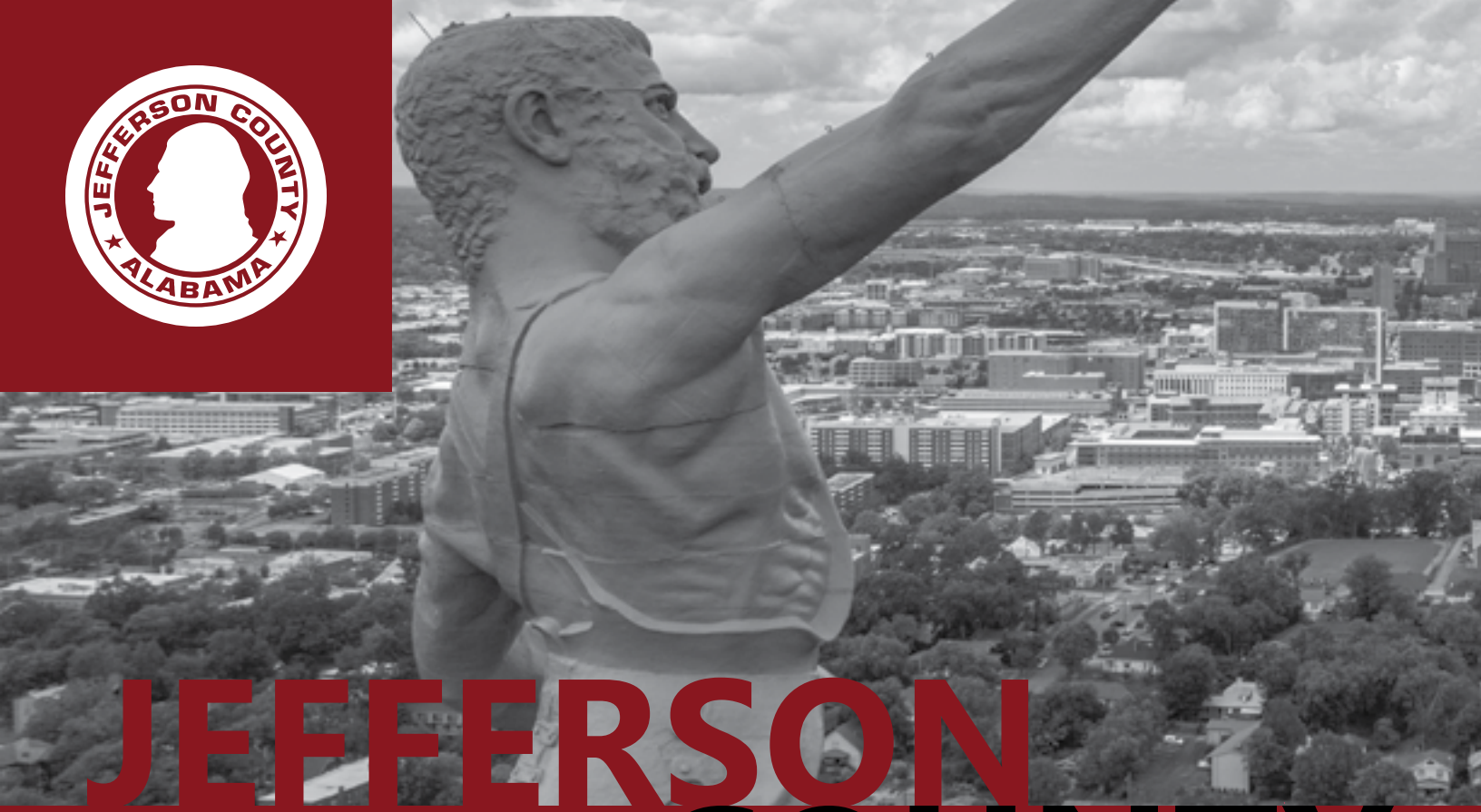

# JEFFERSON COUNTY

## 2023

# EMPLOYEE BENEFIT GUIDE

## BENEFITS THAT SUPPORT YOUR WELL-BEING — AND PROTECT THOSE YOU LOVE

**AUGUST 14th - AUGUST 25th**
**OPEN ENROLLMENT**

This is your annual opportunity to enroll in our benefits program and/or decide if you want to make changes. Changes you make are effective **October 1, 2023, and remain in effect through September 30, 2024,** unless you experience an Internal Revenue Service (IRS) Qualified Life Event (QLE).

We need all benefits-eligible employees to confirm their elections by **end of day on August 25th**. No changes will be permitted after open enrollment ends. It is imperative that you ensure **All Dependent and Beneficiary** information on file is up-to-date.

We encourage you to review each section of this benefit guide and to discuss your benefits with your family members.

Review all your BENEFITS4YOU options and make updates or changes for the 2023-24 plan year, online at:

https://kronos.jccal.org/wfc/logon

https://jccaccess.jccal.org/

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.

This Benefit Enrollment Guide highlights recent plan design changes and is intended to fully comply with the requirement under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept with your most recent Summary Plan Description(s). The Company reserves the right to amend or terminate any of these programs or to require or increase employee premium contributions towards benefits at its sole discretion. Copies of the summary plan descriptions are available free of charge on the firm's intranet or by contacting the EE department. The information in this benefit guide is presented for illustrative purposes. The text contained in this guide was taken from various summary plan descriptions and benefit materials. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this guide and the actual plan documents, the actual plan documents will prevail. Nothing contained in this guide should be construed as a contract for employment, either expressed or implied.



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# ELIGIBILITY AND ENROLLMENT

## WHO IS ELIGIBLE?

All regular employees working, on average, at least 30 hours per week are eligible for the full range of benefits provided by the County.

You may also enroll your eligible dependents in medical, dental, vision, life and supplemental insurance coverages. Eligible dependents may include a legal spouse and children under age 26.

This includes natural children, children that you have legally adopted, or have been placed with you while you are in the process of legal adoption, stepchildren, foster children, or children for whom you have obtained legal guardianship or conservatorship.

When you enroll your dependents, you will have to provide HR with appropriate documentation, such as a marriage certificate for spouses, birth certificates and social security cards for children.

## WHEN DO MY BENEFIT ELECTIONS GO INTO EFFECT?

The benefits you select during Annual Enrollment go into effect on October 1, 2023 and continue through September 30, 2024. Provisions under your medical, dental, and vision plans apply during that 12-month period.

## EX-SPOUSES AND OTHER INELIGIBLE DEPENDENTS

When a dependent loses eligibility for benefits, such as after a divorce, you must notify Human Resources (HR) within 30 days of this change. Otherwise, your ex-spouse, or any other ineligible dependent, will remain enrolled for County benefits. You will therefore continue to pay for coverage that cannot actually be used. Even worse: when an ineligible participant files a claim, it places you at risk of criminal fraud charges — and significant financial penalties.

For these reasons, it is critical that you verify your dependents during Annual Enrollment — either at https://jccaccess.jccal.org/, or https://kronos.jccal.org/wfc/logon, or with Human Resources. If you are carrying an ex-spouse or any other ineligible dependents, be sure to cancel their coverage immediately.

Human Resources periodically audits dependent eligibility. So it is in your best interest to provide HR with documentation for your dependents — and remove those who are ineligible. These are the only ways to avoid potential reversal of claims, financial penalties, termination of your coverage, and any other applicable disciplinary actions, including termination of employment.



# UNDERSTANDING INSURANCE

Medical insurance is extremely valuable. It protects you and your family from the risk of large medical bills and helps ensure that you have access to the healthcare you need. Without medical insurance, most of us wouldn't be able to pay for a major medical event, such as a surgery or cancer treatment.

People can get medical insurance a number of different ways. About 54% of Americans get their medical insurance from their employer. Like many employer health plans, the Jefferson County Health Plan is self-insured.

This means that all plan participants equally share the cost of the health plan. A contribution to the plan is also made by the County on behalf of each enrolled employee. This contribution is a benefit of employment and part of your total compensation as an employee of the County.

## WHAT ARE THE COSTS OF A HEALTH PLAN?

The health plan pays claims for all enrolled members. Each time you visit a doctor or pick up a prescription, a claim is submitted. Some (or all) of the cost for that service is paid by the health plan. The health plan also pays Blue Cross Blue Shield to perform certain administrative tasks for the plan.

## WHAT HAPPENS IF THE COSTS ARE HIGHER THAN EXPECTED?

When large or unexpected claims occur, the cost to the health plan can be higher than planned. When this happens, the County may end up paying more. Participants also end up paying more for health insurance in the future through higher per pay period contributions and increasing copays or deductibles.

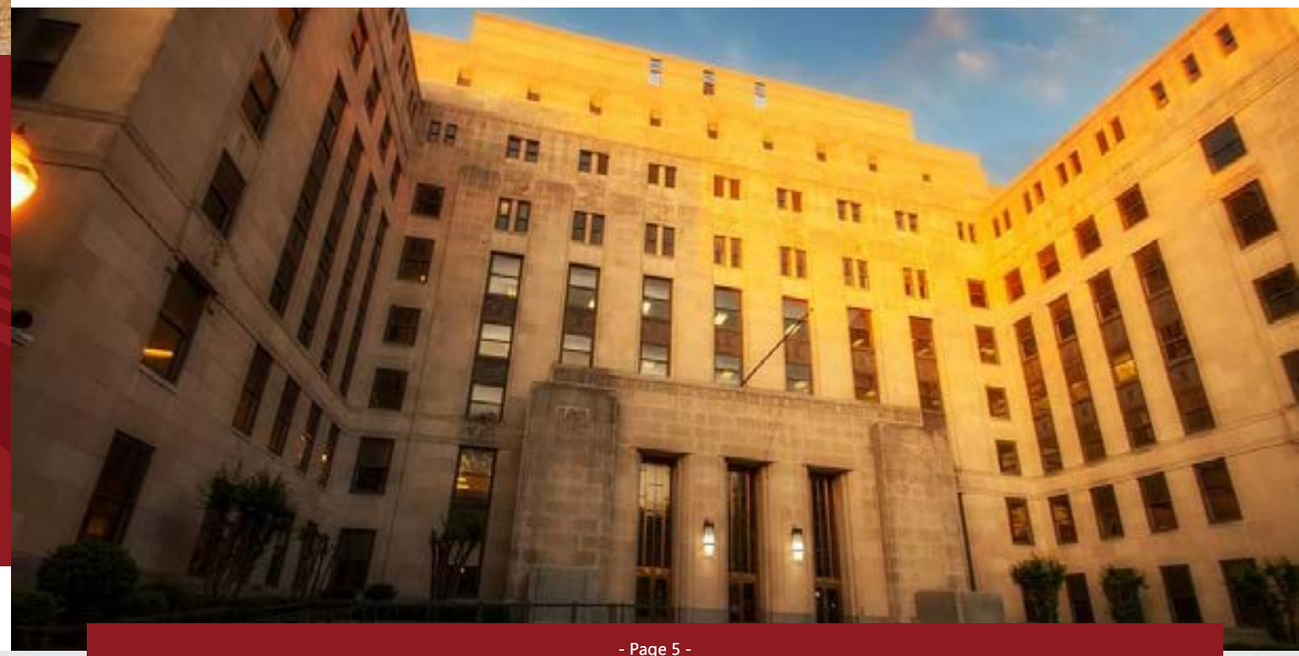
## WHAT HAPPENS IF THE COSTS ARE LOWER THAN EXPECTED?

Since all plan participants equally share the cost of the health plan, this can mean more rewards for participants and the possibility for lower contributions in future years.

## HOW DO WE GET TO LOWER HEALTH PLAN COSTS?

Taking care of your health is an important way to prevent larger health expenses for yourself and the plan. When participants stay healthy and need less healthcare than expected, the costs of the health plan are lower.

You can also shop around for your healthcare needs. Not all providers charge the same amount for the same services. By choosing a provider that provides the best quality and value, you can help make smart choices that keep the cost of care low.



# UNDERSTANDING INSURANCE

IN-NETWORK
PREVENTIVE CARE

**-100%-**

***COVERED***

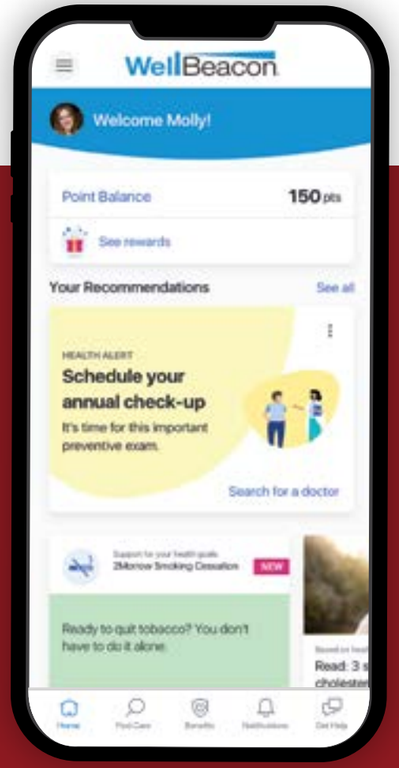
## PROTECT YOUR HEALTH

Did you know according to the U.S. Center for Disease Control and Prevention (CDC), **7 out of 10 Americans die each year from chronic diseases**, many of which are preventable? When preventive care is utilized, illnesses and diseases can be caught early on, and individuals can have better control, or potentially avoid, their underlying health problems. Please read the services that are provided by BlueCrossBlueShield of Alabama.

WellBeacon

## A BETTER WAY TO MANAGE YOUR HEALTH

WellBeacon takes the guesswork out of figuring out where to go, what programs to use and when to use them. WellBeacon helps you navigate all your benefits and have some fun along the way.




## INTRODUCING FIND CARE

The WellBeacon Find Care tool offers price estimates of individual services based on your plan coverage and spending phase. When you search for care with the Find Care tool from WellBeacon, you'll be shown easy-to-understand quality ratings as well as the top rated providers based on your unique profile and search terms.

## WITH FIND CARE YOU CAN:

- Compare cost estimates across providers to estimate what your out-of-pocket costs will be before your visit
- Search for over 1,000 different priced services and specialties to find the care you need
- See relevant benefit programs related to your care package
- Find Care search
- Make confident decisions based on patient ratings and reviews

Log in or register at AlabamaBlue.com/myWellBeacon to access your WellBeacon account.

**Download the WellBeacon app to your phone or other smart device.**

ANDROID APP ON Google play

Available on the App Store



# UNDERSTANDING INSURANCE

When you are sick or injured, there are many options for care, depending on your medical needs. Calling your primary care doctor should always be your first choice for care. If your doctor isn't available and it's an urgent medical concern, you still have options besides the wait and cost of an emergency room (ER) visit.

A virtual visit with a doctor, a retail health clinic, or an urgent care center available to BCBS members are all convenient and less expensive than a trip to the emergency room. Going to the ER or calling 911 is always your best option for emergencies.

## KNOW WHERE TO GO SELECT CARE BASED ON YOUR NEEDS[1]

| PCP | RETAIL HEALTH CLINIC | URGENT CARE CENTER | EMERGENCY ROOM |
|---|---|---|---|
| Usually available during normal business hours and may also provide medical advice by phone after hours | Walk-in care clinics located in certain drugstores and major retailers | Stand-alone facilities open extended hours | Stand-alone facilities or part of hospitals, open 24/7 |
| Cost[7]: $$ | Cost: $$ | Cost: $$$ | Cost: $$$$ |
| Average Wait[2]: 18 MIN | Average Wait[4]: 30 MIN | Average Wait[5]: 30 MIN | Average Wait[6]: 90 MIN |
| Mild asthma, back pain, flu-like symptoms, allergies, fever, sprains, diarrhea, eye or sinus infection, rash, urinary tract infection (UTI), sore throat, earaches, bumps, minor cuts and scrapes, and other nonemergency symptoms | Sore throat, earaches, bumps, minor cuts and scrapes, UTI | Sprain and strains, nausea, diarrhea, ear or sinus pain, minor allergic reactions, cough, sore throat, minor headache, UTI | Signs of a heart attack (Chest pain) or stroke (sudden numbness and slurred speech), dificulty breathing, and severe burn or bleeding - and any other symptoms where it is reasonable to think you are having a life-threatening emergency or your health is in serious jeopardy |

1. *The care options and list of symptoms are not all-inclusive. If possible, consult your PCP for more guidance.*
2. *Business Wire: 9th Annual Vitals Wait Time Report Released (accessed July 2021): businesswire.com.*
3. *LiveHealth Online, internal data 2020.*
4. *Healthcare Finance: Patient wait times show notable impact on satisfaction scores, Vitals study shows (accessed July 2021): healthcarefinancenews.com.*
5. *Urgent Care Association: UCA 2019 Benchmarking Report (accessed July 2021): ucaoa.org.*
6. *Harvard Business Review: To Reduce Emergency Room Wait Times, Tie Them to Payments (accessed July 2021): hbr.org.*
7. *Costs are ranked according to the member's estimated out-of-pocket costs and average health plan copays. Each plan may have different costs. Nonemergency care outside of your network may cost more out of pocket or may not be covered at all. $ = lower cost, and $$$ = higher cost.*

# YOUR MEDICAL PLAN

How to File an Insurance Claim

## GET HELP FINDING AN IN-NETWORK MEDICAL PROVIDER

www.AlabamaBlue.com

(800) 810-BLUE

## GET HELP FINDING AN IN-NETWORK BEHAVIORAL HEALTH PROVIDER

www.behavioralhealthsystems.com

(800) 245-1150

## OVERVIEW OF YOUR MEDICAL PLAN

*When you use Network Providers †*

| | |
|---|---|
| Annual Deductible | $200 per person (*maximum of two per Family*) |
| Out-of-Pocket Max | $2,000 (*maximum of two per Family*) |
| Office Visits | $25 copay |
| Preventive Care | 100% |
| Urgent Care | $25 copay per urgent care visit (*Lab, X-rays, and tests are covered separately*) |
| Emergency Room (ER) | Covered at 100% after $200 copay per ER visit (*waived if admitted within 24 hours*) |
| | Non-emergency use of the Emergency Room is covered at only 50%, subject to the out-of-network deductible |
| Inpatient Hospital | Covered at 100% after $100 copay per day (*first three days*) |
| Outpatient Hospital | Covered at 100% after $100 copay |
| Most Other Services | Generally covered at 100% after applicable copay or deductible (*some services covered at 80%*) |
| Mental Health / Substance Abuse | Covered at either 100% or 80% coinsurance after applicable copay or deductible |
| Prescriptions | Retail Pharmacy Copays, 30-day supply |
| *Tier 1: Generic* | $5 |
| *Tier 2: Preferred Brand* | $40 |
| *Tier 3: Non-Preferred Brand* | $90 |
| *Tier 4: Specialty Drugs* | $150* |
| *Mail Order:* | 90-day supply for only two copays (Tiers 1, 2, 3 Only) |

** Covered only if dispensed at Accredo, Alliance Rx Walgreen's Prime, or CVS/Caremark*

*† Go to https://jccaccess.jccal.org/ for more information about your plan, including the Summary of Benefits and Coverage*



# YOUR MEDICAL PLAN

## YOUR 2023-24 MEDICAL PREMIUMS

The County is pleased to continue to offer you a rich health care plan — at no increase in contribution to you this year.

### MEDICAL PLAN MONTHLY CONTRIBUTIONS

| COVERAGE | YOU WILL PAY | COUNTY WILL PAY | TOTAL PREMIUMS |
|---|---|---|---|
| Employee Only | $123.82 | $732.86 | $856.68 |
| Employee + One Dependent | $275.61 | $1,457.86 | $1,733.47 |
| Family | $358.06 | $2,196.52 | $2,554.58 |

*Deductions taken from two paychecks each month. Your per-paycheck deduction is half the amount shown under "You Will Pay."*

## CHOOSE THE *RIGHT* COVERAGE AT THE *RIGHT* COST

All County health care plans have an Employee + One coverage option. It costs much less than Family coverage. Family coverage is only for those with three or more eligible family members. So, if you are single with one dependent child — or married with no eligible children — then Employee + One is the right choice for you!

# YOUR MEDICAL PLAN

**BENEFITS4YOU** is committed to not only cover you when you're sick, but to also keep you healthy. It's a lot easier (and more pleasant) to prevent a major medical problem than to treat it. And, if you already have a chronic condition, it's better to improve your health than to keep paying more for the same results (or even worse).

The County truly cares about protecting you. That is why we are one of few employers using three leading-edge health management programs — at no cost to you. They are convenient, with services available to you online, by text, in person, and by phone. And they protect both your health and your confidentiality.

All employees and eligible dependents enrolled in the medical plan are automatically eligible for these initiatives. In exchange for the County's substantial financial investment, all we ask is that you be equally invested in your good health!

## CATAPULT HEALTH

Catapult Health conducts free health checkups and biometric screenings. The process, always quick and easy, is now more convenient than ever — thanks to Catapult Health's VirtualCheckup™ Home Kit. After you take your test, from the comfort of home, a registered clinician will reach out to review your results with you and answer your questions. The clinician can also create a personalized action plan for you, to share with your doctors, supplementing their baseline data on your health and supporting their efforts on your behalf.

## ADVANTAGES TO YOU

In addition to the normal benefits of an annual checkup, Catapult gives you unique insight into your overall wellness. Using state-of-the art technology, Catapult analyzes your biometric data. It produces a holistic, integrated examination of your height, weight, body mass index, blood pressure, blood cholesterol, blood glucose, fitness, and other biological measures.

A biometric screening helps you understand not only your current health status, but also your risk for such conditions as diabetes, stroke, and heart attack. With this information, you can take steps to head off serious, possibly life-threatening diseases. And, if you're already dealing with a chronic condition, Catapult's biometric screening can help you find ways to better manage it and avoid additional complications.

## WHY YOU NEED THIS BENEFIT

- According to the Rand Corp., up to 90% of national health care expenditures are for people with chronic health conditions.
- The CDC reports that 80% of heart disease, stroke, and Type 2 diabetes cases are preventable.
- Based on biometric data collected by Catapult, many of you are likely to face such serious health conditions — without even knowing you are at risk.


## AN OUNCE OF KNOWLEDGE IS WORTH A TON OF CURE

Catapult checkups include the following screenings — each associated with, or a leading indicator of, potentially serious medical conditions.

- Total cholesterol, HDL, and LDL
- Triglycerides
- Glucose
- A1c (for diabetics)
- Blood pressure
- ALT and AST liver tests
- Body mass index



# YOUR MEDICAL PLAN

## REWARDING HEALTHY HABITS

Health plan participants can earn up to two $50 Visa gift cards ($100 total) each year.

**Earn a reward by completing one of the approved activities including:**

- Catapult health screening
- Wellbeacon in-app health assessment
- 12-week Pack Health program

Be aware that, while all of your enrolled dependents can (and should) participate in these "healthy" programs, only you, as an enrolled County employee, are eligible for any of the $50 rewards.

If it is unreasonably difficult due to a health condition for you to earn a reward under this program, or if it is inadvisable for you to achieve the standards under this program, contact human resources. We will work with you (and if you wish with your doctor) to develop another way to receive the reward.

## PACK HEALTH

If you have certain health conditions or needs, Pack Health can help you improve your medical outcomes — and enhance your quality of life. Pack Health combines high technology with high touch. You'll have a personal health coach who works with you, one-on-one, as you progress toward a healthier lifestyle. Instead of viewing you as a set of discrete diagnoses, your coach focuses on the bigger picture. He or she gets to know you, understands your health conditions, and helps you establish your personal health goals. Your coach then works with you to define small steps you can take, immediately, to generate quick wins.

Each week, you and your coach have a scheduled phone call to monitor your symptoms (e.g., blood pressure, weight, blood sugar levels), check on what you've achieved, address your questions and concerns, and establish goals for the following seven days.

During the week, your coach continues to interact with you, providing encouragement and support. Then, at the end of the week, you and your coach have your regular phone session. Before long, you will find that your small steps have led to giant leaps in how you look and feel — such as better eating and sleeping habits, sustainable weight loss, decreased a1c and LDL levels, fewer rheumatoid flares, increased energy, and a better outlook on life — just like hundreds of other Pack Health participants!

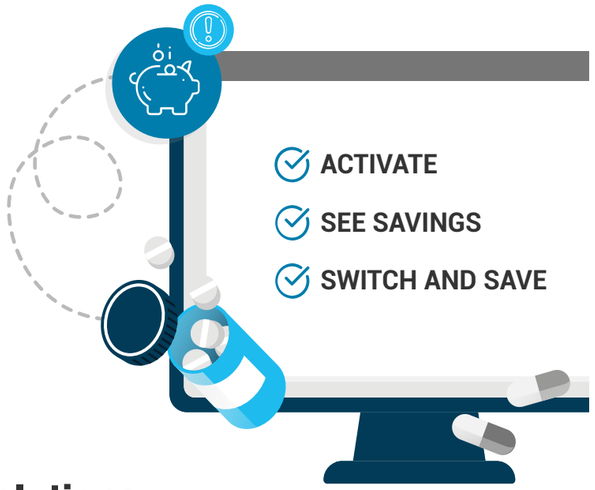
Pack Health offers you individual, personal coaching and support for the following health conditions and needs:

- Type 2 diabetes
- Diabetes prevention
- Hypertension / High blood pressure
- Rheumatoid arthritis
- High cholesterol
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure
- Weight reduction

**For information on Pack Health, call (855) 255-2362**

BlueCross BlueShield of Alabama

# Stop overpaying for your prescriptions




**Introducing Rx Savings Solutions.**
A new way to help lower your prescription drug costs.

Rx Savings Solutions is linked to your health plan, so **everything is personalized according to your medications and insurance.**

**Activate your account now to pay less for prescriptions.**

**Call** 1-800-268-4476

**Visit** myrxss.com/bcbsal

## How it Works

1. Rx Savings Solutions looks at the medications you take and **finds other options that may save you money.**
2. **Your online account shows which lower-cost prescriptions are available** and lets you compare prices.
3. **Switch to a lower-cost option with ease.** Rx Savings Solutions will handle everything with your doctor and pharmacy.
4. Rx Savings Solutions will contact you **anytime you can be spending less.**



# FLEXIBLE SPENDING ACCOUNT

## HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

Hundreds of County employees save big each year by participating in the Health Care FSA. How about you? The Health Care FSA is ideal for predictable, recurring costs. If you or an eligible dependent takes maintenance drugs — for blood pressure, diabetes, cholesterol, sleep, or anxiety — your monthly prescription costs are going to add up! And some of you may already know of certain medical, dental, and vision care expenses you'll have in 2023-24, particularly if planning medical or dental surgery.

**Each year, you must enroll (or re-enroll) in your FSA and select the amount you want to contribute**. Your bi-weekly allocations are taken from each paycheck on a before-tax basis. So your FSA not only reduces the amount of taxes withheld from your pay — it also returns the savings right back to you! That's because taxes that would otherwise be withheld remain included in your take-home pay.

Most participants save 20% to 30% by using an FSA, depending on your tax bracket.

New enrollees can expect to receive a debit card from Ameriflex in early October. For those who participated last year, you will continue to use the same debit card. Your entire contribution for the year (up to $3,050) will be available on October 1. You can use it to cover your eligible expenses as soon as your debit card arrives. There is no better or simpler way to reduce your taxes, and increase your take-home pay.

## DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A dependent care FSA allows you to set aside up to $5,000 on a before-tax basis to pay for qualified dependent care expenses. Funds can be used to pay for day care, preschool, elderly care or other eligible dependent care. To qualify, the IRS requires that the dependent care is necessary for you or your spouse to work, look for work or attend school full-time.

To enroll in this benefit you must have a child under the age of 13 that is currently in daycare or your have a spouse or adult dependent (may include parent or relative) who is physically or mentally incapable of self-care and lives with you for more than half the year.

## HOW TO NOT "LOSE IT" IF YOU DON'T USE IT

County medical records suggest that most employees do have recurring, predictable expenses, like maintenance medication. Yet, relatively few of you elect to participate in this generous tax-saving benefit. Because of the advantages that using pre-tax dollars can provide to you when using an FSA, we suggest taking advantage of this plan.

Take a look at your medical expenses for last year, include the expenses you expect to spend for this year, and remember that you will be able to roll over up to $610 of your FSA to your next plan year. That $610 will simply go into your next year's FSA funding (as long as you elect coverage again). 2023-24 is a great time for you to get started with — and enjoy having — FSAs' many conveniences and savings.

### *DON'T FORGET!*

You may be asked to submit an explanation of benefits, an itemized invoice or a detailed receipt to substantiate claims after using your FSA debit card. This is an IRS requirement to verify that you used your FSA for an eligible expense.

## GET CONNECTED

It is more important than ever to ensure you are connected with your benefits. That's why Ameriflex has a few easy ways to access your funds from anywhere. You can use your funds via your Ameriflex debit card. You can also check fund availability, file for tax-free reimbursement, or request a replacement card at www.MyAmeriflex.com or via the Ameriflex App.

# AND THERE'S MORE!
## THE FOLLOWING IS ALL INCLUDED

All participants in the medical plan can access a range of wellness resources at AlabamaBlue.com/myBlueWellness.

1

**Care Reminders**: Upon log-in, you will see a list of your upcoming or overdue health services.

2

**Personal Health Record**: Once you populate this tool with your claims and other health data, you can chart your progress over time.

3

**Baby Yourself®**: This maternity management program furnishes telephonic and email support — from an experienced registered nurse — throughout your pregnancy and after birth. **Call (800) 222-4379 to enroll**.

4

**BCBS Global Core:** As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Members have access to doctors and hospitals around the world. To learn more about **Blue Cross Blue Shield Global Core**: www.bcbsglobalcore.com or call (800) 810-2583.

5

**Interactive Tools**: WellBeacon gives you personalized recommendations for your next best action. Whether you're a seasoned athlete or doing your best to manage a health condition, WellBeacon helps you find the programs, resources and providers that are best for you.

6

**Blue365 Discounts**: BCBS Members can access exclusive health and wellness discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more. Gain access to 10,000 gyms nationwide for only $29/month with Blue365. To access these deals, employees can register at AlabamaBlue.com/Blue365.

7

**Pack Health Advisors**:

Health advisors (HA) are specially trained to provide support to members and dependents living with chronic conditions. Your HA will act as a guide, helping you set goals that work for your lifestyle.

Visit packhealth.com/jeffco to enroll online or **call 1.855.255.2362**.

8

**Blue Distinction and Blue Distinction Plus Providers and Facilities**: BlueCross BlueShield has designated certain providers and facilities as condition-specific Centers of Excellence. To earn this status, they must maintain a consistent track record of superior outcomes in their respective areas of specialty care. When you need care, why not get it from the best source? You can find Blue Distinction and Blue Distinction Plus providers and facilities, for each major health condition, at https://www.bcbs.com/about-us/capabilities-initiatives/blue-distinction/blue-distinction-specialty-care or by calling the number on the back of your ID card.



# YOUR DENTAL OPTIONS

## YOUR CHOICE OF DELTA DENTAL PLANS

You can choose from two levels of Delta Dental coverage. The Base plan costs less and covers most common dental services. The Premium plan costs more, but provides richer benefits, including coverage for implants and orthodontia.

| DENTAL PLANS | BASE PLAN | PREMIUM PLAN |
|---|---|---|
| Deductible | $50/person ($150 per Family) | $50/person ($150 per Family) |
| Preventive Care | 100%, no Deductible | 100%, no Deductible |
| Basic Services | 80%, after Annual Deductible | 90%, after Annual Deductible |
| Major Services | 50%, after Annual Deductible | 60%, after Annual Deductible |
| Orthodontia | Not Covered | 50%, no Deductible ($2,500 Lifetime Maximum) |
| Annual Maximum Benefit/Participant | $1,250 | $2,500 |
| **MONTHLY CONTRIBUTIONS OCTOBER 1, 2023 – SEPTEMBER 30, 2024** | | |
| Employee | $23.16 | $34.02 |
| Employee + Spouse | $44.20 | $64.92 |
| Family | $60.60 | $89.01 |

*Benefits shown reflect coverage when you use participating Network providers. Out-of-Network benefits are less.*

# YOUR VISION CARE OPTIONS

## YOUR CHOICE OF EYEMED PLANS

Because everyone has different vision care needs, the County offers you a choice of EyeMed benefits.

| VISION PLANS | BASE PLAN | PREMIUM PLAN |
|---|---|---|
| Exam | $10 Copay | $10 Copay |
| Materials | $15 Copay | $15 Copay |
| Allowances<br>Frames<br>Contact Lenses | <br>$130 Retail<br>$130 | <br>$200 Retail<br>$200 |
| Frequency<br>Exams & Lenses<br>Frames | <br>Every 12 Months<br>Every 24 Months | <br>Every 12 Months<br>Every 24 Months |
| **MONTHLY CONTRIBUTIONS OCTOBER 1, 2023 – SEPTEMBER 30, 2024** | | |
| Employee | $5.33 | $7.84 |
| Employee + Spouse | $10.65 | $15.67 |
| Family | $15.62 | $22.98 |

*Benefits shown reflect coverage with Participating (i.e., Network) providers. Out-of-Network benefits may be available for certain vision services — but at a substantially reduced level.*



# LIFE AND AD&D INSURANCE

***$50,000***

of Basic Life and AD&D coverage ***"at no cost to you"***

## SUPPLEMENTAL LIFE INSURANCE FOR YOU

If you'd like additional protection, you can purchase Supplemental Life insurance at low group rates.

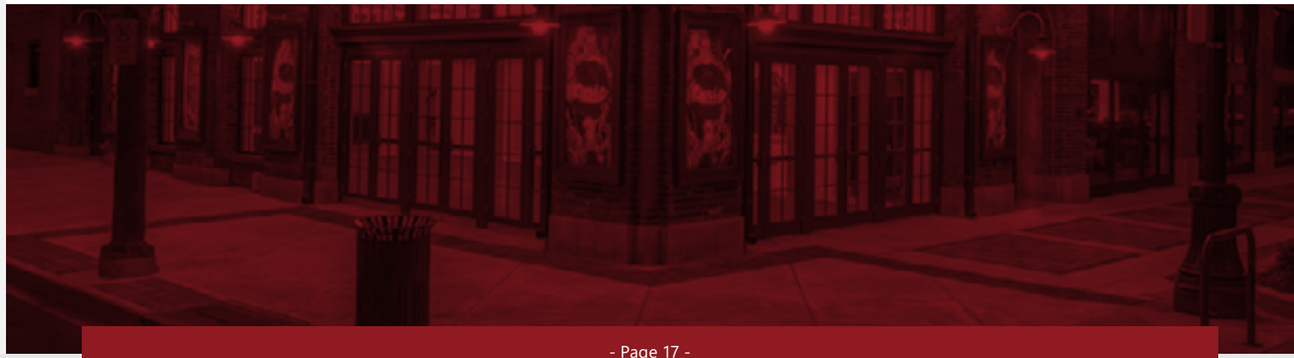
| | |
|---|---|
| Supplemental Life | Available in $5,000 increments, up to five times your salary or $750,000, whichever is less. |
| If Supplemental Coverage was previously declined | You must submit a completed Statement of Health form, which you can request from Human Resources. After reviewing your completed form, MetLife will let you know if you are eligible to enroll. |
| Guaranteed Issue | When you are first eligible for benefits, you can obtain coverage of up to $250,000 or five times your salary, whichever is less — without having to complete a Statement of Health form. |

## NAMING A BENEFICIARY

In the Kronos enrollment system, you must name a beneficiary for your Life and AD&D benefits. Your beneficiary can be a person, business, charitable institution, trust, or even your church. If you want, you can divide proceeds among several beneficiaries. But be sure to name a beneficiary and fill in the requested information.

In addition to your Primary beneficiary, you can also name a Contingent beneficiary — to receive your benefits should your Primary no longer be alive at the time of your death.

Please note that, for spouse and child insurance, you are automatically the beneficiary.



# LIFE AND AD&D INSURANCE

## WANT TO INCREASE CURRENT COVERAGE?

If you have Supplemental Life insurance now, you may be able to increase your coverage by up to $50,000. Requests above this amount, or which bring your coverage above $250,000, must be accompanied by a completed Statement of Health form. Be sure to contact Human Resources, as soon as possible, to request this document.

Coverage guarantees are available solely to current participants and those who have not previously applied or been denied for Supplemental Life Insurance under the County's plan.

## SUPPLEMENTAL AD&D INSURANCE FOR YOU AND YOUR FAMILY

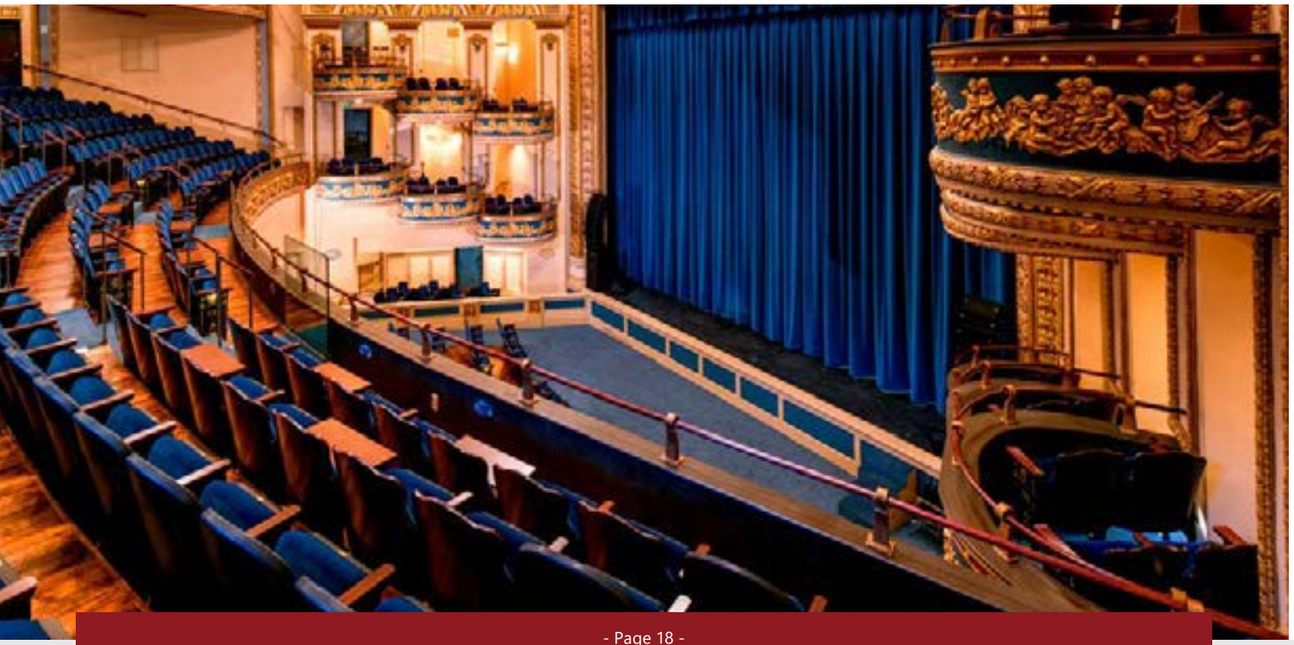
You can elect Supplemental AD&D insurance for yourself or for you and your family (spouse and dependent children to Age 26). Coverage is available in $5,000 increments, up to $750,000 or five times your salary, whichever is less. Unlike Supplemental Life, you can add Supplemental AD&D without having to complete a Statement of Health form.

## LIFE INSURANCE FOR YOUR FAMILY

**Spouse**: If you have Supplemental Life coverage for yourself, you can add Supplemental Life for your spouse. You can choose a benefit of either $25,000 or $50,000, with cost based on your spouse's age. Note that you can obtain spousal coverage, without evidence of insurability, at your first enrollment opportunity — as a new hire or, if later, within 30 days of your marriage.

If you had waived coverage at that time, you must submit a Statement of Health form to determine if you are eligible to add it now.

**Children**: You can also add life insurance for your children. You can choose between two coverage levels: $5,000 or $10,000. The cost for the respective benefits is the same regardless of how many children you have. Coverage for newborns is limited to $500 for the first 15 days after birth.





# SHORT & LONG TERM DISABILITY

With MetLife's short and long-term disability plans, you can get the security of continued income should you be unable to work due to a qualifying disability.

You can choose coverage, at low group rates, for short-term disability (STD), long-term disability (LTD), or both. These plans coordinate with other forms of income replacement you may receive (e.g., Social Security disability benefits) to replace up to 60% of your County salary — tax free.

| VOLUNTARY SHORT-TERM DISABILITY (STD) | |
|---|---|
| Weekly Benefit | • 60% Weekly earnings up to $1,730<br>• Receive cash incentives, such as a 10% benefit increase, for participating in a MetLife approved rehabilitation program |
| Benefits Begin | • 8th day of your qualifying disability |
| Benefit Duration | • As long as your condition qualifies, up to a total of 26 weeks |

**Note on Pregnancy**: If your pregnancy starts after your disability plan has gone into effect, you are eligible for plan benefits. Otherwise, your claim will be subject to the Pre-Existing Condition exclusion (a look-back period of three months).

| VOLUNTARYLONG-TERM DISABILITY (LTD) | |
|---|---|
| Monthly Benefit | • 60% of monthly earnings up to $7,500<br>• Receive cash incentives, such as a 10% benefit increase, for participating in a MetLife approved rehabilitation program |
| Benefits Begin | • 180 days after the start of your qualifying disability |
| Pre-Existing Waiting Period | • Covered after the first 12 months |
| Benefit Duration | • As long as your condition qualifies, up until Age 65.<br>• For those 62 years of age or older, the duration of benefits will vary from 12 to 42 months depending upon your age at the time of the disability |

## SPECIAL FEATURES

Under **BENEFITS4YOU**, your disability plans include provisions that help you recuperate and regain your self-sufficiency. They include the following incentives.

**Rehabilitation**: You can increase your benefits by 10%, simply by participating in a MetLife approved rehabilitation program.

**Family Care**: Need child care so you can go to authorized rehab? MetLife will provide reimbursement for eligible child care expenses.

## USE YOUR PAID LEAVE TIME FIRST!

All disability plans coordinate with other types of benefits so that, in total, they combine to replace 60% of your pay. If you have multiple sources of income replacement, your disability benefit will be offset by these amounts.

Keep in mind that any paid leave time you have continues your pay in full. Since 100% of your pay exceeds the 60% ceiling, you will not receive disability benefits until your paid leave is used up.

# GROUP LEGAL & ID THEFT PROTECTION

## METLIFE LEGAL SERVICES

When you need a lawyer, finding competent, capable, and affordable counsel can be a challenge. And, in today's world, ID theft is an increasing risk. That's why the County is pleased to offer Group Legal and ID Theft Protection — available from MetLife Legal (formerly Hyatt). These plans offer you comprehensive, easy-to-access, and cost effective protection for your legal and ID-related needs.

## GROUP LEGAL

Hourly rates for attorneys can run to $300 or more. Enrolling in MetLife Legal is like having an attorney on retainer at a fixed, low monthly contribution. You'll have unlimited access to network attorneys and legal staff — by phone and face-to-face. And these services are also available to your spouse and dependents!

## EXAMPLES OF COVERED SERVICES

### FINANCIAL MATTERS

- Debt collection defense
- Negotiations with creditors
- Personal bankruptcy
- Tax audit representation
- Wills and trusts
- Power of Attorney and healthcare proxies

### FAMILY AND PERSONAL

- Adoption and guardianship
- Juvenile court defense (civil and criminal)
- Protection from domestic violence
- Immigration
- Vehicles and driving *(traffic tickets, license suspension, repossession)*
- Review of personal legal documents *(self, dependents, and parents)*
- Elder care *(Medicare, Medicaid, nursing home agreements, wills)*

### HOME AND REAL ESTATE

- Sale or purchase of home
- Deeds and Mortgages
- Boundary and title disputes
- Tenant negotiations
- Foreclosure
- Eviction defense

### CIVIL LAWSUITS

- Administrative hearings
- Civil litigation
- Disputes over consumer goods and services
- Small claims assistance

## ID THEFT PROTECTION

When it comes to fighting identity fraud, early detection is the best prevention — and your first line of defense. MetLife Legal works with FraudScout to bring you comprehensive fraud and credit monitoring services, coupled with 24/7 dedicated support.

## YOU PICK!

During Annual Enrollment, choose the option that best meets your needs. You can select Group Legal coverage only ($18 per month) or a package of Group Legal plus ID Theft Protection ($21/month). Whichever you decide, your spouse and dependents are covered, too — at no additional cost!



# OTHER SUPPLEMENTAL INSURANCE

## FEATURES COMMON TO ALL THREE PLANS

These MetLife plans are separate, voluntary benefit options that supplement your medical coverage.

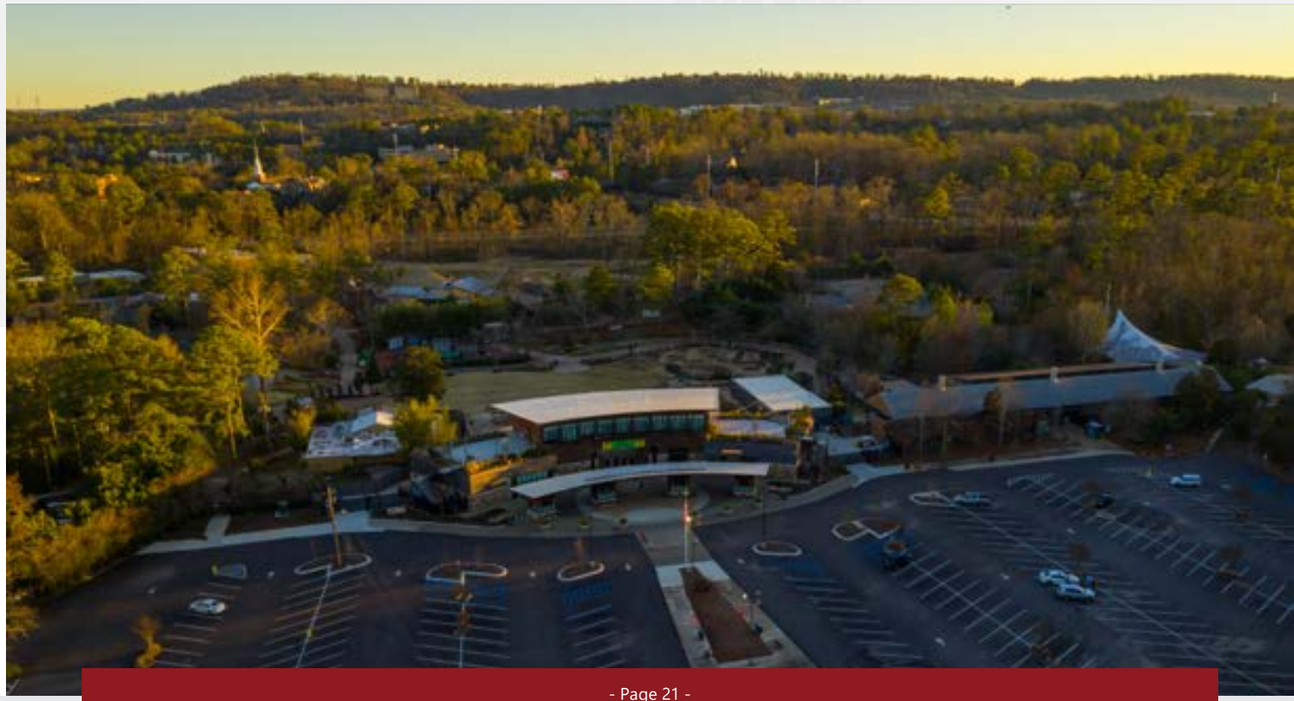
Accidents, hospital stays, and critical illnesses can create significant financial pressure. MetLife's plans can give you added security — and protect your peace of mind — when you're dealing with serious health conditions.

Depending on your personal situation and benefit needs, you can select a single MetLife plan, any combination, or all three options.

All of these plans pay cash benefits — directly to you.

You can use the cash to cover out-of-pocket costs, deductibles, coinsurance, living expenses, child care, and a range of other needs.

You can convert these policies when you leave County employment — and take your coverage with you.



# ACCIDENT & HOSPITAL INDEMNITY

## GROUP ACCIDENT INSURANCE

| COVERAGE CONDITIONS | AMOUNT |
|---|---|
| Fracture | $240 – $6,000 |
| Dislocation | $160 – $4,000 |
| 2nd or 3rd Degree Burn | $75 – $15,000 |
| Concussion/ Coma | $350/$7,500 |
| Laceration | $50 – $600 |
| Ambulance | Ground: $300 Air: $1,000 |
| Emergency Care | $50 – $100 |
| Non-Emergency Initial Care | $50 |
| Therapy Services | $10 |
| Surgical Repair | $125 – $1,250 |
| Hospital Admission | $750 for admission day |
| Hospital Confinement | $225 per day |
| Inpatient Rehabilitation | $100 per day |
| Dismemberment | $750 – $12,500 |

VIDEO of Accident Insurance

VIDEO of Hospital Indemnity

VIDEO of Critical Illness Insurance

## GROUP HOSPITAL INDEMNITY

| COVERAGE CONDITIONS | AMOUNT |
|---|---|
| Hospital Admission | $1,000 |
| ICU Supplemental Admission | $1,000 |
| Hospital Confinement | $150 |
| ICU Supplemental Confinement | $150 |
| Health Screening Benefit | $50 |

**Accident Insurance - Detailed Summary**

**Hospital Indemnity Insurance - Detailed Summary**

## CRITICAL ILLNESS

| INDIVIDUAL | BENEFIT AMOUNT | REQUIREMENTS |
|---|---|---|
| Employee | $15,000 or $30,000 | Coverage is guaranteed provided you are actively at work. |
| Spouse/Domestic Partner | 50% of the Employee's Initial Benefit | Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. |
| Dependent Child(ren) | 50% of the Employee's Initial Benefit | Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate |

| COVERED CONDITIONS | INITIAL BENEFIT | RECURRENCE BENEFIT |
|---|---|---|
| Cancer | 100% of Benefit Amount | 100% of Initial Benefit |
| Coronary Artery Disease | 50% of Benefit Amount | 100% of Initial Benefit |
| Childhood Illness | 100% of Benefit Amount | None |
| Coma | 100% of Benefit Amount | 100% of Initial Benefit |
| Heart Attack | 100% of Benefit Amount | 100% of Initial Amount |
| Infectious Disease | 25% of Benefit Amount | None |
| Kidney Failure | 100% of Benefit Amount | None |
| Major Organ Transplant | 100% of Benefit Amount | None |
| Progressive Disease | 100% of Benefit Amount | None |
| Burn/Stroke | 100% of Benefit Amount | 100% of Initial Amount |

**Critical Illness Insurance - Detailed Summary**



# ELECT YOUR BENEFITS

How to Register for My Benefits

During Annual Enrollment, use Kronos (UKG) to elect or change your benefits,update your personal and family information, and get the coverage you need — for the people you love. The online system walks you through each step in the process, making it easier for you to enroll. To get started, here is what you need to do.

## HOW TO ACCESS THE SYSTEM

Log in at https://jccaccess.jccal.org/ (or at https://kronos.jccal.org/wfc/logon) If you forgot your user name or password, contact the IT Help Desk

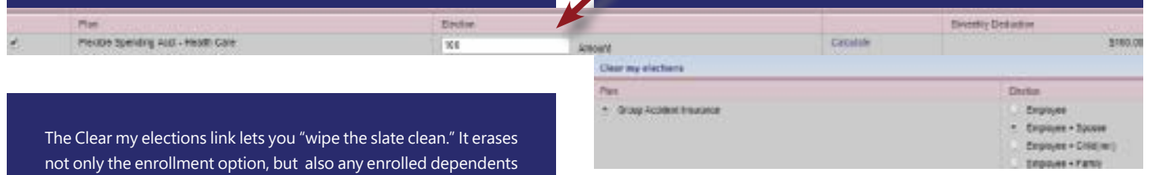
1. Go to the **Employee Home Page**.
2. Once on the **Home Page**, click the **Alert button**, then 2023-2024 **Open Enrollment** to get to **Life Events**.
3. At the **Life Events** home page, click on 2023-2024 **Open Enrollment**.
4. On the **Welcome page**, click **Next**.
5. On the **Address & Phone** and **Emergency Contacts** pages, enter or update your information


Be sure to visit the JCC Benefits page by clicking here. That's where you will find detailed information about your options as well as forms you may need for certain coverages.

6. The system allows you to review all your coverages by clicking the top left of **Updating Your Benefits**. Scroll to the bottom of the screen and click **Next**.
7. One by one, review each of the benefit screens, select the plans and coverages you want, and, as necessary, update your dependent and beneficiary information.

With the exception of benefits the County provides automatically, each screen gives you the option to select or waive coverage. Be careful, though: Waive only those benefits you are sure you do not need. (For example, do NOT waive County Medical coverage unless you are covered under another plan.)

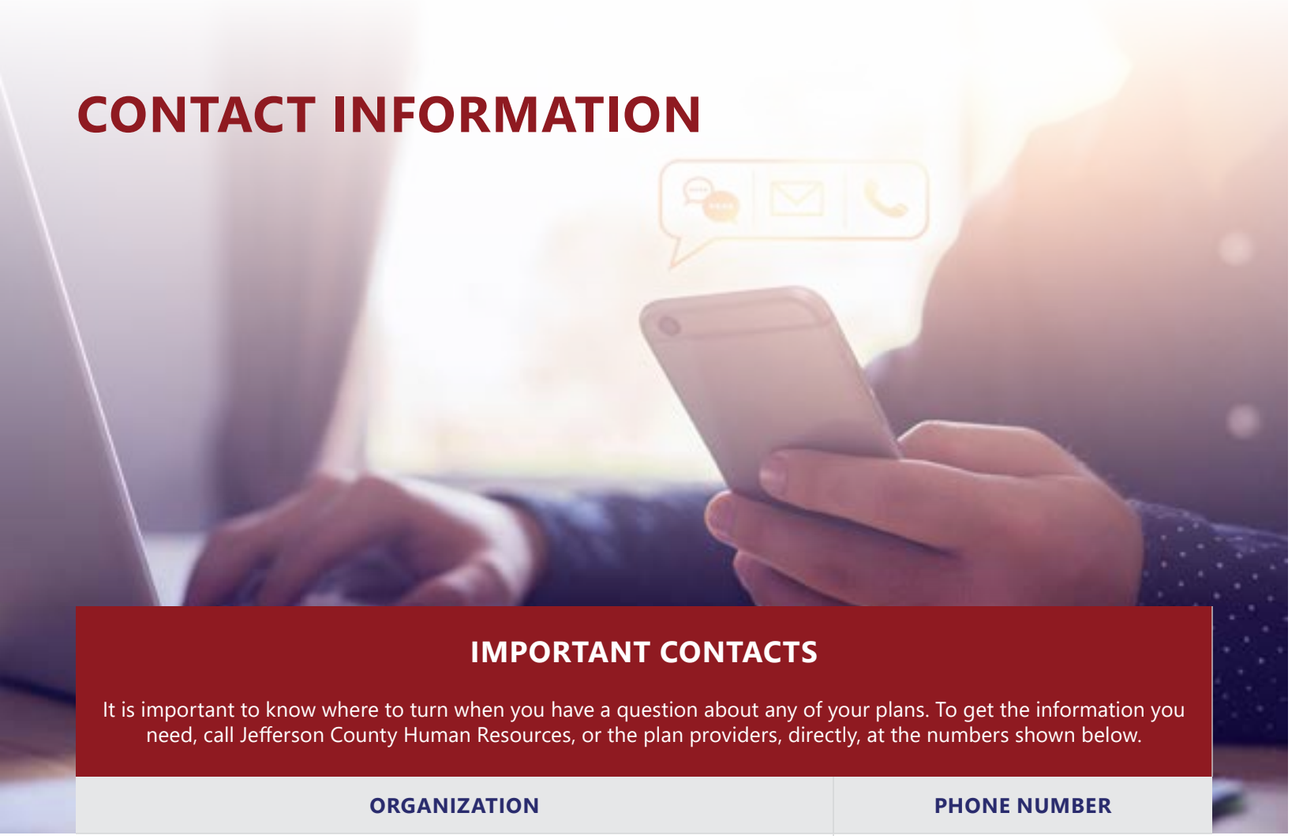
The Election amount you enter in FSA screens reflects how much you want to contribute from each paycheck. Please do not exceed the maximum bi-weekly deductions shown for each account.




The Clear my elections link lets you "wipe the slate clean." It erases not only the enrollment option, but also any enrolled dependents or beneficiaries.

8. Look over the information on each screen and make sure it is complete. Then click **Save & Continue**.
9. Review your Benefit Summary. If you are satisfied with your choices, click **Print** (so you have a copy for your records) then Submit Changes to complete your enrollment. You'll receive a Confirmation Statement once your submission is successful, otherwise please scroll up to check for errors before leaving this page. If you need more time, click **Save** for Later so you can return and complete your enrollment.

# CONTACT INFORMATION



## IMPORTANT CONTACTS

It is important to know where to turn when you have a question about any of your plans. To get the information you need, call Jefferson County Human Resources, or the plan providers, directly, at the numbers shown below.

| ORGANIZATION | PHONE NUMBER |
|---|---|
| Jefferson County Commission Human Resources | (205) 325-5249 (Option 4) |
| BCBS Medical (Group No. 60100) | (877) 255-7250 |
| Behavioral Health Systems | (800) 245-1150 |
| Employee Assistance Program and Mental Health/ Substance Abuse coverage | (800) 245-1150 |
| Ameriflex Flexible Spending Accounts | (888) 868-3539 |
| Delta Dental (Group No. 16059) | (800) 521-2651 |
| EyeMed Vision Care (Group No. 1023534) | (866) 800-5457 |
| *Inquiries during the Annual Enrollment period* | (866) 804-0982 |
| MetLife Life and AD&D Insurance (Group No. 200799) | (800) 300-4296 (Option 2) |
| MetLife Short- and Long-Term Disability Plans (Group No. 200799) *To file a claim* | (800) 300-4296 |
| Hyatt Legal (a MetLife Company) (Group No. 9902584) | (800) 821-6400 |
| MetLife Group Accident, Group Hospital Indemnity, and Critical Illness plans (Group No. 200799) | (800) 300-4296 |

*For all matters related to Family Medical Leave, contact MetLife at (888) 284-3951*



## 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, 2023. Contact your State for more information on eligibility.

### ALABAMA – MEDICAID

Website: http://myalhipp.com/
Phone: 1-855-692-5447

### ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

### ARKANSAS – MEDICAID

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

### CALIFORNIA – MEDICAID

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

### COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

### FLORIDA – MEDICAID

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

### GEORGIA – MEDICAID

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

### INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

### IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

### KANSAS – MEDICAID

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

## KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

## LOUISIANA – MEDICAID

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

## MAINE – MEDICAID

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

## MASSACHUSETTS – MEDICAID & CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

## MINNESOTA – MEDICAID

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

## MISSOURI – MEDICAID

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

## MONTANA – MEDICAID

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

## NEBRASKA – MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

## NEVADA – MEDICAID

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

## NEW HAMPSHIRE – MEDICAID

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

## NEW JERSEY – MEDICAID AND CHIP

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

## NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

## NORTH CAROLINA – MEDICAID

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

## NORTH DAKOTA – MEDICAID

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

## OKLAHOMA – MEDICAID AND CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

## OREGON – MEDICAID

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

## PENNSYLVANIA – MEDICAID

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

## RHODE ISLAND – MEDICAID AND CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

## SOUTH CAROLINA – MEDICAID

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

## SOUTH DAKOTA - MEDICAID

Website: http://dss.sd.gov
Phone: 1-888-828-0059

## TEXAS – MEDICAID

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

## UTAH – MEDICAID AND CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

## VERMONT– MEDICAID

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427



## VIRGINIA – MEDICAID AND CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

## WASHINGTON – MEDICAID

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

## WEST VIRGINIA – MEDICAID

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

## WISCONSIN – MEDICAID AND CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

## WYOMING – MEDICAID

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

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

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

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

## PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

**OMB Control Number 1210-0137 (expires 1/31/2026)**

Employee & Eligible Beneficiaries,

As an employee of Jefferson County Commission and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact human resources.

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

## IMPORTANT NOTICE FROM JEFFERSON COUNTY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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. We have determined the prescription drug coverage offered by Blue Cross Blue Shield of Alabama 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. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens to your Current Coverage if You Decide to Join a Medicare Drug Plan?**
If you decide to join a Medicare drug plan, your current coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. Visit http://www.cms.hhs.gov/CreditableCoverage/ which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

**Note:** In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language exists. Contact human resources for details.



**When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?**
You should also know 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. 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 19 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 in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage 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 or 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 800-MEDICARE (800-633-4227). TTY users should call (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 (800) 772-1213 (TTY 1-800-325-0778).

**Remember to 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).

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) NOTICE OF PRIVACY PRACTICES

HIPAA requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

HIPAA regulations will be followed in administrative activities undertaken by assigned personnel when they involve protected health information (PHI) and e-PHI. The company has adopted a policy that protects the privacy and confidentiality of PHI whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs. PHI refers to individually identifiable health information received by the company's group health plans and/or received by a health care provider, health plan or health care clearinghouse, and includes information regarding medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

All information related to enrollment, changes in enrollment and payroll deductions, aiding in claims problem resolution and explanation of benefits issues, and assistance in coordination of benefits with other providers will be maintained in confidence. Employees shall not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by Human Resources. The Company will consider any breaches in the privacy and confidentiality of handling of PHI to be serious, and disciplinary action will be taken in accordance with our code of conduct. Company records that are governed by this policy will be maintained for a period of no less than six years. Questions or issues regarding PHI should be addressed with Human Resources. You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law. You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

## SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

## GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. '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 that 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.

## WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) OF 1998

WHCRA provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.



This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 lymphedemas.

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). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

NMHPA requires that group health plans and health insurance issuers who offer childbirth coverage 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

## HEALTH AND WELLNESS PROGRAM

Jefferson County Commission and Blue Cross Blue Shield of Alabama provides a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which could include a blood test for blood related conditions such as diabetes. You are not required to complete the assessment or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive. Although you are not required to complete the health assessment or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. Please speak with human resources for specific details regarding incentives, participation requirements or to request reasonable accommodations or alternative standards.

The information from your health assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

## PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Jefferson County Commission may use aggregate information it collects to design a program based on identified health risks in the workplace, the Company's wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) authorized health coaches, nurses or providers in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact human resources.

## YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.



**You are protected from balance billing for:**

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

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

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

**When balance billing isn't allowed, you also have these protections:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Generally, your health plan must:
- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059 the federal phone number for information and complaints. Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

# NOTES

# GET READY TO LEAN INTO YOUR BENEFITS

This summary presents highlights of Jefferson County Commission's BENEFITS4YOU program. Start setting up for success by reviewing this book. Then, join us at an upcoming meeting, held online, at your convenience. You'll learn all about your options, get answers to your questions, and receive individual coaching — to select the plans that pull their weight for you!

# ALABAMA