect to Care:

1. Access MDLIVE by logging into www.myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888-726-3171 (no phone calls for virtual dermatology).
2. Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE.
3. Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care.

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.

Employee Health Clinic



Available to employees and covered dependents that are enrolled in the City's Health Insurance

NO COST MEDICAL CARE (NO COPAYS OR DEDUCTIBLES)

The City of Fort Oglethorpe has partnered with Catoosa County Government to provide you with additional health benefits and resources. The Employee Health Clinic is managed by One to One Health which is a physician led, corporate health management company. One to One Health providers offer high quality care, while being mindful of controlling costs and improving patient satisfaction. They are invested in the health and wellbeing of our community and surrounding areas.

Appointment Clinic Hours

Hours

Monday / Wednesday / Friday

- 8:00am - 3:30pm

Tuesday / Thursday

- 1:00pm - 6:00pm

Walk Ins

Monday / Friday

- 8:00am - 10:00am

Wednesday

- 8:00am - 9:00am

Tuesday / Thursday

- 1:00pm - 2:00pm

Services Available

- Primary Care Services
 - Annual Check-Ups & Physical Exams
- Acute Care
 - Colds, Sore Throat, & Flu
- Routine Lab Work
- Chronic Care
 - Diabetes, High Blood Pressure, High Cholesterol
- Limited Generic Prescriptions

The City will pay you your regular wages for up to 2 hours if your visit is during work hours. If already at work, clock out for your visit and fill out a Leave Sheet. Note "Other - Health Clinic" on your form. Request a work release form at your visit and attach that form to your leave slip. If your visit takes more that 2 hours, you would need to offset your time with Sick leave.

If you are out sick the entire day, you will need to turn in for 8 hours sick leave.

313 Boynton Drive | Ringgold, GA 30736
Call 423-402-8176 to schedule an appointment
New Patient Forms available at www.catoosa.com/clinic

Dental Benefits



Your dental benefits at City of Fort Oglethorpe are provided by **Cigna**. This dental plan is a PPO (similar to your medical plan), in that you may visit any provider that you choose, however, you will most likely see increased benefit levels if you go to a provider in network.

To find a provider in the network, visit www.myCigna.com and click on "Find A Doctor."

Per Pay Period Premiums	Basic	Buy-Up
Employee Only	\$2.03	\$3.66
Employee + Spouse	\$4.05	\$6.73
Employee + Child(ren)	\$4.58	\$7.26
Employee + Family	\$6.85	\$9.98

Dental Benefits	Basic	Buy-Up
Deductible: (Aggregate) Individual / Family	\$50	\$50
Calendar Year Maximum	\$1,500	\$2,000
Benefits Paid by the Plan		
Preventive - Includes exams, cleanings (2 per year), sealants, x-rays	100%	100%
Basic - Fillings, periodontic services, minor oral surgery	80%	80%
Major - Root Canals, periodontic surgery, crowns, dentures, bridges, anesthesia	50%	50%
Orthodontia Coinsurance / Lifetime Maximum	Excluded	Excluded
Dependent Age	26	26

Vision Benefits



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

To find an in-network provider or surgery center, call customer service or go to www.myCigna.com and click on "Find A Doctor."

Per Pay Period Premiums	
Employee Only	\$0.00
Employee + One	\$2.00
Employee + Family	\$5.01

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

Vision Benefits	In-Network	
	Frequency	Details
Vision Exam	Every 12 months	\$10 copay
Prescription Glasses		\$25 copay
<i>Frames</i>	Every 24 months	Up to \$120; Discounts over \$120
<i>Lenses</i>	Every 12 months	
Contact Lenses (instead of glasses)	Every 12 months	Premium fit and follow-up; 10% off retail
<i>Conventional</i>		Up to \$120
<i>Disposable</i>		Up to \$120
<i>Medically Necessary</i>		Covered 100%
<i>Dependent Age</i>		26

Basic and Voluntary Life



Basic Life/AD&D Insurance

At City of Fort Oglethorpe, Basic Life/Accidental Death and Dismemberment (AD&D) Insurance is a provided benefit at no cost to you through **Mutual of Omaha**.

Basic Life/AD&D	
Coverage Amount	\$50,000
Age Reduction	Beginning at age 65

**Benefit will terminate upon retirement.*

AD&D insurance pays an additional amount based on a specific list of losses such as loss of life, limb, or sight due to an accident. Please remember to contact Human Resources when you need to update your beneficiaries.

Voluntary Life and AD&D Insurance

You have the option to purchase Voluntary Term Life and AD&D through **Mutual of Omaha**. You may purchase:

Voluntary Life/AD&D	
Coverage Amount	\$10,000 increments up to a maximum of \$300,000
Guarantee Issue Amount	\$100,000
Age Reduction	Beginning at age 65

You may purchase or increase at anytime by completing an Evidence of Insurability form. Please remember to contact Human Resources when you need to update your beneficiaries. See your plan summary for details.

Disability Products



Short-Term Disability Insurance

Short-Term Disability (STD) Insurance can help support you and your family should you become temporarily disabled. This coverage is provided by **Mutual of Omaha** and is paid entirely by City of Fort Oglethorpe. You are eligible for this benefit after one year of service.

Long-Term Disability Insurance

Long-Term Disability (LTD) Insurance can protect your income in case of a long-term injury or illness. This coverage is provided through **Mutual of Omaha** and paid entirely by City of Fort Oglethorpe.

Disability Details	Short-Term Disability	Long-Term Disability
Income Replacement	100% of weekly earnings	60% of monthly earnings
Maximum Benefit	\$2,500/week	\$6,000/month
Accident Elimination Period	7 days	90 days
Illness Elimination Period	7 days	
Benefit Duration	Up to 12 weeks	Social Security Normal Retirement Age

Employee Assistance Program

With **Mutual of Omaha's** employee assistance program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done. Services include:

Get Unlimited FREE help at:
www.mutualofomaha.com/eap
Or Call 1-800-316-2796

- Toll-free phone and web access 24/7
- Up to 3 sessions per household conducted by either face-to-face counseling or video telehealth via a secure, HIPAA compliant portal
- Unlimited telephonic support - Legal service, financial service, work/life service
- Financial consultations and referrals
- Work/life services for assistance with child care, finding movers, kennels and pet care, vacation planning, and more
- Network of more than 10,000 licensed clinical providers
- All contact is completely confidential

How to Enroll - Employee Navigator

To enroll in your benefits, log onto <https://employeenavigator.com/benefits/Account/Login>.

If you already have an account, enter your username and password.

- If you forgot your username or password, you can click - ***Forgot Username?*** Or ***Forgot Password?***

If this is your first time logging in, select ***Register as a new user.*** Complete your account by entering the following information:

- Company Identifier: **FOCITY**

Next, create your username and password. We recommend using your email address as your username. Your password must be a minimum of 6 characters long and include a number and a symbol. Click ***I agree with terms of use*** and then click ***Next.***

Once you are logged in, complete the system-prompted steps.

In order to submit your benefit elections and beneficiary designations, be sure to select ***Click to Sign*** on the Enrollment Summary page.

employee NAVIGATOR

Username

Password

Login

[Forgot Username? Forgot Password?](#)

[Register as a new user](#)

Enrollment Summary

Below is a summary of your elections and cost for the upcoming plan year. If you have any questions about your enrollment or would like to make changes, please contact HR.

Signature required
You've elected all your benefits but we still require a signature before advancing to the next thing.

Please review the acknowledgment below

I agree to be governed by the terms and conditions of the plans in which I have enrolled. I authorize the Company to deduct contributions from my earnings now or in the future as required under each of the plans. I also understand that if my paycheck is not sufficient to cover my contribution, the Company may, in its sole discretion, automatically collect any such payment(s) from future paycheck(s). I am also aware that it is my responsibility to notify my human resources department of any future change in address that should occur through the course of my enrollment.

Sign to complete enrollment

Click to Sign

Notes



Annual Notices

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

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

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

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

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

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

To see if any other states have added a premium assistance program since **January 31, 2023**, or for more information on special enrollment rights, contact either:

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

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

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

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

For states not listed:
877-543-7669

www.insurekidsnow.gov

OMB Control Number 1210-0137

Expires 1/31/2026

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

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

You do not need prior authorization from your carrier or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your carrier.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

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

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

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

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

If you get other services at these in-network facilities, out-

of-network providers can’t balance bill you, unless you give written consent and give up your protections.

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).

Your health plan will pay out-of-network providers and facilities directly.

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

If you believe you’ve been wrongly billed, you may contact Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

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

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

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

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

of genetic services by applicants, employees, or their family members.

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

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

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be

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

HIPAA SPECIAL ENROLLMENT

SPECIAL ENROLLMENT NOTICE This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

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

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

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

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

Medicaid or CHIP If you or your dependents lose eligibility for

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

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

Cindy Marchant

500 City Hall Drive, Fort Oglethorpe, GA 30742

706-866-2544, ext. 1940

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

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

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

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's

coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

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

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

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

HIPAA PRIVACY NOTICE The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. **As Required by Law.** We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, the right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Individual Rights You may obtain a copy of your health claims records and other health information from us typically within a 30 day period from your request. We may charge a reasonable, cost-based fee. You may ask us to correct your health/claims records if you think they are incorrect. We reserve the right to say “no” to your request, but will give you an explanation in writing within a 60 day period. Requesting a specific way to contact you for confidential reasons is permitted (home or office phone for example), specifically if you would be in danger from a certain form of communication.

If you would like us not to use or share certain health information for treatment, payment or our operations, you are permitted to do so. However, we are not required to agree to your request if it would affect your care. At your request, we will provide you with a list of the times we have shared your health information up to six years prior to your request date, who we shared it with, and why. This list will include all disclosures excluding treatment, payment, and health care operations, as well as other certain disclosures (such as any you ask us to make). We provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You can ask for a paper copy of this notice at any time, which we will promptly provide, even if you have agreed to receive the notice electronically. If you have given someone medical power of attorney or if you have a legal guardian, that person can exercise your rights and make choices about your health information. We will make sure they have this authority and can act in your interests before we take any action.

If you feel that we have violated your rights, you may contact us using the information on the back page, or file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We can assure no retaliation from us against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. You have the right and choice to tell us to share information with your family, close friends, or others involved in payment for your care, and in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest and when needed to lessen a serious and imminent threat to health or safety. We never share your information for marketing purposes or sale of your information without your expressed written consent.

Our Uses and Disclosures We typically use or share your information in several different ways. We help manage the healthcare treatment you receive by sharing information with professionals who are treating you. We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage (this does not apply to long term care plans). Our organization can use and disclose your health information as we pay for your health services, as well as disclose your health information to your health plan sponsor for plan administration.

Other Uses and Disclosures Typically in the matter of public health and safety issues, we can use and share your information. For instance, preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, as

well as preventing or reducing a serious threat to anyone’s health or safety, and health research.

We may need to share your information if state or federal law requires it, including the Department of Health and Human Services if it wishes to see that we’re complying with federal privacy law. Other organizations and professionals we may share your information with are organ procurement organizations, coroners, medical examiners, and funeral directors. We can share your information in special instances such as for worker’s compensation claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

“We, Our, and Us” is defined as the insurance carrier for fully insured plans or the plan administrator or third party administrator for self insured plans.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

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

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA

continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary

will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

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

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

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

If you don’t enroll in Medicare and elect COBRA continuation

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

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

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

If you have questions. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to

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

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

Plan contact information

Cindy Marchant

500 City Hall Drive, Fort Oglethorpe, GA 30742

706-866-2544, ext. 1940



POWERED BY  **BKS PARTNERS**

246 E. 11th Street, Suite 302, Chattanooga, TN 37402
(423) 266-8306 • www.rbabenefits.com

Produced and Printed by Russ Blakely and Associates, LLC, 10/2023

Important Notice from Our Company About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Our Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Our Company has determined that the prescription drug coverage offered by the medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every

month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Date	01/2024
Name of Entity	City of Fort Oglethorpe
Contact	Cindy Marchant
Address	500 City Hall Drive Fort Oglethorpe, GA 30742
Phone	706-866-2544, ext. 1940

FORT EST. 1949
O

FORT OGLETHORPE
GEORGIA