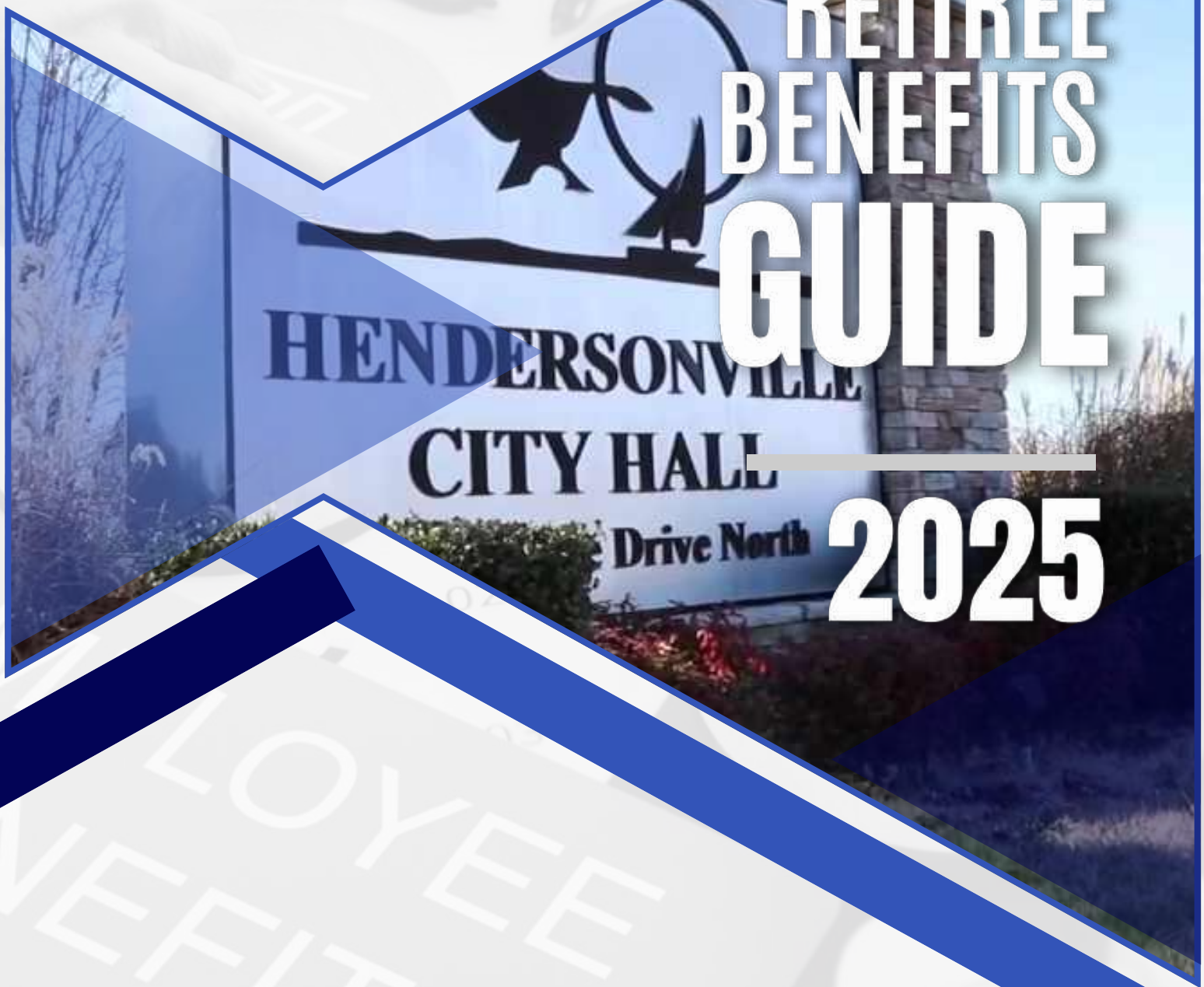
CITY OF
HENDERSONVILLE
TENNESSEE



RETIREE BENEFITS GUIDE

2025

Revised 6/3/25

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BENEFITS BASICS

Who is Covered?

Coverage is provided for former full-time employees who meet the requirements for continued retiree insurance coverage.

The City currently has contract provisions with Medical, Dental, and Vision carriers which allow employees eligible for retirement the privilege of remaining covered under the City's plan until they are eligible to receive Medicare. The benefits of this arrangement are that employees can receive coverage at group rates.

Employees hired July 1, 2008 or later must pay the full cost of the coverage for each month they wish to continue the plan through the City.

Employees hired June 30, 2008 or before and who are either age 60 or have 30 years of service with the City of Hendersonville are eligible to receive a City-paid portion of their Medical insurance if the employee elects to continue on the plan.

When Does Coverage End?

Upon your retirement from the City of Hendersonville, selections made during your initial enrollment as a retiree are the coverage(s) that you will maintain until you or your spouse, if applicable, become Medicare eligible. For example, if you do not select medical insurance at this time, you will not be allowed to add it at a later date, nor will you be allowed to add spouse to any coverage(s) if you do not initially take that coverage for them.

Employees that meet the criteria to be an eligible retiree with the City of Hendersonville have the option to elect to continue dental/vision coverage at full cost (until Medicare eligible). There is no city-paid supplement for these coverages. It is also important to note that, if at any point, you drop any coverage(s) as a retiree, you will not be allowed to pick those coverages back up.

WHAT'S NEW IN 2025

Health Insurance

There are only two slight changes to our health insurance plans.

- Prescriptions in our HSA Plan have changed slightly. Preventive drugs will now be subject to your deductible and coinsurance.
- Due to a federal law change, Teladoc is no longer included in our HSA PLan at no cost.. If you use this service, you will be subject to a $49 copay.

Dental Insurance

- We have chosen a new provider this year, Equitable.
- Our PPO Plan has been improved. The maximum annual benefit has been increased to $1,200 and preventive services will no longer count toward the maximum benefit. This means that you will be able to get your preventve services and still have $1,200 for other services.

Vision Insurance

- Equitable will also be our new vision provider.
- The allowances for contacts and eyeglass frames have been increased from $180 to $200.

ONLINE ENROLLMENT

This year, all enrollments will be completed through Employee Navigator - our new online benefits enrollment portal. Here's how to enroll!

1. **Visit Employee Navigator.** Visit EmployeeNavigator.com and click "Login" in the top right corner of the page.

2. Set **up your account**. Click on "Register as a new user." You will need your name, Birth Date, Last 4 digits of your SSN and our Company Identifier ("HvilleTN").

3. **Log in and click "Start".**

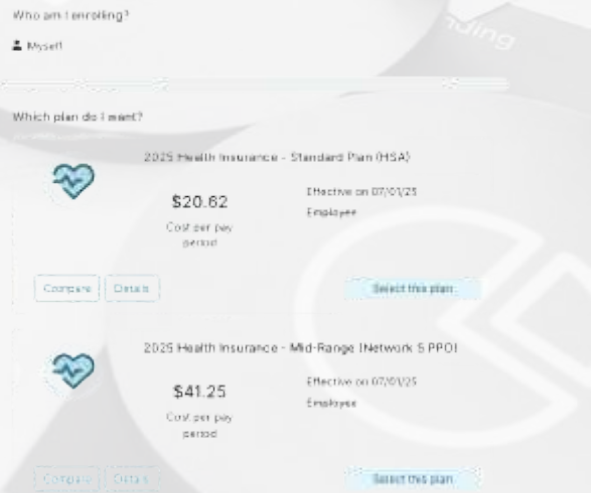
4. **Update your Personal Information.** Follow the left-hand bar and make sure that your personal information is correct. Then, click "Save & Continue."

5. **Update your Dependents' Information.** If you need to add a dependent or dependents, click "add dependent". If you do not cover dependents, you may click "Save & Continue".

6. **Select your coverage level for each product.** Follow the progress bar on the right side of the page as you add or waive each plan. For each benefit, you will select who to cover and which plan you would like (if there is more than one available). For health and dental insurance, you can compare all plans by clicking *Compare*.

If electing a benefit, click Select this plan. If you do not want a benefit, you should click Don't want this benefit? and select the reason.

When you finish each benefit, you should click Save & continue ›



7. **Add your beneficiaries.** When electing life insurance, be sure to designate your beneficiary(ies).

8. **Review your Enrollment Summary and submit your enrollment.**, Review your enrollment summary and total payroll deductions. You may change or remove products at this time. When done reviewing, select Click to Sign

9. **Congratulations! You are now enrolled.**

HEALTH INSURANCE

For this Open Enrollment, there are only very minor changes to our Standard (HSA Plan). In the Standard Plan, preventive drugs will now be subject to the plan deductible and Teladoc consultations will cost $49. Our other health insurance plans will continue to have $0 Teladoc consultations.

As a reminder, two of our plans, the Standard Plan and the Premier Plan, use BlueCross BlueShield's Network P and one plan, the Mid-Range Plan, uses Network S. Network S does not include some doctors, nor does it include HCA/Tristar facilities. You should always ensure that your doctors and providers participate in the appropriate BlueCross network by clicking on the "Find a Provider" link in Employee Navigator.

The following chart describes our plans:

	Standard Plan Network P HSA	Mid-Range Plan Network S PPO	Premier Plan Network P PPO
Annual Deductible (Individual / Family)	$3,500 / $7,000	$2,500 net / $5,000 net	$1,000 net / $2,000 net
Coinsurance	50%	70%	70%
Out-of-Pocket Limit (Individual/Family)	$5,500 / $11,000	$6,500 / $13,000	$5,000 / $10,000
Doctor Visit	Subject to Deductible & Coinsurance	Primary Care - $40 / Specialist - $80	Primary Care - $30 / Specialist - $50
Urgent Care Visit	Subject to Deductible & Coinsurance	$80	$50
ER Visit	Subject to Deductible & Coinsurance	Subject to Deductible & Coinsurance	$250
Prescriptions	Subject to Deductible & Coinsurance	$15 / $50 / $90 / $180	$10 / $45 / $70 / $140

of Tennessee

Revised 6/3/25

HEALTH SAVINGS ACCOUNTS

Every employee who elects to participate in the Standard Plan will also have a health savings account (if you elect) through Pinnacle Financial Partners.

Health savings accounts (HSAs) are a great way to save money and efficiently pay for medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs), like our Standard Plan. There are certain advantages to putting money into these accounts, including investment earnings and favorable tax treatment.

HSA money can be used tax-free when paying for qualified medical expenses. At the end of the year, you keep any unspent money in your HSA. This rolled over money can grow with tax-deferred investment earnings, and, if it is used to pay for qualified medical expenses, the money will continue to be tax-free. Your HSA (and the money in it) belongs to you—not the City nor any insurance company.

For this fiscal year, the City will continue to contribute $100 per month to your HSA if you are enrolled in our Standard health plan. You may also make contributions to your HSA on a pre-tax basis. That means that your HSA contribution will be taken out of your paycheck and no federal income tax or employment tax will be withheld on the contribution.

For 2025, the maximum you may contribute is $4,300 for single coverage and $8,550 for family coverage. For 2025, these limits will increase to $4,400 for single coverage and $8,750 for family coverage.These maximum amounts include both the City's contributions and your contributions. Individuals who are age 55 and older can also make additional "catch-up" contributions of up to $1,000 annually.

Please note – per IRS regulations, if you are enrolled in Medicare (Parts A and/or B), you are not eligible to contribute to or receive the City's contributions to an HSA.

Pinnacle℠
Health & Benefits

Pinnacle℠ Health & Benefits

HEALTH SAVINGS ACCOUNTS

Qualified Medical Expenses

The Internal Revenue Service (IRS) defines qualified medical care expenses as amounts paid for the diagnosis, cure or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness. The products and services listed below are examples of medical expenses eligible for payment under your HSA, when such services are not covered by your high-deductible health plan. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

This list is not all-inclusive; additional expenses may qualify, and the items listed below are subject to change in accordance with IRS regulations. For more information or clarification on individual list items, refer to Publication 502 or consult a tax professional.

Acupuncture	Chiropractor	Hearing aids	Osteopath	Stop-smoking programs
Ambulance	Contact lenses	Home care	Oxygen	Surgery
Annual physical exam	Crutches	Home improvements	Physical examination	Therapy
Artificial limb	Dental treatment	Hospital services	Pregnancy test kit	Transplants
Artificial teeth	Diagnostic devices	Laboratory fees	Prescribed weight-loss programs	Transportation
Bandages	Drug addiction	Lactation expenses	Prescriptions drugs	Tuition
Birth control pills	Eye exam	Learning disability	Prosthesis	Vasectomy
Body scan	Eyeglasses	Medicines	Psychiatric care	Vision correction surgery
Braille books and magazines	Eye surgery	Nursing services	Psychoanalysis	Wheelchair
Breast pumps and supplies	Fertility enhancement	Operations	Psychologist	X-ray
Breast reconstruction surgery	Guide dog	Optometrist	Sterilization	And many more

HEALTH REIMBURSEMENT ARRANGEMENT

The City is continuing to provide a Health Reimbursement Account for employees who participate in the Mid-Range or Premier health insurance plans. Through the HRA, the City will pay a portion of your health insurance deductible in order to help you with the most affordable healthcare possible.

Employees who participate in the Mid-Range Plan will have up to $2,500 of their deductible reimbursed ($5,000 for employees with Employee + One or Family coverage) and employees in the Premier Plan will have up to $2,000 of deductible reimbursed ($4,000 for employees who cover spouses and/or dependents). The HRA will begin reimbursing once you have incurred $1,000 of deductible expense ($2,000 for employees with Employee + One or Family coverage).

DENTAL INSURANCE

This year, we have chosen Equitable as our dental provider and will continue to offer two dental options for you. One plan is called a “DHMO” plan. In this plan, you will pay a lower cost for your coverage, but will have a smaller network of providers from which to use and no access to out-of-network benefits.. Our second plan, the “DPPO” plan has a much larger network of providers and access to out of network benefits. . We encourage you to determine if your dentists participate in the DHMO network by visiting the provider directory and searching for your dentist in the DHMO network. The PPO Plan allows you to use any dentist you want, although you will always receive better pricing if you use an Equitable network provider. You may find network providers by following the link in Employee Navigator.

The chart below describes the benefits in our two dental plans:

	PPO Plan	DHMO Plan (Amount you pay)
Preventive Services	Exams, cleanings, X-rays – 100%	Exams, cleanings, X-rays – $0
Basic Services	Fillings, simple extractions, oral surgery, endodontics, periodontics – 90% up to the Annual Maximum	Fillings - $57 - $65 Simple extractions – $35 - $65 (depending on procedure) Oral surgery – $105 - $270 (depending on procedure) Endodontics – $32 - $549 (depending on procedure) Periodontics – $0 - $502 (depending on procedure)
Major Services	Crowns, bridges, etc. – 50% up to the Annual Maximum	Crowns –$290 - $400 (depending on procedure)
Annual Maximum	$1,200 per person (Preventive Services are excluded)	N/A
Orthodontic Services	Children - 50% to age 26; $1,000 Lifetime Maximum	25% discount

EQUITABLE

VISION INSURANCE

This year, we have chosen Equitable as our vision insurance provider. This year, you will have access to a higher allowance for contact lenses or eyeglass frames. Equitable utilizes the VSP network, plus additional retail locations, such as Visionworks; therefore, you have access to the largest possible vision provider network.

Your vision benefits include:

- Routine vision exams for a $10 copay (every 12 months)
- $200 allowance for eyeglass frames plus 20% off of the balance (every 24 months). For featured brands, the allowance will increase to $220.
- $25 copay for basic eyeglass lenses, plus additional copays for lens add-ons (every 12 months)
- $200 allowance for contact lenses (every 12 months)

vsp

Our Vision Plan uses the VSP Network of vision providers...just like our previous plan!

EQUITABLE

ANNUAL DISCLOSURES

Summary of Benefits and Coverage (SBC)

The required summary of benefits and coverage notice is available online at www.hvilletnbenefits.com, or upon request. It is a standardized four-page document that highlights key provisions, limitations and exceptions for all The City of Hendersonville's medical plans.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law in 1986; COBRA gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances. Qualified individuals may be required to pay the entire premium for coverage up to 10% of the cost of the plan. COBRA generally requires that group health plans sponsored by employers offer Team Members and their families the opportunity for a temporary extension of health coverage in certain instances where coverage under the plan would otherwise end. COBRA outlines how Team members and family members pay and elect to continue their coverage. Please see your Human Resources Representative for more information.

Newborns' and Mothers' Health Protection Act Disclosure

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).

The Women's Health Cancer Rights Act of 1998 (WHCRA)

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

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

ANNUAL DISCLOSURES

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Medicare Creditable Coverage Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Hendersonville, Tennessee 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. The City of Hendersonville has determined that the prescription drug coverage offered by the (Insert Name of 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 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 The City of Hendersonville coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage.

ANNUAL DISCLOSURES

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

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 the City of Hendersonville 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 The City of Hendersonville Management Corp. 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).

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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).

Name of Entity/Sender: City of Hendersonville, TN
Contact--Position/Office: Jason Gallo, Administrative Services Director
Address: 101 Maple Dr. N. Hendersonville, TN 37075
Phone Number: (615) 264-5314

Title VI

It is the policy of The City of Hendersonville to ensure compliance with Title VI of the Civil Rights Act of 1964; 49 CFR, Part 21; Related statutes and regulations to the end that no person shall be excluded from participation in or denied benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance from the U.S. Department of Transportation on the grounds of race, color, sex, or national origin.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) is a comprehensive civil rights law prohibiting discrimination based on disability. The ADA law broadly protects the rights of individuals with disabilities in employment, access to State and local government services, places of public accommodations, transportation and other important areas of American life. The ADA law also requires newly designed and constructed or altered State and local government facilities, public accommodations and commercial facilities to be readily accessible to and usable by individuals with disabilities.

In accordance with the requirements of Title II of the Americans with Disabilities Act of 1990, the Freeland Auto will not discriminate against qualified individuals with disabilities based on disability in its services, programs, or activities.

Children's Health Insurance Program Notice

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.

ANNUAL DISCLOSURES

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

ANNUAL DISCLOSURES

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

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KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

ANNUAL DISCLOSURES

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicai Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa. CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Websit Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah CHIP Website: https://chip.utah.gov/

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

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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The information in this Benefits Guide is presented for illustrative purposes and is based on information provided by each insurance company. The information contained in this summary 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 Benefits Snapshot 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 this summary, contact Human Resources.

Revised 6/3/25