2023

Associate Benefits Guide

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2023 BENEFITS OVERVIEW

IMPORTANT DATES

Open Enrollment runs

October 31st –

November 10th

WELCOME TO THE 2023 BENEFITS OPEN ENROLLMENT

The Jackson County annual insurance open enrollment period is about to begin!

We recognize the importance of benefits within the overall compensation package provided to all of our eligible associates. This year we reviewed all of our associate benefit options. Although most plans will remain the same, we will be moving our dental and vision programs to Ameritas. This move will provide our associates with enhanced benefits and lower payroll deductions.

COMPLETE 2023 OPEN ENROLLMENT BENEFITS IN PAYCOR

All associates will have to complete the online Benefit Enrollment in Paycor, even if you do not wish to make any changes. The guide to accessing Paycor for enrollment will be provided on page 4.

If you currently have or wish to apply for Domestic Partner coverage under any of our benefits, please contact Vivian Eads at vmeads@jacksongov.org or Kristen Ford at kdford@jacksongov.org and they will assist you in your enrollment.

All forms and additional benefit information can be located on the following:

SharePoint - https://jacksonmo.sharepoint.com/sites/JacksonCountyMO/SitePages/OpenEnrollment.aspx

Any associate who does not currently elect Jackson County Benefits will need to complete the online enrollment by waiving their benefits for 2023.

As always, we value you as a member of the Jackson County family and look forward to a healthy and safe 2023.

2023 CHANGES AT A GLANCE:

- $2,800 deductible increased to $3,000 to meet IRS guidelines on both the $2,800 QHDHP and QHDHP + Spira Care plans.
  - You will receive a new ID card if you are currently enrolled in either QHDHP plans.
- ***New!*** Ameritas is the new vision and dental carrier.
  - You will receive a new ID card for the Ameritas Vision and Ameritas Dental.

TIP **REMEMBER! Open enrollment is the one time of year you can make adjustments for the upcoming plan year.**

UPDATE YOUR PERSONAL INFORMATION:

Once you are in Paycor and have clicked on “Start Your Enrollment” you will be asked to update your personal information, (e.g. address, date of birth, etc.)

If you have an address change, you must notify Vivian Eads or Kristen Ford by email of your new address at vmeads@jacksongov.org or kdford@jacksongov.org. HR will notify all benefit providers of your change of address.

Update your cell phone number & work phone number.

Update or add your personal email address. Please do not remove your work email from Paycor.

DEFINITION OF DOMESTIC PARTNERS:

Persons at least 18 years of age, have exclusive mutual commitments to share responsibility for each other’s welfare and financial obligations which has existed for at least 12 months and is expected to last indefinitely, have maintained the same residence for at least 12 months, are competent to contract at the time the domestic partnership statement is completed, are not legally married to any person and not related in any way that would prohibit marriage in the State of Missouri, and are each other’s sole domestic partners.

UPDATE/ADD YOUR DEPENDENTS:

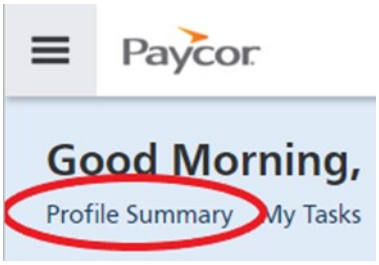
Add any dependent that will be covered under any of your benefits. You must have social security numbers and dates of birth to add dependents to your profile.

Dependents over 26 years of age as of January 1 are not eligible to be covered under your benefits.

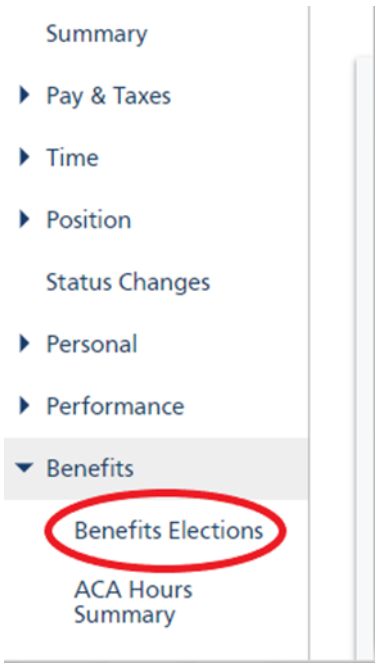
If you have a disabled child as a dependent on your coverage you must complete the Dependent Eligibility Verification Form each year and submit the form to Vivian Eads at vmeads@jacksongov.org or Kristen Ford at kdford@jacksongov.org .

GUIDE TO ACCESSING BENEFITS IN PAYCOR

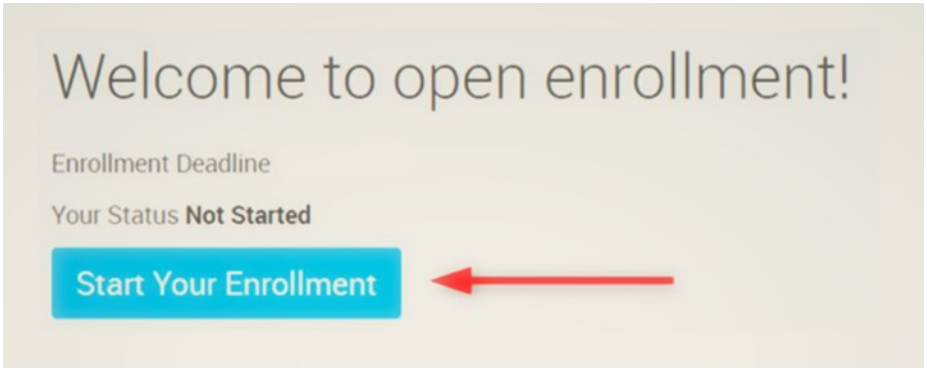
1. LOGIN TO PAYCOR



2. ON THE LEFT SIDE OF YOUR PROFILE SUMMARY, CLICK BENEFITS, THEN BENEFITS ELECTIONS.



3. THIS BRINGS YOU TO YOUR BENEFITS LANDING PAGE. DURING OPEN ENROLLMENT, YOU WILL SEE THE BLUE 'START ENROLLMENT' BUTTON, WHICH WILL ALLOW YOU MAKE YOUR OPEN ENROLLMENT BENEFIT ELECTIONS.



CONTACTS

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact your Jackson County Human Resources representative or applicable benefit vendor listed below.

MEDICAL INSURANCE
Blue Cross Blue Shield of Kansas City
www.mybluekc.com
Customer Service: 816-935-2945
Toll Free: 800-441-5478

DENTAL INSURANCE
Ameritas
www.ameritas.com
Customer Service: 800-487-5553

FCL Dental
www.fcldental.com
Customer Service: 866-481-9473

VISION INSURANCE
Ameritas
www.ameritas.com
Customer Service: 800-487-5553

LEGAL INSURANCE
MetLife Legal
www.legalplans.com
Customer Service: 800-821-6400

HEALTH SAVINGS ACCOUNT (HSA)
UMB Bank
www.umb.com
Customer Service: 1-800-860-4862

FLEXIBLE SPENDING ACCOUNT (FSA)
ASIFlex
www.asiflex.com
Customer Service: 1-800-659-3035

LONG TERM DISABILITY, BASIC LIFE, VOLUNTARY LIFE, & DEPENDENT LIFE
Standard
www.standard.com
Customer Service: 1-888-937-4783

DEFERRED COMPENSATION PLANS
Nationwide / Voya / Empower
www.nationwide.com
Nationwide Customer Service: 1-877-677-3678
www.voya.com/accounts
Voya Customer Service: 855-698-4900
www.participant.empower-retirement.com
Empower Customer Service: 855-756-4738

AFLAC
www.aflac.com
AFLAC Agent, Craig Johnston: 816-582-1062

UNIVERSAL LIFE
AllState
Call Center: 866-668-5421

LONG TERM CARE
Unum
www.unum.com
Customer Service: 866-679-3054

JACKSON COUNTY BENEFITS TEAM
Vivian Eads, Benefits Analyst
vmeads@jacksongov.org
816.881.3136

Kristen Ford, Human Resources Administrator
kdford@jacksongov.org
816.881.1206

Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As an eligible associate, you have a choice of medical plan options, each of which utilizes either the Blue Select Plus, Preferred Care Blue, or Blue Care networks with Blue Cross Blue Shield of Kansas City.

Please note these changes effective January 1, 2023:

- QHDHP deductible change to $3,000 single / $6,000 family per federal guidelines.
- Formulary change from Preferred to Premium Formulary
- If you are not changing your medical plan, just click on "Keep My Selection." (See page 6 for more details)
- If you are electing the HMO plan for the first time or changing your primary care physician (PCP), you MUST contact Blue Cross Blue Shield at their Customer Service 816-395-2945 or Toll Free 800-441-5478. Customer Service Hours are Monday-Friday from 8:00am to 5:00pm. You will not be able to elect or change your Primary Care Physician (PCP) within Benefits Advisor.
- To locate a Blue Cross provider, visit https://employers.bluekc.com/Home/FindCare.
- If you wish to waive the election (no longer have the benefit), click "I don't want this benefit (waive)."

The chart on the following page provides brief summaries of the medical benefits. Please refer to the full Blue Cross Blue Shield of Kansas City Benefit Summaries provided at open enrollment for greater detail.

UNIVERSITY HEALTH/TRUMAN MEDICAL CENTER (TMC ADVANTAGE)

When you use your BCBS HMO or EPO benefits at a TMC medical office you save money.

- $0 copays for primary care office visits (from approved list of providers).
- $0 copays for specialist office visits (from approved list of providers).
- $0 copays for imaging services (MRI, MRA, CT and PET scans)
- $0 copay will not apply to procedures or diagnostic tests.
- Must schedule and have imaging services completed at the UH Medical Imaging Lakewood, UH Medical Imaging Independence, or UH1 Medical Imaging locations only.
- $0 copays do not apply to Emergency Room visits.
- Must present both BCBS HMO or BCBS EPO and University Health cards at each visit.

HOW TO GET STARTED

SELECT YOUR MEDICAL PLAN

SPIRA CARE QHDHP PLAN FEATURE:

- Blue Select Plus network
- Access to Spira Care Centers
- Health Savings Account (HSA) eligible

QHDHP PLAN FEATURE:

- Preferred Care Blue Network
- Health Savings Account (HSA) eligible

HMO PLAN FEATURE:

- Blue Care Network
- Flexible Savings Account (FSA) eligible

EPO PLAN FEATURE:

- Blue Select Plus Network
- Flexible Savings Account (FSA) eligible

PPO PLAN FEATURE:

- Preferred-Care Blue Network
- Flexible Savings Account (FSA) eligible

MEDICAL INSURANCE

Blue Cross Blue Shield of Kansas City	**HMO Plan** Blue Care Network	**PPO Plan** Preferred-Care Blue Network	**QHDHP HSA Plan** Preferred-Care Blue Network	**EPO Plan** BlueSelect Plus Network	**QHDHP HSA Plan + Spira Care** BlueSelect Plus Network
	Associate Cost Per Pay Period	**Associate Cost Per Pay Period**	**Associate Cost Per Pay Period**	**Associate Cost Per Pay Period**	**Associate Cost Per Pay Period**
Associate Associate + One Associate + Family	$57.34 $160.12 $244.26	$50.74 $151.03 $231.10	$38.55 $133.19 $215.55	$37.24 $127.28 $209.11	$33.14 $114.64 $185.40
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Deductible Individual / Family	N/A	$1,000 / $2,000	$3,000 / $6,000	N/A	$3,000 / $6,000
Coinsurance (Member Pays)	N/A	20%	0%	0%	0%
Out-of-Pocket Maximum Individual / Family	$3,500 / $8,750	$4,500 / $9,000	$3,000 / $6,000	$3,500/ $8,750	$3,000 / $6,000
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care Spira Care	Covered at 100% $30 Copay $60 Copay $250 $60 N/A	Covered at 100% $30 Copay $60 Copay Ded. then coin. $60 N/A	Deductible Deductible Deductible Deductible Deductible N/A	Covered at 100% $30 Copay $60 Copay $250 $60 N/A	Deductible Deductible Deductible Deductible Deductible Deductible
Hospital Visits Inpatient Care (Facility / Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	$400 per visit up to 5 $400 per visit up to 5 $250 $300	Ded. then coin. Ded. then coin. Ded. then coin. $250	Deductible Deductible Deductible Deductible	$400 per visit up to 5 $400 per visit up to 5 $250 $300	Deductible Deductible Deductible Deductible
Prescription Drug Tier 1 / 2 / 3	**Click here to view and research your prescriptions on the New Premium Formulary Drug List**				
	$12 / 20% up to $100 / 50% up to $250	$12 / 20% up to $100 / 50% up to $250	Deductible then 0%	$12 / 20% up to $100 / 50% up to $250	Deductible then 0%

The Medical Plan chart above is for illustrative purposes only and does not include all benefits, plan limitations, and/or exclusions. This represents in-network benefits only. Please refer to the Blue Cross Blue Shield of Kansas City summary for greater detail. In the event there is a discrepancy in benefits, the carrier benefit summary/SPD will always govern. Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

SPIRA CARE

BLUE CROSS BLUE SHIELD OF KANSAS CITY

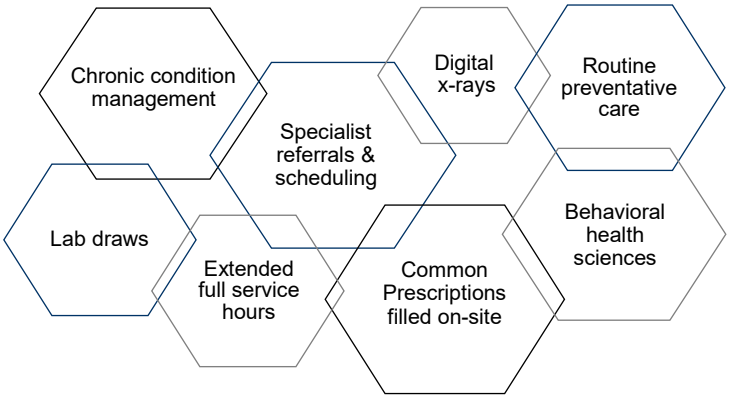
WHAT IS SPIRA CARE?

Blue KC has collaborated with one of the highest-performing Blue KC Medical Homes to create Spira Care – an innovative new offering centered on a reimagined primary care experience.

Spira members will benefit from the network's lower overall costs and convenient access to local providers across the metro area. Spira membership and care locations are exclusive to those employer groups enrolled.

WHAT SERVICES ARE INCLUDED IN SPIRA CARE?

Diagnostic services on your Spira Care $3,000 HSA Plan are subject to a maximum allowable charge.



WHERE ARE THE CLINICS LOCATED?

There are nine Spira Care clinics.

OLATHE
15710 West 135th St
Olathe, KS 66062

LEE'S SUMMIT
760 NW Blue Pkwy
Lee's Summit, MO 64086

CROSSROADS
1916 Grand Blvd
Kansas City, MO 64108

TIFFANY SPRINGS
8765 N Ambassador Drive
Kansas City, MO 64154

INDEPENDENCE
Opening December 2022
3717 S Whitney Ave
Independence, MO 64055

SHAWNEE
10824 Shawnee Mission Pkwy
Shawnee, KS 66203

LIBERTY
8350 N Church Rd
Kansas City, MO 64158

WYANDOTTE
9800 Troup Avenue
Kanas City, KS 66111

OVERLAND PARK
7341 W. 133rd Street
Overland Park, KS 66213

HOW DO I FIND A PROVIDER?

1. Go to **www.bluekc.com**, and "Find Care"
2. Click "Find a Doctor or Hospital" and log in to complete the process or click "Find a Doctor or Hospital As Guest"
3. **If you are searching as a guest:** Leave the button set to "I have or might get a Blue KC health plan through my employer"
4. Select the network which corresponds to your plan

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.bluekc.com.

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

TELEHEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

A "virtual visit," lets you see and talk to a doctor from your mobile device or computer anytime and anywhere! Download the Blue KC Virtual Care app (available for iOS and Android) or visit BLUEKCvirtualcare.com to get started.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

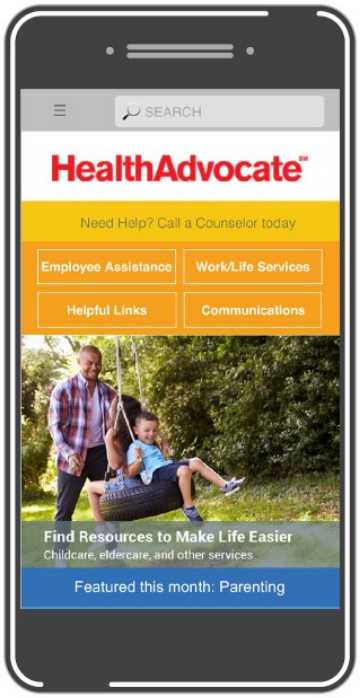
Primary Care vs. Urgent Care vs. ER

EMPLOYEE ASSISTANCE PROGRAM

HealthAdvocate℠

We're here to help anywhere, anytime

- **Review Member Benefits**
- **Confidential support** from Licensed Professional Counselors for personal, family and work issues
- **Work/Life Services** locates the right help with childcare/eldercare, legal/financial, relocation and more
- **One-Touch Calling:** Talk to a Licensed Professional Counselor
- **Quick Email Contact:** Ask a question or address an issue
- **24/7 EAP+Work/Life Website**
  - View EAP+Work/Life Orientation Video
  - Enhance your skills with Online Trainings
  - View our Webinars
  - Take Health and Well-being Assessments
  - Browse topics from caregiving to retirement planning
  - Access calculators for budgeting, loans, college, etc.



Your mobile app is now available!

Free • Convenient • On-the-Go Help

888.293.6948

Organization Name: The Standard - EAP - 3 Visits

Email: answers@HealthAdvocate.com

Web: HealthAdvocate.com/standard3

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

- Regular payroll deductions on a pre-tax basis, and
- Lump-sum contributions of any amount, anytime, up to the maximum limit.
- If you elected one of the Qualified High Deductible Health Plans (QHDHP) you will have an HSA account set up through UMB Bank.
- The County will contribute to your HSA account quarterly on January 20th, April 14th, July 7th, October 13th.
- $1,300 for Associate Only coverage
- $1,800 for Associate + 1 coverage
- $2,300 for Family coverage
- You can also elect to contribute to your HSA account through payroll deductions, to be deducted from all 26 pay periods.
- If you wish to start, change, or cancel your HSA contribution, you will need to complete the *2023 HSA Contribution Payroll Deduction Form.* Once completed, return your form to Human Resources. The associate payroll deduction election can be changed at any time throughout the year.
- If you are not changing your election, no action is required.
- If you are electing a QHDHP for the first time and have a Flexible Spending account, you must have a **$0 (zero) balance** in your Flexible Spending Account **by December 31, 2022**. You will not receive the January employer contribution if there is a balance in your Medical FSA.
- If you are enrolling in Medicare you cannot enroll in an HSA.

What Is A Health Savings Account?

Contribute up to $3,850 Single or $7,750 Family

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2023 are $3,850 for Single and $7,750 for Family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications (such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

FLEXIBLE SPENDING ACCOUNTS (FSA)

You **must** enroll on the ASIFlex website, www.asiflex.com, to elect an FSA for Medical Reimbursement and/or Dependent Care expenses by **November 10, 2022**. Directions on how to enroll are on the FSA Online Enrollment Instructions form on SharePoint.

- **Your previous year elections do not roll over – you must re-enroll for the new plan year!**
- Annual FSA IRS Maximum Contribution limits for 2023 are below. Your payroll deduction will come out of all 26 pay periods.
  - FSA for Medical Reimbursements $3,050
  - FSA for Dependent Care Expenses $5,000

You may not enroll in a Medical FSA if you elected a QHDHP with an HSA; however, you may enroll in a Dependent Care FSA.

The deadline to submit medical or dependent care claims for 2022 is March 31, 2023! **Funds not used will be forfeited**. However, you may roll over up to $610 of your 2022 Medical FSA balance into 2023.

If you do not want this benefit, no action is required.

SELECT YOUR FSA ACCOUNTS

- HEALTH CARE FLEXIBLE SPENDING ACCOUNT
- DEPENDENT CARE EXPENSE ACCOUNT

HOW DO THE FSA ACCOUNTS WORK?

Flexible Spending Accounts are a tool to allow you to pay certain dental, orthodontic, vision, or dependent care expenses with pre-tax dollars. When you have out-of-pocket expenses (such as copayments, deductibles, and dependent care expenses), you submit an FSA claim form with your receipt to Further. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check. See IRS Publication 969 for full details on eligible expenses.

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, “Credit for Child and Dependent Care Expenses.” Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited. **The Dependent Care Expense Account may be combined with a Health Savings Account.**

2023 Maximum Contributions

Health Care Flexible Spending Account	**$3,050 max**
Dependent Care Expense Account	**$5,000 max**

What Is A Flexible Spending Account?

The deadline to submit medical or dependent care claims for 2022 is March 31, 2023! Funds not used will be forfeited except the rollover amount of $610.

DENTAL INSURANCE

REVIEW YOUR DENTAL PLAN

NEW! AMERITAS IS THE PPO DENTAL CARRIER FOR 2023.

Jackson County dental plan offers a choice between a DHMO plan (still offered through FCL Dental), a Base PPO Plan or Buy– Up PPO Plan. The Ameritas plans offer coverage in and out-of-network. It is to your advantage to utilize an in-network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Ameritas' negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the year in which they turn age 26.

DENTAL INSURANCE PLAN OPTIONS AND COSTS

	FCL DENTAL DHMO Associate Cost Per Pay Period	Ameritas BASE PLAN Associate Cost Per Pay Period	Ameritas BUY UP PLAN Associate Cost Per Pay Period	To locate an Ameritas dental provider, visit https://www.ameritas.com/employee-benefits/find-a-provider/. **All associates who elect the PPO Base or Buy Up dental plans will need to elect coverage with Ameritas.**
Associate Associate + 1 Associate + Family	$2.19 $3.56 $5.50	$8.35 $14.62 $24.75	$13.75 $26.36 $42.09	
	In-Network	**In-Network**	**In-Network**	
Deductible Individual / Family	N/A	$50 / $150	$50 / $150	Applies to Basic & Major Services
Annual Maximum	N/A	$1,500	$1,500	Applies to Preventative, Basic & Major Services
Carrier Pays				
Type I Preventive	100%	100%	100%	■ Oral Evaluations ■ Cleanings ■ X-Rays ■ Fluoride Treatments (for dependents <19) ■ Sealants (for dependents <19) ■ Space Maintainers
Type II Basic	Copay	80%	80%	■ Fillings ■ Endodontics ■ Periodontics ■ Simple & Surgical Extractions ■ General Anesthesia
Type II Major	Copay	N/A	50%	■ Single Crowns ■ Inlays/Onlays ■ Bridges & Dentures ■ Prosthodontics
Orthodontia Services	25%	N/A	60% up to the $1,500 lifetime maximum	

Those electing FCL Dental plan: if you are **adding** the plan this year or wish to **change** your dental provider you must contact Customer Service at 866-481-9473. To locate a FCL Dental Dentist go to www.fcldental.com, click on Find a Dentist, select a "Network" Plan: H=DHMO JC only. Type in your zip code, select a radius, select General Dentist under Specialty, then click search. You must have contacted FCL Dental to elect a dental provider prior to setting an appointment with your new dentist. FCL Dental does not provide dental cards for associates.

If you wish to waive the election (no longer have the benefit), click "I don't want this benefit (waive)."

With Ameritas being the new dental provider, you will receive a new dental ID card.

What Is Dental Insurance?

VISION INSURANCE

REVIEW YOUR VISION PLAN

NEW! AMERITAS IS THE VISION CARRIER FOR 2023.

The vision plan offers coverage both in-network and out-of-network.
It is to your advantage to utilize an in-network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Ameritas offers you a choice between VSP Network or EyeMed Network. VSP offers the nation's largest network of independent doctors. Retail locations include Costco, Walmart, Sam's Club, and VisionWorks. EyeMed's Insight Network includes some of the most recognized names including LensCrafters, Pearl Vision, and Target Optical. Associates must choose at enrollment between VSP or EyeMed network. This choice is effective through the entirety of the plan year.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to www.ameritas.com.

VISION INSURANCE PLAN OPTIONS AND COSTS

AMERITAS	ASSOCIATE COST PER PAY PERIOD	
Associate Associate + Spouse Associate + Child(ren) Associate + Family	$2.54 $4.82 $5.07 $7.43	
	VSP	**EyeMed**
Examination Copay	$10 copay	$10 copay
Frequency of Service Exam Lenses Frames	Every 12 months Every 12 months Every 24 months	
Lenses Single Bifocal Trifocal	$20 copay; 100% covered $20 copay; 100% covered $20 copay; 100% covered	$20 copay; 100% covered $20 copay; 100% covered $20 copay; 100% covered
Frames	$150 allowance, 20% off balance over $150	$150 allowance, 20% off balance over $150
Conventional Contacts	$150 allowance	$150 allowance
Medically Necessary Contacts	$0 copay, paid-in-full	$0 copay, paid-in-full
Contact Fit & Follow Up Exams	Up to $60	Standard: up to $40 Premium (Allowance): 10% off of retail

FIND A VISION PROVIDER

To locate an Ameritas vision provider, visit https://www.ameritas.com/employee-benefits/find-a-provider/.

If you wish to waive the election (no longer have the benefit), click "I don't want this benefit (waive)."

With Ameritas being the new vision provider, you will receive a new vision ID card.

ADDITIONAL SUPPLEMENTAL BENEFITS

METLIFE LEGAL PLAN

Associates in this program may receive unlimited telephone advice and office consultations on virtually any personal legal matter with a plan attorney of your choice. Services include but are not limited to wills, living trusts, powers of attorney, mortgages, deeds and review of personal legal documents. Services also include representation for the purchase, sale or refinancing of your primary residence; Traffic Ticket Defense (No DUI); Wills & Power of Attorneys; Debt Matters & Identity Theft Defense; and Uncontested Adoptions and Guardianships. This program covers the associate, spouse, and dependents for $17.50 per month, which is deducted the 1st pay period of each month. For a complete list of providers near you, use the Provider Locator at www.members.legalplans.com or call 1-800-821-6400.

If you are not changing your MetLife plan, just click on "Keep My Selection."

If you wish to waive the election (no longer have the benefit), click "I don't want this benefit (waive)."

THE FOLLOWING BENEFITS ON PAGES 15-17 WILL NOT BE ON THE ONLINE PAYCOR ENROLLMENT. IF ANY OF THESE BENEFITS ARE DESIRED THEY REQUIRE ACTION BY PAPER FORM OR SEPARATE ONLINE ENROLLMENT.

ADDITIONAL SUPPLEMENTAL BENEFITS

DEFERRED COMPENSATION PLANS 457(B) (NATIONWIDE, VOYA, EMPOWER)

There are three (3) options NATIONWIDE, VOYA, and Empower (formerly MASS MUTUAL) .Traditional and Roth savings plan for retirement are available. Associates choose the dollar amount of deferral and selects one or more combinations of investment options. Maximum contribution is $20,500 or if over age 50, $27,000, 3 year catch-up $39,000 for 2023. If you wish to add, change, or drop your Deferred Compensation plan, you must contact a provider representative directly.

Nationwide at sunder@nationwide.com or 816-803-2700

VOYA at www.voyaretirementplans.com or 913-661-3735

Empower (formerly MASS MUTUAL) at myteam.g@empower.com or call at 800-695-4952 ext 40458.

See the Deferred Compensation Comparison on SharePoint. Your election can be changed at any time throughout the year. The providers will send all changes to Human Resources.

AFLAC

This plan covers indirect costs that are not covered by your major medical health insurance and pays over and above your health insurance coverage. The following coverage options are offered: Heart & Stroke, Hospital Protection, Accident Expense Policy; Intensive Care Protection; Personal Cancer Protector I, II, III; Short Term Disability; and Critical Illness. Premiums are deducted over 24 pay periods.

If you wish to add, change, or drop any of your AFLAC policies, you must contact AFLAC directly. Please call our AFLAC agent: Craig Johnston at 816-582-1062.

For information on AFLAC, please visit their website https://www.aflac.com or view plan documents on SharePoint.

AFLAC will send all changes to Human Resources.

UNIVERSAL LIFE

Jackson County associates are eligible to elect Universal Life Insurance coverage. Premiums provide coverage to at least age 85, it is portable—you can take it with you if you change job or retire, and coverage is available for your whole family. A "Statement of Health" is not required if you and your spouse are actively working and age 65 or younger during the enrollment period. Premiums are deducted over 24 pay periods.

If you wish to add, change, or drop your Allstate Universal Life coverage, you must contact their Call Center at 866-668-5421 and a representative will be able to assist you. For more details, see Allstate policy documents on SharePoint.

Allstate will send all changes to Human Resources.

LONG TERM CARE

UNUM Long-term care coverage helps pay for the types of expenses on would normally incur for long-term care needs.

Someone with a long physical illness, a disability, or a cognitive impairment (such as Alzheimer's Disease) often needs long-term care. Services may include help with activities of daily living, home health care, respite care, adult day care, care in a nursing home and care in an assisted living facility. Premiums are deducted over 24 pay periods. Associates must complete an Evidence of Insurability Form if electing Plan 4, and/or electing any plan coverage for spouse. http://unuminfo.com/jacksoncountymissouri.

If you wish to add, change, or drop your Unum Long Term Care coverage, you must go to https://unuminfo.com/jacksoncountymissouri/default.aspx.

Unum will send all changes to Human Resources.

LIFE INSURANCE AND AD&D

REVIEW YOUR LIFE INSURANCE POLICY

- ADD YOUR SPOUSE
- ADD YOUR DEPENDENTS
- INCREASE YOUR COVERAGE

BASIC LIFE AND AD&D

Jackson County provides $15,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance. This coverage is offered through Standard Insurance Company at no cost to you.

Note: there is a 50% benefit reduction in the basic $15,000 life insurance for associates age 70 or over.

VOLUNTARY LIFE AND DEPENDENT LIFE

You can purchase additional Life Coverage beyond what Jackson County provides.

- **Voluntary Associate Life :** $10,000, $20,000, $35,000, $50,000, $75,000, $100,000, $150,000, $200,000, $250,000, and $300,000 may be purchased. Cost is dependent on age and deducted on the second pay period of each month. *Note: there is a 35% benefit reduction for associates age 70-74 and 50% benefit reduction for associates age 75+. A medical health statement is required for elections over $200,000.*
- **Dependent Spouse Life :** $10,000.
- **Dependent Child Life :** 6 months —$500, 6 months to 26 years—choose between $5,000.
    - The cost for dependent voluntary life is $2.50 per month.
- A statement of health, or evidence of insurability, is a health questionnaire required for approval of your elected benefit. This is required if:
- You previously declined this benefit and wish to elect coverage.
- You are currently enrolled and wish to increase coverage beyond two or more increments or $250,000 and above.
- You are newly eligible and wish to elect coverage beyond the guarantee issue amount.

If you and your spouse are both employed by Jackson County, plan provisions prohibit you from electing Dependent Spousal Life insurance on your spouse. Further, only one of you is eligible to elect Dependent Child Life insurance on eligible children.

What Is Life And AD&D Insurance?

Complete a *Standard Life Insurance Enrollment* Change form and be sure to sign and date the form, if you wish to do any of the following:

1) **Increase** your voluntary life insurance one level (ex. from $10,000 to $20,000), you ***must***:

- Complete all sections of the form; in the Coverage Section, mark "Additional Life requested amount $_____" and enter the new amount you wish to receive (i.e. $20,000).

2) **Electing voluntary life for the first time** or wish to increase your coverage more than one level (ex. $10,000 to $50,000) or to $250,000 or $300,000, you ***must***:.

- Complete all sections of the form; in the Coverage Section, mark "Additional Life requested amount $_____" and enter the new amount you wish to receive (i.e. $250,000).

Complete an online Medical History Statement at the following link: https://www3.standard.com/w/PA_AmuBridgeWeb/MuServlet/?id=eb55d8045567ae8f62c8785f830ef8de

3) **Decrease** your coverage level, you ***must***:

- Complete all sections of the form; in the Coverage Section, mark "Additional Life requested amount $_____" and enter the new amount you wish to receive.

4) If you are **electing dependent life for the first time** or adding a new dependent to your coverage:

- Complete all sections of the form; in the Coverage Section under Dependents Life Insurance, mark "Spouse Life / Child(ren) Life.

Complete an online Medical History Statement for each dependent (spouse and/or child(ren) at the following link: https://www3.standard.com/w/PA_AmuBridgeWeb/MuServlet/?id=eb55d8045567ae8f62c8785f830ef8de

5) If you currently have coverage and wish to **waive** the election.

- Complete all sections of the form; in the Coverage Section, next to "Additional Life requested amount $_____," write "Waive".

All enrollment forms must be returned to Human Resources and online Medical History Statements (if applicable) completed by November 10, 2022.

If you are not changing your election or voluntary life plan, no action is required.

DISABILITY INSURANCE

REVIEW YOUR DISABILITY COVERAGE

- LONG-TERM DISABILITY

LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance is offered through Standard Insurance Company. Jackson County provides at no cost (to non-probationary associates) a two-year disability benefit. The benefit provides monthly replacement income of 60% of your average monthly base salary up to a maximum monthly benefit of $5,000; with a 90-day elimination period. This means the benefit begins on the 91st day.

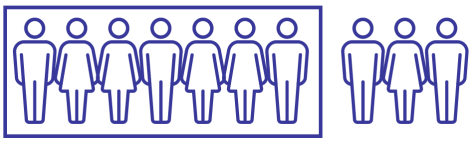
ADDITIONAL LONG-TERM DISABILITY COVERAGE

Non-probationary associates may purchase additional long-term disability coverage; associates may purchase either a 5-year additional benefit or benefit to age 65. Rates are based on associate's salary and age, and deducted the second pay-period of each month.

Maximum Benefit Period	5-year option	To age 65 option
66	1 year 9 months	3 years 6 months
67	1 year 6 months	3 years
68	1 year 3 months	2 years 6 months
69 or older	1 year	1 year

DID YOU KNOW?

Nearly **70%** of workers that apply to Social Security Disability Insurance **are denied.**



Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

Complete a Long Term Disability Enrollment form and be sure to sign and date the form, if you wish to do any of the following:

1) If you are **electing a buy-up LTD option for the first time** or wish to increase your coverage from the "5 Year" plan to the "To age 65" plan, you must:

- Complete all sections of the form; in the Disability Section, mark "To Age 65."

Complete an online Medical History Statement at the following link: https://www3.standard.com/w/PA_AmuBridgeWeb/MuServlet/?id=eb55d8045567ae8f62c8785f830ef8de

2) If you wish to **decrease your coverage** from the "To Age 65" plan to the "5 Year" plan, you must:

- Complete all sections of the form; in the Disability Section, mark "5 Year."

3) If you currently have **coverage and wish to waive the election**, you must:

- Complete all sections of the form; mark "Cancel" at the top.

All enrollment forms must be returned to Human Resources and online Medical History Statements (if applicable) completed by November 10, 2022.

Remember your disability premiums may increase based on your age and annual income.

If you are not changing your election or disability plan, no action is required.

What Is Disability Insurance?

VIDEO RESOURCES

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- HDHP vs. PPO
- HDHP With HSA Overview

INSURANCE 101

- Benefits Key Terms Explained
- How To Read An EOB
- What Is A Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What Is A Health Savings Account?
- What Is A Flexible Spending Account?

OPEN ENROLLMENT RUNS
OCTOBER 31st -
NOVEMBER 10th

ANCILLARY BENEFITS

- What Is Dental Insurance?
- What Is Vision Insurance?
- What Is Life And AD&D Insurance?
- What Is Accident Insurance?
- What Is Critical Illness Insurance?
- What Is Paid Time Off?

GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Jackson County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Jackson County 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. Jackson County has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Kansas City health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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 Jackson County coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Jackson County medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

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

You should also know that if you drop or lose your current coverage with Jackson 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 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Jackson 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:	10/09/2022
Name of Entity/Sender:	Jackson County
Contact--Position/Office:	Kristen Ford, Human Resources Administrator
Address:	415 E 12th St, Kansas City, MO 64106
Phone Number:	816.881.1206

Premium Assistance Under Medicaid and theChildren'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, 2022. Contact your State for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & ChildHealth Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance- buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecove ry.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-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	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
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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	SOUTH DAKOTA-Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, or for more information onspecial 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, anddisplays 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 personshall 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 1/31/2023)

INITIAL COBRA NOTICE *[FOR NEW HIRES OR NEW BENEFITS ELIGIBLE ONLY]*

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: Kristen Ford, 816-881-1206

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Kristen Ford, 816-881-1206

This notice is a summary. For a full description of all of Jackson County's benefit plans, please refer to the Summary Plan Descriptions, located at: Jackson County HR Department.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your Plan Administrator at 816-881-1206.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether they were covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2023. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Jackson County may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health 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 individuals who will receive your personally identifiable health information are health professionals 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 Kristen Ford at 816-881-1206

NOTICE OF MATERIAL CHANGE (ALSO MATERIAL REDUCTION IN BENEFITS)

Jackson County has amended the Dental and Vision benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Human Resources.

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MARKETPLACE COVERAGE OPTIONS

[FOR NEW HIRES ONLY]

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. ***Note:*** *If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.1*

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact Jackson County HR department.

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

1 An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

MARKETPLACE COVERAGE OPTIONS CONTINUED

[FOR NEW HIRES ONLY]

PART B: Information About Health Coverage Offered By Your Employer

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

Employer Name: Jackson County	**Employer Identification Number (EIN):** 44-6000524
Employer Address: 415 E 12th St, Kansas City, MO 64106	**Employer Phone Number:** 816.881.1206
Who can we contact about employee health coverage at this job? Kristen Ford	**Phone Number:** 816.881.1206 **Email Address:** kdford@jacksongov.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  All employees. Eligible employees are:

  ✔ Full time employees, working a minimum 30 hours per week on a regular basis.

- With respect to dependents:

  ✔ We do offer coverage. Eligible dependents are: Spouses and dependents up to the age of 26 of full-time employees.

  ✔ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

YOUR NOTES

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The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.