

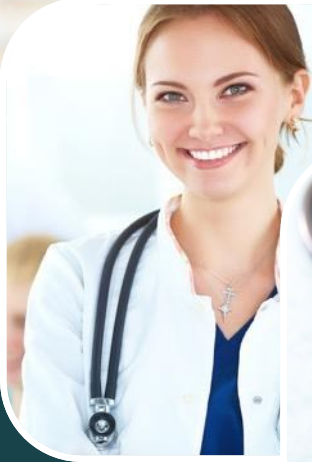


2026

2026 EMPLOYEE BENEFIT GUIDE

Lamar County BOC

January 1, 2026 -
December 31, 2026



Benefits Guide

This Benefits Guide is intended to highlight the main features of the employee benefits program. It does not include all plan rules, details, limitations, or exclusions. The terms of the benefit plans are governed by legal documents, including insurance contracts and a Summary Plan Description (SPD). Should there be an inconsistency between this brochure and any of the legal plan documents, the plan documents prevail. Lamar County Board of Commissioners reserves the right to change or discontinue its employee benefits plans at any time.

Important Contacts

Coverage	Carrier	Group Number	Phone	Website/Email
Medical	Anthem BCBS	L05833	855-397-9267	www.Anthem.com
Dental	Anthem BCBS	L05833	855-397-9267	www.Anthem.com
Vision	Anthem BCBS	L05833	855-392-9267	www.Anthem.com
Life Insurance	The Standard	CM10002597	800-552-2137	www.Standard.com
Disability	The Standard	CM10002597	800-232-0113	www.Standard.com
Employee Assistance Program	The Standard	CM10002597	888-209-7840	Carelonwellbeing.com/resourceadvisor
Travel Assistance	The Standard	CM10002597	The US & Canada: 866-295-4890 All Other: 202-296-7482 (call collect)	
Melinda Corley	Human Resources/Payroll Director		470-464-7268	MCorley@LamarCountyGA.com





Welcome to your benefits!

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We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a range of benefits to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement. This brochure was designed to answer some of the basic questions you may have about your benefits. Please take the time to review the material to make sure you understand the benefits that are available to you and your family. Be sure to take action before the enrollment period ends.

This brochure highlights the main features of our employee benefits program. It does not include all plan rules, details, limitations, or exclusions. The terms of your benefit plans are governed by legal documents, including the Summary Plan Description (SPD). Should there be an inconsistency between this brochure and the legal plan documents, the plan documents prevail. Lamar County reserves the right to change or discontinue its employee benefits plans at any time.



Eligibility

If you work at least 30 hours per week, you are eligible for benefits. **Your benefits are effective on the first day of the month following your date of hire.** You may also enroll your eligible dependents for coverage. Eligible dependents could be:

- Your legal spouse
- Children younger than 26, regardless of dependency or student or marital status

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a qualified life event. If you do not make changes to your benefits within 30 days of the qualified life event, you will have to wait until the next annual open enrollment period to make changes (unless you experience another qualified life event).

Qualified Life Event		Documentation Needed
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal separation	Copy of divorce decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Stepchild	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

Medical



Medical insurance is essential to your well-being, and our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

Important Parts of Your Medical Plan

- Preventative care is always covered at 100% when you use in-network providers. It includes things like physical exams, flu shots, and health screenings.
- Annual deductibles are the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- Annual out-of-pocket maximums are the most you will pay each year for eligible in-network and out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.
- Copays are fixed amounts you pay for healthcare services. Copays do not count toward your deductible, but they do count toward your annual out-of-pocket maximum.
- Coinsurance is your share of the cost of care after you've met your deductible.



Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the legal notices in the back of this guide for more details.

2026 Medical Plan Options



Lamar County will be offering medical coverage through Anthem (Blue Cross Blue Shield of Georgia). There are 2 plans that are very similar to the current 2025 plan. Please refer to the Summary of Benefits and Coverage (SBC) for detailed information.

Benefits Highlights	Plan 1: Base	Plan 2: Buy-Up
In-Network		
Calendar Year Deductible:		
Individual	\$5,000	\$1,500
Family	\$10,000	\$3,000
Out-of-Pocket Maximum:		
Individual	\$7,900	\$7,150
Family	\$15,800	\$14,300
Preventive Care	Covered at 100%	Covered at 100%
Office Visits:		
Primary Care Physician	\$35 Copay	\$20 Copay
Specialist	\$50 Copay	\$35 Copay
Emergency:		
Urgent Care	\$75 Copay	\$75 Copay
Emergency Room	After \$350 Copay, Covered at 70%	After \$250 Copay, Covered at 100%
Inpatient/Outpatient:		
Inpatient	After Ded, Covered at 70%	After Ded, Covered at 100%
Outpatient Surgery	After Ded, Covered at 70%	After Ded, Covered at 100%
Major Diagnostic	After Ded, Covered at 70%	After Ded, Covered at 100%
Retail Rx:		
Generic	\$15 Copay	\$15 Copay
Brand (preferred)	\$45 Copay	\$45 Copay
Brand (non-preferred)	\$60 Copay	\$60 Copay
Specialty	25% (Up To \$350)	25% (Up To \$350)
Out-of-Network		
Deductible (Individual/Family)	\$3,000 / \$6,000	\$10,000 / \$20,000
Out-of-Pocket Max (Ind/Family)	\$7,150 / \$14,300	\$23,700 / \$47,400
Coinsurance (Plan/Member Pays)	30%	50%

Per Pay Period Premium (24)	Plan 1: Base	Plan 2: Buy-Up
Employee Only	\$0.00	\$89.77
Employee + Spouse	\$668.53	\$878.59
Employee + Child(ren)	\$429.75	\$596.84
Family	\$1,050.68	\$1,329.49

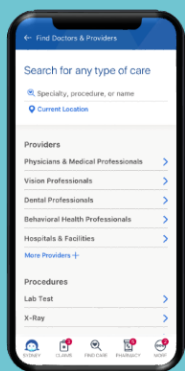
Connect with Sydney



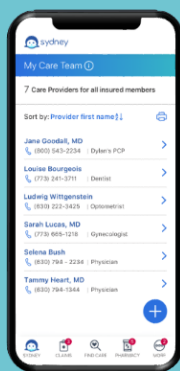
Choosing a provider you trust is important – and choosing one in your plan’s network can help keep your costs down. Finding high-quality, cost-effective care is simple when you use the Find Care tool on the Sydney Health mobile app or anthem.com.

How to use Find Care

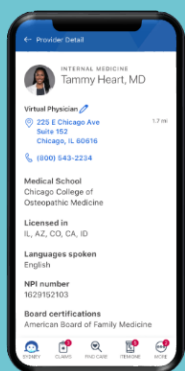
The Find Care tool brings together details about doctors, dentists, hospitals, labs, and healthcare facilities in your plan’s network. You can easily compare information such as costs, location, and office hours. You can:



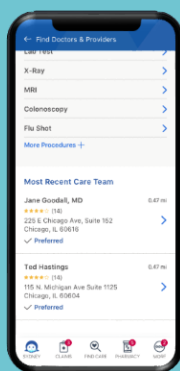
1 Search for providers and facilities in your plan’s network by name, specialty, or procedure.



2 Customize the list of providers you see in your search based on factors that are most important to you, such as languages spoken, affiliated hospitals, and location.



3 Review details about doctors/ dentists such as their specialties, gender, educational background, and contact information.



4 Choose a doctor/ dentist from the list to review their patient ratings and compare costs for services.

You can start using Find Care by downloading the Sydney Health app to your mobile device or logging into anthem.com. Find Care tool will guide you through the steps.



Download Sydney Health today to find a provider that’s right for you. Use your smartphone camera to scan this QR code.



LiveHealth On-line



When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best.

Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

Video visits on LiveHealth Online, allow you to:

See a board-certified doctor 24/7.

You don't need an appointment to see a doctor. They're always available to assess your condition and send a prescription to the pharmacy you choose, if needed. It's a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue.

Visit a licensed therapist in four days or less.

Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more. Schedule your appointment online or call **1-888-548-3432** from **8 a.m. to 8 p.m.**, seven days a week.

Consult a board-certified psychiatrist within two weeks.

If you're over 18 years old, you can get medication support to help you manage a mental health condition. To schedule your appointment, call **1-888-548-3432** from **8 a.m. to 8 p.m.**, seven days a week.

You've got access to affordable & convenient care:

Your Anthem plans includes benefits FREE primary care, medical acute/urgent care, mental health & substance abuse care for video visits using LiveHealth Online.





Dental



Lamar Country continues to offer Dental coverage through Anthem. Please refer to the Benefit Summaries for detailed information.

Taking care of your oral health is not a luxury; it is a necessity for long-term optimal health. With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will pay only a small deductible and coinsurance for basic & major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees and not to balance bill, which means you won't get charged more than you expected.

In-Network Benefits Highlights	
Calendar Year Plan Maximum: Per Individual	\$1,500 per Individual
Calendar Year Deductible: Individual Family	\$50 \$150
Preventive Care: Exams, Cleanings, X-ray	Covered at 100%
Basic Care: Fillings, Sealants, Extractions, Emergency Exams	After Ded, Covered at 80%
Major Care: Crowns, Inlays/Onlays, Dentures, Bridgework, Repairs, Implants	After Ded, Covered at 50%
Orthodontia: Benefit Eligibility	Covered at 50%. \$1,000 Lifetime Maximum Dependent Children Only (up to 19 th birthday)

Per Pay Period Premium (24)	Dental Plan
Employee Only	\$0.00
Employee + Spouse	\$16.12
Employee + Child(ren)	\$20.96
Family	\$40.95



Vision



Healthy eyes and clear vision are important parts of your overall health and quality of life. You do not have to be enrolled in medical coverage to elect vision coverage, nor do you have to cover the same dependents that you cover under medical and vision.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions. Your Vision Plan uses LensCrafters, Target Optical and many other providers.

Benefits Highlights	In-Network	Out-of-Network
Exam (Once every 12 months)	\$10 copay	Up to \$42
Lenses (Once every 12 months): Single Lenses Bifocals Trifocals	\$20 copay	Up to \$40 Up to \$60 Up to \$80
Frames (Once every 24 months)	Up to \$130	Up to \$45
Contact Lenses (Once every 12 months): Conventional Disposables Medically Necessary	Up to \$130 Up to \$130 Covered in Full	Up to \$105 Up to \$105 Up to \$210

Per Pay Period Premium (24)	Vision Plan
Employee Only	\$0.00
Employee + Spouse	\$3.10
Employee + Child(ren)	\$3.84
Family	\$7.81

FSA (Flexible Spending Account)

New for 2026

FSA's are a great way to save. Using pretax dollars, you can stretch your dollars further by participating in a healthcare and/or dependent care reimbursement account, also known as a Flexible Spending Account (FSA). You set aside pre-tax money through payroll deductions up to IRS limits and use this money each time you have an eligible expense. There are two types of FSAs: the Healthcare FSA (HCFSA) & the Dependent Care FSA (DCFSA). The HCFSA covers eligible copays, deductibles, coinsurance, prescriptions, dental care, eye exams & most over-the-counter medicines. The DCFSA can be used for eligible childcare and senior care expenses. View a complete list of eligible funds at www.irs.gov.

The HCFSA maximum is \$3,400 and the DCFSA maximum is \$7,500 for 2026. All of your HCFSA funds are available to use as of January 1. For a DCFSA, funds are available only after they are deposited. If you have unused funds in your HCFSA at the end of the plan year, up to \$680 of that money will rollover into the new plan year. On the other hand, DCFSA must be used during the plan year - it will not roll over into your account. Any money left in the account will be forfeited.

Prepaid Benefits Debit Card

Your Prepaid Benefits Debit Card from Admin America can be used at any plan-approved vendor or service provider to make your qualified plan expense purchase. [View eligible and ineligible expenses \(PDF\)](#).

- If you have chosen the prepaid benefits debit card as your primary reimbursement option, you will automatically receive two debit cards at your home address.
- Both cards will have your name embossed as the primary participant but may be signed and used by your spouse (or qualified dependent), unless otherwise elected during enrollment.
- If you lose your card or require additional cards for your family there will be a \$10 FEE debited from your available account balance.

Important Considerations

- Your elections cannot be changed during the plan year, unless you experience a qualifying life event.
- You need to keep your receipts as proof that your expenses were eligible for IRS purposes.



Life and Disability



Basic Life and AD&D Insurance - Paid for by Lamar County:

Basic life insurance pays your beneficiary \$20,000 if you die. AD&D provides another layer of benefits to either you or your beneficiary by paying an additional \$20,000 if you die in an accident.

Voluntary Life and AD&D Coverage - 100% Employee Paid:

You may choose to buy additional coverage for yourself or your family by enrolling in voluntary life and AD&D insurance. You will have to be approved by The Standard for the entire amount by submitting the Evidence Of Insurability (EOI). If you are new hire, only the amounts that exceed the guaranteed issue (GI) will require EOI.

You pay the full cost. Spousal & child amounts can only be elected if the employee is enrolled.

Benefit	Employee	Spouse	Children
Coverage Election	\$10,000 increments	\$5,000 increments	\$5,000 increments
Maximum	Lesser of 5x salary or \$500,000	Lesser of \$150,000 or 50% of Employees Amount	\$10,000 (for age 6 months to 25) \$1,000 (for 15 days to 6 months)
Guarantee Issue (GI) Amount *	\$100,000	\$25,000	\$10,000

* Only applies to new hires

Short-Term Disability (STD) - 100% Employee Paid:

Short-Term Disability coverage pays you a benefit if you temporarily can't work because of an injury, illness or maternity leave. Benefits may be reduced by income from other income sources such as paid time off. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition.

- Weekly Benefit: 60% of your basic earnings
- Maximum Weekly Benefit: \$750
- Benefits begin: After 14 days of sickness
- Maximum Payment Period: 24 weeks

Long-Term Disability (LTD) - 100% Employee Paid:

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long period of time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

- Monthly Benefit: 60% of your basic earnings
- Maximum Monthly Benefit: \$5,000
- Benefits begin: After 180 day waiting period
- Maximum Payment Period: Social Security Normal Retirement Age (SSNRA)

Life and Disability



Voluntary Life Premium

Employee / Spouse Age	Monthly Rate per \$1,000	Employee / Spouse Age	Monthly Rate per \$1,000
< 29	\$0.08	50 - 54	\$0.48
30 - 34	\$0.10	55 - 59	\$0.65
35 - 39	\$0.12	60 - 64	\$0.94
40 - 44	\$0.19	65 - 69	\$1.69
45 - 49	\$0.32	70+	\$2.80

Child(ren) Unit	Monthly Rate per Unit	Child(ren) Unit	Monthly Rate per Unit
\$5,000	\$1.00	\$10,000	\$2.00

Short-term Disability Premium

Long-Term Disability Premium

Employee Age	Monthly Rate per \$10	Employee Age	Monthly Rate per \$100
0-24	\$0.512	0-24	\$0.072
25-29	\$0.520	25-29	\$0.072
30-34	\$0.520	30-34	\$0.224
35-39	\$0.496	35-39	\$0.336
40-44	\$0.496	40-44	\$0.519
45-49	\$0.544	45-49	\$0.623
50-54	\$0.600	50-54	\$0.975
55-59	\$0.840	55-59	\$1.119
60-64	\$0.920	60-64	\$1.191
65+	\$0.920	70+	\$0.448

Please be sure that you review your designated Beneficiaries for accuracy & if you do not have one listed, you must designate a Beneficiary

Additional Benefits



Employee Assistance Program

Resource Advisor is a confidential member assistance program offering counseling, resources and services to you and your family members. The program includes up to three (3) sessions with a counselor per problem, via face-to-face, video, telephone or text, at no cost.

Support is available 24/7 by calling **888 209-7840** or visiting your member website: **carelonwellbeing.com/resourceadvisor**

Find confidential counseling, resources and support services for you and your family to help with:

- Anxiety
- Depression
- Relationships
- Stress
- Work-life balance
- Substance Use
- Legal/Financial issue

Travel Assistance Services

Illness and injury can happen anywhere – even when you travel. That’s why your Standard Insurance Company group life plan includes Generali Global Assistance, Inc. (GGA) travel assistance services. Travel assistance ensures that you and your dependents receive the care you need 24/7. These services are available if you’re more than 100 miles from home for 90 days or less. GGA can also give you useful tips before you travel, such as vaccine and passport requirements, foreign exchange rates, and travel advisories.

Travel assistance

Provided by Generali Global Assistance, Inc. for The Standard[®]

For help, call the number below based on your location. All services must be arranged in advance by GGA to be covered.

U.S. and Canada: [866-295-4890](tel:866-295-4890)

All other locations (call collect): [202-296-7482](tel:202-296-7482)

Valid only for eligible members. Retirees are not eligible for travel assistance services.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

Remember that all services must be arranged in advance by GGA to be covered by your plan. If you pay for covered services without a written approval by GGA, they might not be able to reimburse you. You may have to pay for certain other services GGA provides, such as cash advances.



Annual Notices

Legal Notices

Women’s Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. For further details on WHCRA benefits, please refer to the Plan’s Summary Plan Description.

Newborns’ and Mothers’ Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in your employer’s health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in your employer’s health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in your employer’s health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

COBRA Continuation Coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

HIPAA: Notice of Privacy Practices

We are required by applicable federal and state law to maintain the privacy of your protected health information. We also maintain the HIPAA Notice of Privacy Practices, which describes our legal duties and your rights concerning your medical information. This notice is available to you by contacting Human Resources.

What You Need to Know About the “No Surprises” Rules

The “No Surprises” rules protect you from surprise medical bills in situations where you can’t easily choose a provider who’s in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you’re no longer in need of emergency care. These are called “post-stabilization services.” You shouldn’t get this notice and consent form if you’re getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren’t required to sign the form and shouldn’t sign the form if you didn’t have a choice of health care provider or facility before scheduling care. If you don’t sign, you may have to reschedule your care with a provider or facility in your health plan’s network.

[View a sample notice and consent form \(PDF\).](#)

This applies to you if you’re a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Legal Notices

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 July 31, 2025. Contact your State for more information on eligibility.

ALABAMA - Medicaid

<http://myalhipp.com>
855-692-5447

ALASKA - Medicaid

The AK Health Insurance Premium Payment Program: <http://myakhipp.com>
866-251-4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS - Medicaid

<http://myarhipp.com>
855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid

Health Insurance Premium Payment (HIPP) Program: <http://dhcs.ca.gov/hipp>
916-445-8322
Fax: 916-440-5676
hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado:
<https://www.healthfirstcolorado.com>
800-221-3943, State Relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
800-359-1991, State Relay 711
HIBI: <https://www.mycohibi.com>
855-692-6442

FLORIDA - Medicaid

<https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
877-357-3268

GEORGIA - Medicaid

HIPP:
<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
678-564-1162, Press 1
CHIPRA:
<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
678-564-1162, Press 2

INDIANA - Medicaid

Health Insurance Premium Payment Program All other Medicaid:
<https://www.in.gov/medicaid>
<http://www.in.gov/fssa/dfr>
Family and Social Services Administration: 800-403-0864
Member Services: 800-457-4584

IOWA - Medicaid and CHIP (Hawki)

Medicaid:
<https://hhs.iowa.gov/programs/welcom-e-iowa-medicaid>
800-338-8366
Hawki:
<https://hhs.iowa.gov/programs/welcom-e-iowa-medicaid/iowa-health-link/hawki>
800-257-8563
HIPP:
<https://hhs.iowa.gov/programs/welcom-e-iowa-medicaid/fee-service/hipp>
888-346-9562

KANSAS - Medicaid

<https://www.kancare.ks.gov>
800-792-4884
HIPP Phone: 800-967-4660

KENTUCKY - Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
855-459-6328
KIHIPPPROGRAM@ky.gov
KCHIP: <https://kynect.ky.gov>
877-524-4718
Medicaid:
<https://chfs.ky.gov/agencies/dms>

LOUISIANA - Medicaid

www.medicaid.la.gov or
<http://www.ldh.la.gov/lahipp>
888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)

MAINE - Medicaid

https://www.mymaineconnection.gov/benefits/s/?language=en_US
800-442-6003 (TTY: Maine relay 711)
Private Health Insurance Premium:
<https://www.maine.gov/dhhs/ofi/applications-forms>
800-977-6740 (TTY: Maine relay 711)

MASSACHUSETTS - Medicaid and CHIP

<https://www.mass.gov/masshealth/pa>
800-862-4840 (TTY: 711)
masspremassistance@accenture.com

MINNESOTA - Medicaid

<https://mn.gov/dhs/health-care-coverage>
800-657-3672

MISSOURI - Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
573-751-2005

Legal Notices

MONTANA - Medicaid

<https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
800-694-3084
HHSHIPProgram@mt.gov

NEBRASKA - Medicaid

<http://www.ACCESSNebraska.ne.gov>
855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA - Medicaid

<http://dhcfp.nv.gov>
800-992-0900

NEW HAMPSHIRE - Medicaid

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
603-271-5218
Toll free number for the HIPP program: 800-852-3345, ext. 15218
DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid and CHIP

Medicaid:
<http://www.state.nj.us/humanservice/s/dmahs/clients/medicaid>
800-356-1561
CHIP Premium Assistance: 609-631-2392
CHIP:
<http://www.njfamilycare.org/index.html>
800-701-0710 (TTY: 711)

NEW YORK - Medicaid

https://www.health.ny.gov/health_care/medicaid
800-541-2831

NORTH CAROLINA - Medicaid

<https://medicaid.ncdhhs.gov>
919-855-4100

NORTH DAKOTA - Medicaid

<https://www.hhs.nd.gov/healthcare>
866-614-6005

OKLAHOMA - Medicaid and CHIP

<http://www.insureoklahoma.org>
888-365-3742

OREGON - Medicaid and CHIP

<http://healthcare.oregon.gov/Pages/index.aspx>
800-699-9075

PENNSYLVANIA - Medicaid and CHIP

<https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
800-692-7462
CHIP:
<https://www.pa.gov/en/agencies/dhs/resources/chip.html>
800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP

<http://www.eohhs.ri.gov>
855-697-4347, or 401-462-0311
(Direct Rlte Share Line)

SOUTH CAROLINA - Medicaid

<https://www.scdhhs.gov>
888-549-0820

SOUTH DAKOTA - Medicaid

<http://dss.sd.gov>
888-828-0059

TEXAS - Medicaid

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
800-440-0493

UTAH - Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) :
<https://medicaid.utah.gov/upp>
upp@utah.gov
888-222-2542
Adult Expansion:
<https://medicaid.utah.gov/expansion>
Utah Medicaid Buyout Program:
<https://medicaid.utah.gov/buyout-program>
CHIP: <https://chip.utah.gov>

VERMONT- Medicaid

<https://dvha.vermont.gov/members/medicaid/hipp-program>
800-250-8427

VIRGINIA - Medicaid and CHIP

<https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
800-432-5924

WASHINGTON - Medicaid

<https://www.hca.wa.gov>
800-562-3022

WEST VIRGINIA - Medicaid and CHIP

<https://dhhr.wv.gov/bms>
<http://mywvhipp.com>
304-558-1700
CHIP Toll-free phone: 855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
800-362-3002

WYOMING - Medicaid

<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility>
800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact:

U.S. Department of Labor Employee Benefits Security Administration

dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

Legal Notices

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. Lamar County has determined that the prescription drug coverage offered by the Lamar County Medical plans 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 Lamar County coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Lamar County is creditable (e.g. as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Lamar County prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Lamar County 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 one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent 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 Lamar County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare Prescription Drug Coverage:

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

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

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

Date: January 1, 2026

Name of Entity/Sender: Lamar County

Contact - Position/Office: Melinda Corley - Human Resources / Payroll Director

Address: 790 Veterans Pkwy, Barnesville, GA 30204

Phone Number: (470) 464-7268

