ANNUAL NOTICES
for Eligible Employees and Beneficiaries of
EMPLOYEE BENEFIT PLAN
sponsored by
New Hanover County Government

Electronic Notice Disclosure

These Annual Notices provide important information to eligible employees and beneficiaries of the various benefits offered by New Hanover County Government through the Plan. If you received these annual notices electronically, you have the right to request and obtain a paper version of such document, and you will receive a paper copy at no cost to you. Please contact Human Resources at (910) 798-7178 or libbymoore@nhcgov.com to make that request.

NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="3">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website:
http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="3">Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid</td></tr>
<tr><td>Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
</table>

IDAHO – Medicaid	**MONTANA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

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

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

Notice of Grandfathered Group Health Plan

Name of Plan Sponsor: New Hanover County Government

Date of Notice:

Grandfathered Status for Current Plan Year: NON-GRANDFATHERED

The health plan provided by the Plan Sponsor listed above for the eligible participants is not a "grandfathered health plan" under the federal Patient Protection and Affordable Care Act (PPACA).

As such, this plan is fully compliant with all consumer protections of PPACA that apply to other plans as well as other changes to the health plan to meet the mandates required under that law at renewal.

Questions regarding which protections apply and which protections do not apply to a Non-Grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the individual listed below. You may also contact the Employee Benefits Security Administration, which is a part of the U.S. Department of Labor at 1-866-444-3272. For further information on which protections do and do not apply to grandfathered health plans, you may also visit their website at www.dol.gov/ebsa/healthreform.

If you have any questions on these notices, please contact:

Human Resources
(910) 798-7178
libbymoore@nhcgov.com

HEALTH INSURANCE MARKETPLACE NOTICE
Your Health Coverage and Coverage Options
For Employees of New Hanover County Government

Introduction
Key parts of the health care law went into effect in 2014 including a new way to buy health insurance offered to individuals throughout America: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by New Hanover County Government.

What is the Health Insurance Marketplace?
The Marketplace has been designed as another avenue to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace ended in March 2014 but will begin again on November 15, 2014 through February 15, 2015.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but **only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards**. The savings on your premium that you're eligible for depends on your household income and size, as well as the cost of certain plans in the Marketplace.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of any plan offered by your employer for just your coverage (employee only) is more than 9.5% of your income for the year, or if the coverage your employer provides does not meet the "minimum value" standard[1] set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage, and will not be eligible for a premium subsidy through the Marketplace. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Payments for coverage through the Marketplace must be made with after-tax earnings that you and your household may earn annually.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your Summary of Benefits and Coverage or contact Human Resources at (910) 798-7178 or libbymoore@nhcgov.com.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (IRC § 36B(c)(2)(C)(ii))

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
New Hanover County Government	**56-60000324**
5. Employer address	6. Employer phone number
230 Government Center Drive, Suite 135	**(910) 798-7178**

7. City	8. State	9. ZIP code
Wilmington	**NC**	**28403**

10. Who can we contact about employee health coverage at this job?	
Human Resources	
11. Phone number (if different from above)	12. Email address
(910) 798-7178	**libbymoore@nhcgov.com**

Here is some basic information about health coverage offered by New Hanover County Government:

As your employer, we offer a health plan to:

- ☐ All employees.
- ☑ Some employees. Eligible employees are: Those employees who work, on average, 20 or more hours per week.

With respect to dependents:

- ☑ We do offer coverage. Eligible dependents are: Legally married spouse and children up to the age of 26
- ☐ We do not offer coverage to dependents.

Based on the information available at the time of preparation of this Notice, the health benefits provided by New Hanover County Government meets the minimum value standard, and the cost of this coverage to you does not exceed the maximum allowable based on employee wages.[2]

As a result, employees and their dependents who are eligible (whether enrolled or not) in the group health benefits sponsored by New Hanover County Government are likely not eligible for premium subsidies in the Marketplace. However the final results may vary based on additional factors such as affordability and your income.

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

You can also contact Chris S. Harrison of EbenConcepts at 910-323-0290 or csharrison@ebenconcepts.com to help walk you through the process to determine if you are eligible.

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

Important Notice from New Hanover County Government About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered through a group health plan sponsored by New Hanover County Government 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. Based on the standards established by CMS, we have determined that the prescription drug coverage offered as part of the New Hanover County Government group health and prescription drug plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan..

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. You should also know that if you drop or lose your current coverage 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.

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

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 at the bottom of this notice. **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 New Hanover County Government changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 1, 2013
Name of Entity/Sender:	New Hanover County Government
Contact--Position/Office:	Human Resources
Address:	230 Government Center Drive, Suite 135
	Wilmington, NC 28403
Phone Number:	(910) 798-7178

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

➔ Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

➔ Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;

- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws, or http://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/index.html.

Newborn's and Mothers' Health Protection Act Notice

Under Federal and state law you have certain rights and protections regarding your maternity benefits under the Plan. Under the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (910) 798-7178 for more information.

Michelle's Law Notice

Beginning January 1, 2010, if you have a dependent child older than age 18 who is enrolled at a post-secondary institution (e.g., college or university) on a full-time basis, he or she may be eligible to continue to be covered as a dependent if he or she loses full-time student status due to a serious injury or illness. In order to be eligible to continue coverage as a dependent under Michelle's Law:

- the dependent child must be enrolled in our group health plan based on full-time student status immediately before the first day of the medically necessary leave of absence;
- a doctor's written certification of the medically necessary leave of absence must be submitted to the health insurance company; and

- proof of full-time student status before the leave of absence may also be required to be submitted to the health insurance company.

Continued dependent coverage will be extended for at least one year after the first day of the leave of absence, but may end earlier if the dependent child does not meet the dependent eligibility requirements under our group health plan, such as meeting the limiting age for dependent eligibility under the plan. If dependent coverage under Michelle's Law ends, the dependent may be eligible for continuation coverage under the provisions of our group health plan.

If an eligible dependent remains enrolled in our group health plan under Michelle's Law, the dependent child will continue to be in the same medical benefit options that he or she was in prior to the medical leave of absence.

To obtain additional information about Michelle's Law, please contact:

Human Resources, New Hanover County Government
230 Government Center Drive, Suite 135
Wilmington, NC 28403
(910) 798-7178
libbymoore@nhcgov.com

Notice of Rescission of Coverage

Coverage may only be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation, or due to failure to pay premiums. A 30 day advance notice is now required before coverage can be rescinded.

Notice on Dependent Child Coverage to Age 26

Name of Plan Sponsor: New Hanover County Government

Date of Notice: June 4, 2014

Under the Patient Protection and Affordable Care Act ("PPACA"), health plans are now required to offer dependent coverage for all children of enrolled employees up to age 26. This notice is being furnished to you in compliance with the requirements of the law.

- Children under age 26 who were not eligible, or whose coverage ended due to an age limitation or due to marriage, are now eligible to enroll or re-enroll in the plan. Coverage begins on the first day of the plan year beginning thereafter.

- Children under age 26 are eligible for coverage without regard to student status, marital status, primary residence status, tax dependent status, or the amount of financial support from the parent.

- Coverage/premiums for children under age 26 will be the same as that offered to other dependent children.

- A child who enrolls under this provision will be required to provide proof of Creditable Coverage, and will be subject to the preexisting condition limitations of the plan if there has been a lapse in coverage of more than 63 days.

- Coverage will end on the child's 26th birthday, or until coverage otherwise terminates as defined by the plan.

If you have any questions, or need the form to enroll a dependent child, please contact:

Human Resources
(910) 798-7178
libbymoore@nhcgov.com

Patient Protection Disclosure

New Hanover County Government sponsors a Group Health Plan that, in some situations, generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources at (910) 798-7178 or libbymoore@nhcgov.com.

Life Insurance Conversion Rights

What is the conversion privilege? The right of an individual insured under the New Hanover County Government's Group Life Insurance policy to replace all or part of the Life Insurance Benefit with an individual policy if all or part of his coverage under the group policy terminates. No medical examination or other evidence of good health is required for a conversion policy.

The converted policy will be effective 31 days after coverage under the group policy terminates. This 31-day period is referred to as the conversion period. The group policy and your certificate may specify a different conversion period. If a person insured under the group policy dies within the conversion period, any death benefit provided by the group policy will be paid.

When can you convert? An individual eligible to convert, as described below, can convert during the conversion period, which follows immediately after the date s/he ceases to be eligible under the group policy.

Who is eligible to convert?

1. An Insured whose Life Insurance ends for any reason except for nonpayment of premiums is eligible to convert. If coverage ends because the group policy terminates, or because the class of insureds to which the insured belongs is terminated, the additional limitations, described below, apply.

2. An Insured whose Life Insurance is reduced or terminated because of age, retirement, or change in benefit amounts, is eligible to convert the amount reduced or terminated.

3. An Insured's covered dependent may convert if the dependent ceases to be eligible because the insured ceases to be eligible, or because the dependent ceases to be an eligible dependent, as defined in the Group Policy. Each dependent eligible to convert must complete an application for an individual policy.

How much can be converted?

1. An insured employee or an insured dependent, whose coverage terminates because the employee or the dependent ceases to be eligible under the group policy, may convert up to the amount of coverage terminating under the group policy.

2. If the group policy terminates, or if coverage for a class of employees terminates, insured employees and dependents who were covered under the group life insurance policy for at least three years may convert $10,000 or the amount of terminating group insurance, if less. Insurance regulations in some states require that an insured be permitted to convert after being insured under the group policy for a shorter period, or be permitted to convert a greater amount of terminating coverage. Please consult your Group Insurance Certificate or your Plan Administrator for details of your eligibility and amounts of coverage available to you.

Who receives the insurance benefits in the event of the insured's death? The beneficiary(ies) named on the application will receive the death benefit of the insured person. If one person, the Primary Beneficiary, is named, that individual will receive the entire death benefit. If two or more persons are named, they will share equally in the death benefit unless a percentage is specified for each individual. A contingent beneficiary who will receive the benefits in case the Primary Beneficiary should die before or at the same time as the insured, may also be named. This should be indicated as follows:

Primary Beneficiary: Marilyn Smith, wife*
Contingent Beneficiary: William P. Smith, Jr., son

* If a beneficiary is a married woman, use her given name, for example, Mary J. Smith and not Mrs. William Smith. If there is no relationship between the insured and the beneficiary, the application should indicate "no relationship" and the beneficiary's address and social security number must be entered on the application.

What type of policy can you convert to? Conversion may be to any permanent Life Insurance Policy, except term insurance. Benefits other than pure life insurance (such as Waiver of Premium, AD&D or Accelerated Benefits) are not included in the individual policy (unless specified in the group contract).

How to apply for conversion

1. Request from the Life Insurance Conversion packet, with the Notice of the Right to Covert completed.

2. Select the amount of insurance you want to convert, and indicate this amount on the application.

3. Calculate your premium for the amount you selected.

4. Send the completed application and premium payment to the address indicated in the packet. The premium payment should be by check or money order (do not send cash) and made payable as indicated in the packet.

GINA Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law.

To comply with this law, we are asking that you not provide any genetic information when responding to any request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact than an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an

individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

USERRA Notice

In General

The Uniformed Services Employment and Re-Employment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain Employees who are involved in the Uniformed Services (defined below). In addition to the rights that you have under COBRA (described in the section on COBRA), you are entitled under USERRA to continue the coverage you had under this Plan.

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered Spouse or Children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the COBRA section (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage. COBRA and USERRA coverage run concurrently.

"Uniformed Services" means the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training or Full-Time National Guard duty), and the commissioned corps of the Public Health Service. Moreover, the President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

"Service in the Uniformed Services" or "Service" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, inactive duty training, Full-Time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

Duration of USERRA Coverage and Premium Payments

General rule: 24 month maximum. When a Covered Person takes a leave for Service in the Uniformed Services, USERRA coverage for the Employee (and covered Spouses and Children for whom coverage is elected) begins the day after the Employee loses coverage under the Plan, and it continues for up to twenty-four (24) months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.

COBRA and USERRA coverage are concurrent. This means that both COBRA coverage and USERRA coverage begin upon commencement of the Employee's leave, and COBRA coverage continues for up to eighteen (18) months while USERRA coverage continues for up to twenty-four (24) months, up to six (6) months longer than COBRA.. COBRA coverage (but not USERRA coverage) may continue for longer, as described in the COBRA section. For example, George takes a Leave of Absence for service in the Uniformed Services beginning on August 1, 2006. George elects COBRA/USERRA continuation coverage and pays the required one hundred two percent (102%) of the premium each month for the next eighteen (18) months. Although George's COBRA coverage would terminate at the end of this eighteen (18) month period, USERRA coverage could continue for another six (6) months, unless coverage is terminated earlier due to non-payment of premiums or other permitted event.

If you elect to continue your health coverage (or your Spouse or Children's coverage) pursuant to USERRA, you will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if your Uniformed Service Leave of Absence is less than thirty-one (31) days, you are not required to pay more than the amount that you pay as an active Employee for that coverage.

HIPAA Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN A COPY FOR YOUR RECORDS.

Dear Employee:

This is your Notice of Privacy Practices from New Hanover County Government. Please read it carefully. You have received this notice because of your employee benefits. New Hanover County Government strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to *New Hanover County Government* as "us", "we", or "our".

This notice describes how we protect the protected health information we have about you which relates to your New Hanover County Government employee benefits and how we may use and disclose this information. Protected Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to your Protected Health Information and how you can exercise those rights.

NOTICE OF PRIVACY PRACTICES

Under applicable law, New Hanover County Government (referred to as "we," "our,") is required to protect the privacy of your individual health information (information we refer to in this notice as "Protected Health Information" or "PHI"). PHI includes all information that relates to: the past, present, or future physical or mental health of an individual; the provision of health care to an individual; and the past, present, or future payment for the provision of health care to an individual. We are required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information, and to abide by the terms of this notice, as it may be updated from time to time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes without obtaining your authorization.

For treatment purposes, we may use and disclose your PHI for the purpose of providing, coordinating, or managing the delivery of healthcare services to you by one or more healthcare providers, including doctors, nurses, technicians, medical students or other hospital personnel who are involved in taking care of you. For example, your primary care physician may consult with us regarding your condition or treatment. We do not limit the use or disclosure of your PHI for purposes of your care or treatment. Otherwise, we limit use and disclosure of PHI to that which is reasonably necessary for a permitted purpose.

For payment purposes, we may use and disclose your PHI to obtain payment or reimbursement for providing healthcare services, such as when we request payment from your insurer, health plan, or a government benefit program.

For healthcare operations purposes, we may use and disclose your PHI internally in a number of ways, including for quality assessment and improvement, for planning and development, management, and administration. Your

information could be used, for example, to assist in the evaluation of the quality of services that you were provided. Healthcare operations also includes conducting training programs in which students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills.

- In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Where applicable, we may disclose your health information to your health plan sponsor. This applies to a group health plan, a health insurance issuer, or a Health Maintenance Organization (HMO) with respect to a group health plan.

We may use and disclose your PHI, without your authorization, for treatment, payment, and health care operations purposes, with health care providers, health plans, and those that process health care claims, benefits and related information. We are also permitted to share your PHI, without your authorization, in the other limited instances.

We may also use or disclosure your PHI as permitted or required by law, including, for example:

- To public health authorities for the purposes of preventing or controlling disease or other public health purposes;
- To appropriate government authorities to report about victims of suspected abuse, neglect, or domestic violence;
- To the Food and Drug Administration to report quality, safety, or effectiveness of the FDA-regulated products or activities;
- In certain limited circumstances to an employer such as if we are asked to evaluate or treat a work-related illness or injury;
- To qualified health authorities for purposes of conducting health oversight activities;
- In response to subpoenas, discovery requests, or other lawful legal processes in the course of a judicial or administrative proceeding;
- To law enforcement authorities as required or permitted by law such as, for example, to report a death, to report a crime on our premises, or if it appears necessary to alert law enforcement to respond to an emergency;
- To persons involved with respect to matters pertaining to a decedent, or relating to cadaveric organ, eye or tissue donation;
- In certain instances, for research purposes;
- We may disclose your PHI if we believe, in good faith, that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
- We may disclose your PHI for certain specialized government functions such as, for example, to Armed Forces Authorities with reference to military personnel or for national security purposes.

Unless you object, we may also disclose to a member of your family or other relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to that person's involvement with your care or payment related to your care. In addition, unless you object, orally or in writing, to another employee or our Privacy Officer, we may use or disclose the PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick up filled prescriptions, medical supplies, test results, or other similar actions involving disclosure of PHI.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization by notifying us by contacting our Privacy Officer as described below. We may not sell your protected health information.

Contact Information. We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act (HIPAA). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please contact Human Resources, or you may submit questions in writing directly to:

New Hanover County Government
Human Resources
230 Government Center Drive, Suite 135
Wilmington, NC 28403

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any PHI we receive in the future. You will receive a copy of any revised notice from New Hanover County Government by mail, email, hand delivery or other appropriate means.

Continuation Coverage Rights Under COBRA

Introduction
You are receiving this notice because you are or have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the 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 [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to the Plan Contact identified below. Any notice of change must be provided in writing or electronically at the email indicated below.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. In order to be able to claim the disability extension, you must provide the notice received from the Social Security Administration prior to the end of your initial period of continuation coverage. This information should be provided to the contact indicated below.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is

properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

New Hanover County Government
Human Resources
(910) 798-7178
libbymoore@nhcgov.com

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 four 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, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 10/31/2016)