Jackson
HEALTH SYSTEM

Miracles made daily.

Strong. Healthy. United.

YOUR WELLNESS JOURNEY

2023 EMPLOYEE BENEFITS GUIDE

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ONLINE RESOURCES:

Click below to view important information:

- **Jackson Benefits Website JacksonBenefits.org**
- **Enroll Online myfbmc.com**
- **View the 2023 Benefits Reference Guide**
- **Make an appointment at https://fbmc-scheduler.com/JHS-OE or use the QR code below:**

SCAN ME

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 56 for more details.

WHAT'S HAPPENING AT JHS?

Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

STAY CONNECTED

For news and happenings across all campuses, visit jacksonhealth.org/newsroom and follow JacksonHealth on social media.

MORE CONTACT INFO

For more information, you can contact the FBMC Benefits Management, Inc. Service Center at 855-56JHS4U (855-565-4748), Monday- Friday, 7 a.m. - 7 p.m. ET. You can also contact the on-site FBMC Service Center at 305-585-6512 or visit the office at 1611 N.W. 12th Avenue, Park Plaza West L-109B, Miami, FL 33136-1096 or email JHSFieldOffice@fbmc.com.

Connect With Us

JacksonBenefits.org

Important Dates to Remember

Your Open Enrollment dates are:
Nov. 7, 2022 through Nov. 23, 2022

Your plan year dates are:
Jan. 1, 2023 through Dec. 31, 2023

Think of Jackson First

KEY THINGS TO KNOW

2023 Plan Highlights

Welcome To Your 2023 Jackson Health System Benefits Open Enrollment!

Review and update your current benefit elections. Read this guide to understand how benefit changes may impact you and your covered dependents, effective Jan. 1, 2023.

- **This is a REQUIRED enrollment:** If you do not enroll during the Open Enrollment period, your current medical coverage and those of your dependents will be auto assigned to the Jackson First HMO Plan. All other benefits and those of your dependents will roll over for the 2023 Plan Year with the exception of any flexible spending accounts (FSA). If you are currently enrolled in an FSA and wish to continue, you must annually re-enroll.
- **Wellness Medical Premiums:** All employees enrolled in a medical plan had the opportunity to secure a wellness medical premium rate for the 2023 Plan Year. Employees who did not complete their wellness visit will see an increase of $50 bi-weekly for the 2023 Plan Year.

What's New?

- **Medical Premium Increase of 10% for all plans with the exception of the Jackson First HMO.** Please refer to page 13 of this Benefits Reference Guide for more details.
- **There will also be a Dental Increase of 10%**. Please refer to page 24 of this Benefits Reference Guide for more details.
- **Dental PPO Plan Design Enhancements:**
  - The maximum benefit amount for the Dental PPO Enriched plan will increase from $1,500 to $2,000
  - The Orthodontia lifetime maximum benefit amount will increase from $1,000 to $1,300
  - Implants will now be covered at 50% up to the annual maximum benefit amount
  - Temporomandibular Joint disfruntion (TMJ) night guards will be covered at 50% up to the annual maximum benefit amount
- **Flexible Spending Account max increased to $2,850**

Important Reminders

- **Jackson Select HMO:** Offers the "Away from Home" wraparound program for covered dependents who reside outside the tri-county area (Miami-Dade, Broward and Palm Beach). **Please complete an "Away from Home" form available on JacksonBenefits.org**
- **Jackson First HMO** Jackson First Rider ($45 per pay period) plan will offer the "Away from Home" wraparound program, known as the Jackson Rider for covered dependents who reside outside the tri-county area (Miami-Dade, Broward and Palm Beach). Please complete an "Away from Home" form available on **JacksonBenefits.org**.
- **Wellness Medical Premiums: Complete an annual wellness visit with your respective provider.**
- An Over Age Dependent Affidavit is required yearly.
- Dependent Verification Documents are required for any newly added dependent.

KEY THINGS TO KNOW

UHealth Jackson Urgent Care

At UHealth Jackson Urgent Care we provide the highest standard of care, while keeping you safe. With our board-certified physicians from the University of Miami Health System on site 365 days a year*, you'll get the treatment you need—so you can get back to being you again.

UHealth Jackson Urgent Care

Walk-ins welcome. Most insurance plans accepted.

To reserve your spot, visit **JacksonUrgentCare.com**.

Country Walk
13707 S.W. 152nd St.
Miami, FL 33177
305-585-9200
8 a.m. – 8 p.m.

Cutler Bay
18910 South Dixie Hwy.
Cutler Bay, FL 33157
305-585-9230
8 a.m. – 8 p.m.

Doral
7400 N.W. 104th Ave.
Doral, FL 33178
305-585-9250
8 a.m. – 8 p.m.

Keystone Point
13120 Biscayne Blvd.
North Miami, FL 33181
305-585-9210
8 a.m. – 8 p.m.

North Dade
16555 N.W. 25th Ave.
Miami Gardens, FL 33054
786-466-1900
Monday – Saturday:
8 a.m. – 8 p.m.
Sunday: Closed.

*Our charges for medical services are less than the charges for comparable medical services at Jackson Memorial Hospital. *North Dade Urgent Care is closed on Sundays.*

BOARD CERTIFIED DOCTORS ALWAYS ON DUTY.

JMG PHYSICIANS DIRECTORY

Meet the Jackson Medical Group Doctors!

Meet Our Miracle Workers.

Welcome to Jackson Medical Group. Jackson Health System's specialty physician group provides patients convenient, high-quality options close to home and work. To make it even easier to access our specialists, we've created this directory for patients and their doctors. Now you have world-renowned care right at your fingertips.

For full physician bios, visit JacksonMedicalGroup.org.

Physician Directory

1. Jackson Medical Group | Jackson North
2. Colorectal And Minimally Invasive Surgery Specialists
3. Jackson Medical Group | Jackson South
4. Jackson Medical Group and Jackson Heart Institute | Health District
5. Jackson Orthopedics Center | Kendall
6. Jackson Maternal-Fetal Medicine Center | Kendall
7. Jackson Medical Group | Jackson West

A Network of Miracle Workers.

To make an appointment, call 305-585-4JMG or visit JacksonMedicalGroup.org.

North Miami Beach Practices

Jackson Medical Group | Jackson North
100 N.W. 170th Street, Suite 410
North Miami Beach, FL 33169

Jackson Heart Institute

Cardiac Electrophysiology

Assaf Tzur, MD

Interventional Cardiology

Bashar Obeidat, MD, FACC, FSCAI

Camilo A. Gomez, MD

Hector Rivera, MD, FACP

Gastric Sleeve Center

Bariatric & General Surgery

Elias Chousleb, MD, FACS

Gastroenterology

William Rengifo-Cam MD, PhD

Orthopedics and Sports Medicine

José Inzunza, MD

Orthopedic Surgery

Jeffrey Rich, DO

Obstetrics And Gynecology

Adrian Roznowski, MD, FACOG

Jamell Walker, MD

Urology & Urologic Oncology

Abhishek Bhat, MD

Primary Care

Shamfa Joseph, MD

Downtown Practices

Jackson Medical Group | Health District
1801 N.W. 9th Avenue, Second Floor
Miami, FL 33136

Obstetrics And Gynecology

Rachel Franklyn, MD

Angela Reyes Truong, MD, FACOG

Dana Horner, MD, FACOG

Catherine G. Hoeppner, MD, MS

Maternal-Fetal Medicine

Yvette Cordova, MD, FACOG

Carmen M. Tudela, MD, FACOG

Felipe Tudela, MD, FACOG

Endocrinology

Daisy Acevedo, MD

Primary Care

Berta Pita, MD

Urology & Urologic Oncology

Abhishek Bhat, MD

Jackson Heart Institute | Health District
1801 N.W. 9th Avenue, Suite 600
Miami, FL 33136

Jackson Heart Institute

Interventional Cardiology

Alexandre Ferreira, MD, FACC

Cesar Mendoza, MD, FACC, FSCAI

Joao Braghiroli, MD, FACC

Cardiac Electrophysiology

Ivan Mendoza, MD, FACC

Chaitra Mohan, MD

General Cardiology

Ivan Buitrago, MD

Rosario Colombo, MD, FACC

General Cardiology

Anita Veerani, MD, FACC

Rhea Sancassani, MD, FACC

Jorge L. Penalver, MD

Cardiac Surgery

Romualdo Segurola, MD, FACS

Efren Buitrago, MD

Julius A. Carrillo, MD

South Miami Practice

Colorectal And Minimally Invasive Surgery Specialists
9195 Sunset Drive, Suite 230
Miami, FL 33173

Colorectal & General Surgery

Gustavo Plasencia, MD

Rene Hartmann, MD

Henry Lujan, MD

Marianna Zeichen, MD

South Dade Practices

Jackson Medical Group | Jackson South
9380 S.W. 150th Street, Second Floor
Miami, FL 33176

Jackson Heart Institute

General Cardiology

Ivan Buitrago, MD

Jose Luis Velazquez Cocana, MD

Cardiac Electrophysiology

Ivan Mendoza, MD, FACC

Interventional Cardiology

Juan Zambrano, MD, FACC, FSCAI

Bashar Obeidat, MD, FACC, FSCAI

Gastric Sleeve Center

Bariatric & General Surgery

Moises Jacobs, MD, FACS

Eddie Gomez, MD, FACS, FASMBS

Roderick Romero, MD, FACS

Kendall Practice

Jackson Orthopedics Center | Kendall
7887 North Kendall Drive, Suite 225
Miami, FL 33156

Orthopedic Surgery

Jeffrey Rich, DO

Orthopedics and Sports Medicine

José Inzunza, MD

Kendall Practice

Jackson Maternal-Fetal Medicine Center | Kendall
11760 S.W. 40th Street, Suite 646
Miami FL, 33175

Yvette Cordova, MD, FACOG

Carmen M. Tudela, MD, FACOG

Felipe Tudela, MD, FACOG

Doral Practices

Jackson Medical Group | Jackson West
2801 N.W. 79th Avenue, Suite 402
Doral, FL 33122

Jackson Heart Institute

Interventional Cardiology

Camilo A. Gomez, MD

Cardiac Electrophysiology

Ivan Mendoza, MD, FACC

Colorectal & General Surgery

Gustavo Rubio, MD

Gastric Sleeve Center

Bariatric & General Surgery

Eddie Gomez, MD, FACS, FASMBS

Irving Miranda, MD

ELIGIBILITY + COVERAGE

Who is Eligible for Coverage?

Jackson Health System Employees: Any full-time employee, Housestaff employee, or part-time employee with benefits status is eligible for coverage.

New Hires: Newly-eligible employee benefits become effective the first of the month following a 60-day waiting period from the date of hire. New Housestaff medical, dental, vision, and FSA benefits become effective the first day of employment.

Change In Status: Any employee changing employment status from non-benefit eligible to benefits eligible. Medical, dental, vision, and FSA Benefits become effective the first day of the change.

Note: New hires and election change event employees have 45 days from date of hire or date of change to complete their 2023 benefits selection through Lawson Employee Self Service (ESS). New Housestaff select their benefits through New Innovations during their hiring process. If you do not enroll within the allotted time, you will be auto-assigned to Jackson First HMO, employee-only coverage.

Premiums

According to current IRS regulations, insurance premiums for domestic partners and/or DP's child(ren) must be deducted on a post-tax basis and subject to imputed income tax.

The IRS rules prohibit changing premiums mid-year from pretax to post-tax (or vice-versa). For example: An employee who elects "Employee + Child(ren)" covers his/her own child(ren) with pretax premiums. If the employee adds his/her Domestic Partner's child during the plan year, the premiums become post tax. IRS rules govern post-tax elections during the plan year, so you must wait until the next Open Enrollment to add your DP's child.

Dependent Eligibility

Eligible Dependents include:

- Spouse
- Dependent Children**
- Domestic Partner**
- Children
- Newborn Children
- Disabled Children
- Grandchildren****

DEPENDENT QUALIFYING DOCUMENTATION INFORMATION >>

AVMED OVER AGE DEPENDENT AFFIDAVIT HERE >>

* Your spouse is considered your eligible dependent for as long as you are lawfully married, unless he/she is also a Jackson Health System benefits-eligible employee. If you are both employed by Jackson Health System and eligible for benefits, separate coverage must be maintained by each employee.

** Children can include natural born children, stepchildren, adopted children, children of a domestic partner and children for whom you have been appointed legal guardian. Your child(ren) is/are not considered an eligible dependent for coverage if employed by Jackson Health System and eligible for benefits. The Affordable Care Act permits married or unmarried dependent children to be covered under the medical plans to the last day of the calendar year that they reach the age of 26. An unmarried dependent child may be covered for medical beyond age 26 to age 30, if the criteria established by Florida Statutes is satisfied. Dependent children enrolled for dental, vision, and life insurance coverage are eligible to the end of the calendar year in which they turn age 26.

***Jackson Health System extends health insurance eligibility and other benefits to domestic partners (DP) of Jackson Health System Employees. This applies to both same sex and common law relationships. Benefit plans for an employee's spouse and dependent children (medical, dental, vision, and voluntary benefit plans are extended to include domestic partners and their dependent children). Eligibility does not extend to include expense reimbursement for healthcare or dependent care spending accounts for DP's and their children. **Affidavit is required and need to be issued before coverage is effective.**

**** Grandchildren can be added to the plan from birth for 18 months max, if the parent is currently covered under the group.

ELIGIBILITY + COVERAGE

Affordable Care Act

Affordable Care Act (ACA) Employer Mandate – Any employee who is currently not eligible for health insurance (e.g., on-call/pool, TR, PT No Benefits) and has worked 30+ hours per week during the annual measurement period of Oct. 12, 2021 to Oct. 11, 2022, can enroll in medical insurance at Open Enrollment with an effective date of January 2023.

Imputed Income

The Internal Revenue Service allows employees to receive health insurance subsidies for themselves and their eligible dependents "tax free," as defined under IRS guidelines, excluding amounts attributable to coverage of adult children, a Domestic Partner (DP) and/or dependents of a DP who are not tax dependents of the employee. Where such coverage is paid by pretax contributions, Jackson Health System must include the fair market value of the coverage in the employee's income, referred to as "imputed income," and this imputed income will be taxed accordingly. Imputed income is adding value to cash or non-cash employee compensation to accurately withhold employment and income taxes. Basically, imputed income is the value of any benefits or services provided to an employee. Employers must add imputed income to an employee's gross wages to accurately withhold employment taxes.

Changes During the Year

The IRS requires your participation in the Flexible Benefits Plan to continue for the entire plan year, which is Jan. 1 through Dec. 31, 2023. You can change your pretax benefit election during the plan year ONLY if you experience a permitted election change event, as authorized by the IRS and in accordance with your employer's plan. Complete your Election Change Event form online at **JacksonBenefits.org**. The requested change must be consistent with the event. The request must be submitted to the on-site FBMC Service Center with the appropriate documentation within 30 days of the event.

If your covered dependents become ineligible during the plan year, you must notify the on-site FBMC Service Center within 30 days. Your notification must include the appropriate documentation of the ineligibility to allow for any reduction in premiums. Failure to notify the FBMC Service Center may result in excess premiums being deducted from your pay, which cannot be refunded, and no coverage will be available to your dependents.

Dependent Eligibility Verification

Dependent Eligibility Verification is required for newly added dependents. Please provide the proof of eligibility/verification and Social Security numbers for all dependents you would like to cover through any Jackson Health System-sponsored health insurance benefit plan by November 23th 2022, or through the end of your New Hire enrollment period. Failure to provide verification documentation for your dependents will result in the inability to enroll them in coverage. You may provide your documents during Open Enrollment, or at the end of your New Hire enrollment period at the on-site FBMC Service Center on the main campus in Jackson Towers or fax it to 305-355-2324 or email JHSFieldOffice@fbmc.com.

Official documents of birth and/or marriage from anywhere in the United States may be obtained through **vitalchek.com** or by calling 866-285-7453 (some fees may apply). All documents provided during the dependent verification audit are securely stored and protected through physical, electronic, and procedural safeguards.

All documentation must be submitted no later than the end of your enrollment, in order to begin coverage for your dependents.

CLICK HERE FOR DEPENDENT VERIFICATION FORM >>

ELIGIBILITY + COVERAGE

Special Enrollment Rights Pertaining to Medical Benefits

You may decline medical insurance coverage for yourself and your dependents (including your spouse) because of other health insurance coverage. You may, in the future, be able to enroll yourself and your dependents in your employer's plan – provided that you follow the directions outlined in the Changes During the Year section listed above.

Over Age Dependents (Age 26-30):

1. Notarized Affidavit of Extended Eligibility
2. Submit one of the following:
   a. A copy of your dependent's Fall 2022 or Spring 2023 semester school schedule or letter from the school verifying that your child is a student enrolled for Fall 2022 or Spring 2023
   b. OR, a copy of your child's Florida drivers license, FL issued ID, or FL Voters ID
   c. If your dependent is residing outside of the state of Florida, a school schedule is REQUIRED
3. If you are newly enrolling a dependent who was not covered under your plan for 2022, you must submit a Certificate of Creditable Coverage or any other documentation that shows proof of prior coverage without a gap of more than 63 days

ELECTION CHANGE EVENT CHART HERE >>

FLEXIBLE BENEFITS PLAN

Jackson Health System offers the Flexible Benefits Plan to help you reduce your taxes and increase your spendable income. You reduce your benefit costs when you pay certain benefits and expenses through the plan.

How does the Flexible Benefits Plan Work?

1. You select the benefits you and your family need — Group Medical, Group Dental and Group Vision, Healthcare and/or Dependent Care Flexible Spending Account (FSA) and Short-Term and Long-Term Disability Income Protection. Each pay period, all tax-free premium deductions for benefits you have chosen are taken from your pay before federal income and Social Security taxes are calculated. This reduces your tax liability so you pay less tax.

   Note: If disability premiums are paid entirely with pretax dollars, disability benefits are taxable. If disability premiums are paid entirely with after-tax dollars, disability benefits are not taxable.

2. After all tax-free premiums have been deducted, Federal Income and Social Security taxes are calculated on the remainder of your salary.

3. The amount remaining in your paycheck is your take-home pay for that pay period after premiums have been deducted. Since you have paid less tax, you have more spendable income.

How much does it cost?

The administrative fee for your Flexible Benefits Plan is $0.75 per pay period for your medical, and/or dental plan premiums (if your premiums total $10 or more), Vision $0.20, and $1.66 per pay period for each Flexible Spending Account. Your overall administrative fees for the Flexible Benefits Plan will not exceed $3.35 per pay period. The tax savings you receive from participation in the Flexible Benefits Plan far outweigh the administrative fees, which are also tax free. *The breakdown above is representing 2022 Administrative Fee and subject to change/increase.

Annual Enrollment Appeals

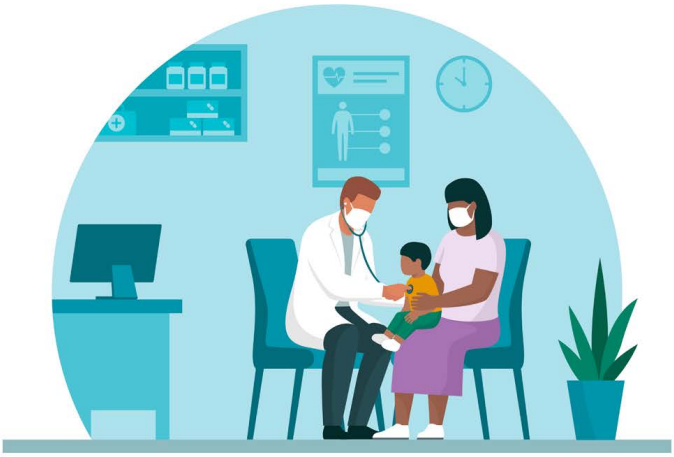
Appeals are approved only if the extenuating circumstances, as supported by written documentation, are authorized by the plan, carrier, and IRS regulations. If you are denied a request for a mid-plan year election change or post annual enrollment change request, you have the right to appeal the denial by sending a written request for review within 30 days of your receipt of denial to:

On-site FBMC Service Center
Jackson Memorial Hospital
Fax: 305-355-2324

How may FSA contributions affect my Federal Earned Income Tax Credit (EITC)?

Payroll contributions made through an FSA will lower your taxable income and taxes. Payroll deductions (including contributions to one or both FSAs) will reduce earned income for purposes of the Federal Earned Income Tax Credit (EITC). Depending on your income level, your EITC may either increase or decrease if you make payroll deductions through an FSA. This means that for some of you, participation in either FSA or both may provide you an additional advantage by increasing your EITC (based on 2022 tax tables).

MEDICAL PLANS



Group Medical Plans

What AvMed medical plans are offered?

- Jackson First HMO
- Jackson Select HMO
- Jackson Point of Service (POS)

NOTE: Members are required to select a primary care physician if selecting health insurance.

Jackson First HMO

Plan offers "no referral needed" to access the Jackson-only network. Employee and covered dependents must reside in Miami-Dade, Broward or Palm Beach Counties. The plan provides 100% of benefits for services performed at Jackson Health System facilities and University of Miami (except emergency care) or by any AvMed physician with admitting privileges at Jackson Health System. Concierge services are available under this plan.

- No deductibles
- No copays
- No coinsurance
- Concierge services

Jackson First Rider: Jackson First Rider ($45 per pay period) Designed for dependents living outside of the South Florida coverage service area. Offers nationwide network for dependents residing outside the service area. "Away from Home" form required.

Jackson Select HMO

Plan offers "no referral needed" to access the Jackson Select HMO Network of providers. The plan provides 100% of benefits for covered services after applicable copays. Concierge services and SmartShopper benefits are available under this plan. Provides an "Away from Home" wraparound program for dependents who reside outside of the coverage area.

Jackson Point of Service (POS)

IN NETWORK - Plan offers "no referral needed" to access an expanded network of providers. The plan provides 100% of benefits for covered services after the applicable copayments. SmartShopper benefits are available under this plan.

OUT OF NETWORK - A fee for service program that provides you the freedom to use any physician or accredited hospital of your choice outside of the network. Payments are based on Maximum Allowable Payment (MAP) charges. Providers who do not participate in the network may balance bill you for the amount which exceeds MAP. Coverage is subject to deductibles and coinsurance.

Why I Choose
Jackson First

"There's no better feeling than knowing I can get the medical help I need without stressing about how much it'll cost me. In these current financial times, health insurance, specifically Jackson First, feels like a luxury to have. I'm grateful to be able to take advantage of it."

– Valmarie Montes De Oca, Associate Administrator, Rosie Lee Wesley Health Center

To learn more about the Jackson First HMO or to enroll online, visit **JacksonBenefits.org**.

MEDICAL PLANS

Understanding Your Medical Options

Is my group medical coverage guaranteed?

Yes. Enrollment in any of the group medical plans is guaranteed for those eligible.

How do I pay for these medical plans?

Medical plans are paid through automatic, biweekly payroll deductions. Premiums are deducted from your salary on a pretax* basis to pay for any medical insurance premiums before Federal Income and Social Security taxes are calculated. This reduces your taxable income and increases your spendable income.

How much do the plans cost?

Premiums vary according to the plan you select. Jackson Health System will pay the cost of your personal coverage in the Jackson First HMO medical plan. Dependent premiums are your responsibility and will be deducted from your biweekly check.

Eligible employees will be required to pay a portion of the employees premium for the Jackson Select HMO and Jackson Point of Service (POS) plans.

*Note: Premiums are deducted from your salary on a post-tax basis for Domestic Partners and Adult Children.

Why I Choose Jackson First

Plumber, Engineering Services, Jackson Memorial Hospital

"For many years while working in construction, I had never been a part of an organization that offered health care, let alone free health care. People don't understand how important it is to have insurance until it's too late. I'm truly blessed to work somewhere that puts the care of their employees first. It gives me peace of mind that not only am I healthy, but I if ever need medical care in the future, Jackson First has me covered."

– Jasmanny Alex Medina, Plumber, Engineering Services, Jackson Memorial Hospital

To learn more about the Jackson First HMO or to enroll online, visit **JacksonBenefits.org**.

Did You Complete Your Wellness Visit?

Employees have the Fiscal Year 2023 (Oct. 1, 2022 - Sept. 30, 2023) to complete an annual wellness visit with their respective provider; employees who do not complete their wellness visit will see an increase of $50 bi-weekly for the 2024 Plan Year.

CLICK TO DOWNLOAD THE ANNUAL WELLNESS VISIT - PROVIDER VERIFICATION FORM >>


Jackson HEALTH SYSTEM

2023 Annual Wellness Visit
PROVIDER VERIFICATION FORM

HEALTHCARE PROVIDER MUST PROVIDE CERTIFICATION BY COMPLETING THIS FORM

Employee Name (Print): _____

Phone Number: _____ Lawson # / Badge # _____

I attest that all information is true and accurate. If document is falsified I will be responsible for paying retroactive surcharges and may face disciplinary action up to and including termination of employment.

Signature of Employee: _____

PHYSICAL PROVIDER MUST SIGN AND DATE THE BELOW

SCREENING COMPLETED BY:

Date of Visit: ____ / ____ / ____

Healthcare Provider Name (Print): _____

Healthcare Provider's Signature: _____

Healthcare Provider's Phone Number: _____

Healthcare Provider's Address: _____

Street Address

City, State, & ZIP

MD Office Stamp

A primary care annual wellness visit will include the vital signs, (height, weight, pulse, BP, BMI), the history, physical exam, labs ((CBC, CMP, Lipid panel, UA), immunization assessment, and Mammogram/Colonoscopy (as appropriate)).

The provider verification form can be found and submitted on Lawson Employee Self-Service under the "Wellness" section and "Annual Wellness Visit." To find a primary care physician near you, visit AuMed.org/jhs. Please note: Wellness visits are 100 percent covered when using one of Jackson's health plans at any location of your choosing.

When you stay up-to-date on preventive healthcare, you are taking action toward a longer, healthier, and happier life!

For questions, please call 305-585-LIVE or email HR-Benefits@jhsmiami.org.

MEDICAL PLANS

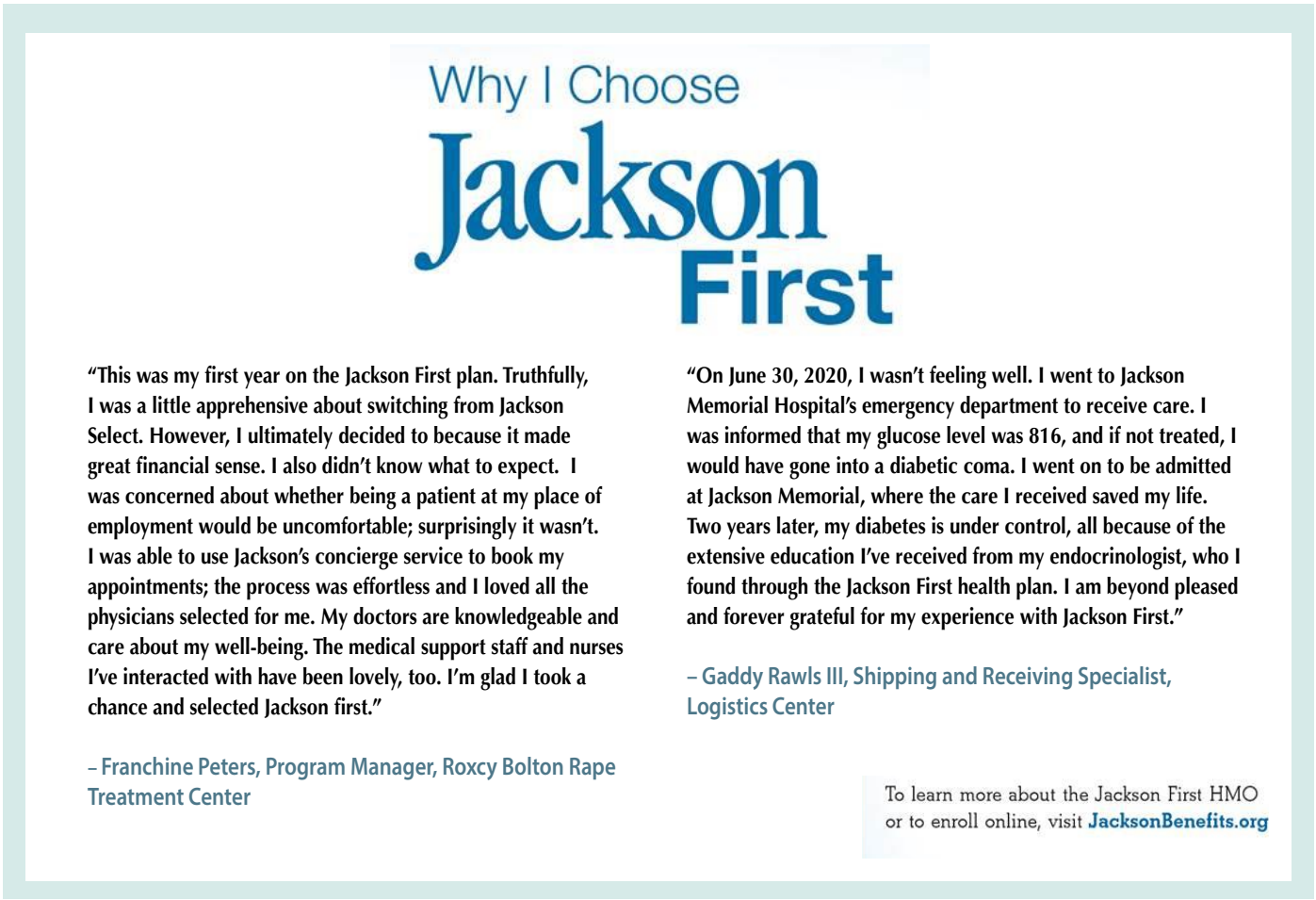
Medical Biweekly Rates

AvMed Employee, Spouse, Domestic Partner & Child(ren)

	WELLNESS MEDICAL PREMIUM		
	JACKSON FIRST HMO PLAN	JACKSON SELECT HMO PLAN	JACKSON POS PLAN
Employee	$0.00	$55.00	$165.00
Employee + Child(ren)†	$105.00	$188.01	$419.48
Employee + Spouse/DP	$120.00	$221.43	$505.59
Family†	$160.00	$314.98	$873.98

† Option also applies to Adult Child(ren) (AC) between 26 through 30 years of age and/or Child(ren) of a Domestic Partner (CDP)

Premiums above are subject to the completion of your Annual Wellness. If you did not complete your wellness visit, your premiums will include an additional $50 increase bi-weekly.



MEDICAL PLANS

Understanding Your Medical Options

2023 MEDICAL PLAN CHARTS - avmed.org/jhs		
	JACKSON FIRST HMO	**JACKSON SELECT HMO**
	• Freedom to choose from a variety of JHS and UM healthcare professionals. • Jackson First Rider Wraparound: separate plan with buy-up option of $45 per pay period; designed for dependents living outside of South Florida. • Access to a concierge appointment scheduling • Savings of up to $4,029.35 annually	HMO Plan offered to Jackson Health System employees and covered dependents who reside or work in Miami-Dade, Broward and Palm Beach counties. Members who enroll in the JHS Select Network plan must receive all medical care except for emergency and urgent care services through an AvMed contracted Jackson Health System Select HMO Network Provider. • Offers nationwide network for dependents residing outside of service area
Concierge Services	Concierge Services Available	Concierge Services and Smartshopper Benefits Are Available
Deductibles	$0	$0
PCP Office Visits	$0	$15
Specialist Office Visits	$0	$30
Preventive Services	$0	$0
Pediatrician Office Visits	$0	$15
Routine Physical	$0	$0
Obstetrical/Gynecological	$0	$30
Maternity	$0	$30 Copay for First Visit. No Charge For Subsequent Visits
Preventive Mammogram/Pap Smears	$0	$0
Hospitalization - In-Patient	Benefits Covered At 100%	Benefits payable at 100% after $100 copayment
Urgent Care	$50 participating; $100 non-participating; $5 copay/visit at Uhealth Jackson Urgent Care Centers	
Emergency	$100 copay, or $50 if 17 and under (waived if admitted)	$100 copay, or $50 if 17 and under (waived if admitted)
Outpatient Surgery	$0	$200

MEDICAL PLANS

Understanding Your Medical Options

2023 MEDICAL PLAN CHARTS - avmed.org/jhs		
	JACKSON POS IN NETWORK	**JACKSON POS OUT OF NETWORK**
	Access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area.	A fee for service program that provides Jackson Health System employees and covered dependents the freedom to use any physician or accredited hospital of their choice outside of the network. Payments are based on maximum allowable payment (MAP) charges. Providers who do not participate in the network may balance bill members for the amount which exceeds MAP. Coverage is subject to deductibles and coinsurance.
Concierge Services	Smartshopper Benefits Are Available	Smartshopper Benefits Are Available
Deductibles	$0	$200 Deductible Individual/$500 Family
PCP Office Visits	$15	Plan Pays 70% Coinsurance, After Deductible Is Met
Specialist Office Visits	$30	Plan Pays 70% Coinsurance, After Deductible Is Met
Preventive Services	$0	Plan Pays 70% Coinsurance, After Deductible Is Met
Pediatrician Office Visits	$15	Plan Pays 70% Coinsurance, After Deductible Is Met
Routine Physical	$0	Plan Pays 70% Coinsurance, After Deductible Is Met
Obstetrical/Gynecological	$30	Plan Pays 70% Coinsurance, After Deductible Is Met
Maternity	$30 copay for first visit. No charge for subsequent visits.	Plan Pays 70% Coinsurance, After Deductible Is Met
Preventive Mammogram/Pap Smears	$0	Plan Pays 70% Coinsurance, After Deductible Is Met
Hospitalization - In-Patient	Benefits payable at 100% after $200 copayment	Plan Pays 70% Coinsurance, After Deductible Is Met
Urgent Care	$100 at both participating and non-participating; $5 copay/visit at Uhealth Jackson Urgent Care Centers	
Emergency	$150 copay/$100 for age 17 and under (Waived if Admitted)	$150 copay/$100 for age 17 and under (Waived if Admitted)
Outpatient Surgery	Benefits payable at 100% after $200 copayment	Plan Pays 70% Coinsurance, After Deductible Is Met

Chart continued on next page.

MEDICAL PLANS

2023 MEDICAL PLAN CHARTS - avmed.org/jhs		
	JACKSON FIRST HMO	**JACKSON SELECT HMO**
Prescription Drugs	If member/physician selects brand when generic is available, member pays difference in cost plus brand copayment. **Participating pharmacy retail are CVS, Target, Navarro and Publix (in addition to JHS pharmacies)**. No charge for generic medications under Jackson First HMO for employees using the Jackson pharmacy.	
Participating Network Pharmacy	$15 Generic/$25 Brand/ $40 Non-Preferred For 30-Day Supply	$15 Generic/$25 Brand/ $40 Non-Preferred For 30-Day Supply
Mail Order	$30 Generic/$50 Brand/ $80 Non-Preferred For 90-Day Supply	$30 Generic/$50 Brand/ $80 Non-Preferred For 90-Day Supply
Specialty Rx	$50 For 30-Day Supply Through Specialty Pharmacy	$50 For 30-Day Supply Through Specialty Pharmacy
Substance Abuse Treatment		
Inpatient	$0	$100
Outpatient	$0	$15 per visit
Behavioral Health		
Inpatient	$0	$100
Outpatient	$0	$15 per visit
Durable Medical Equipment (DME)	$50 Per Episode Per Illness	$50 Per Episode Per Illness
Coverage Area	Jackson Health System; University of Miami • Dependents residing outside the network area may be covered through the PCHS network by electing to buy into the Jackson First Rider. Must complete a "Away From Home" form	Network includes over 33 hospitals and over 7,000 physicians. All AvMed participating providers with admitting privileges at one of the covered hospitals are also covered in the Select HMO. Dependents residing outside the network area may be covered through the PHCS network (Must complete "Away From Home" form for approval).

MEDICAL PLANS

2023 MEDICAL PLAN CHARTS - avmed.org/jhs		
	JACKSON POS IN NETWORK	**JACKSON POS OUT OF NETWORK**
Prescription Drugs	Includes prescription contraceptives at participating pharmacies nationwide. **Participating pharmacy retail are CVS, Target, Navarro and Publix (in addition to JHS pharmacies)**. If member/physician selects Brand when Generic is available, member pays difference in cost plus Brand copayment.	
Participating Network Pharmacy	$15 Generic/$40 Brand/ $55 Non-Preferred For 30-Day Supply	Plan Pays 70% Coinsurance, After Deductible Is Met
Mail Order	$30 Generic/$80 Brand/$110 Non-Preferred For 90-Day Supply	Plan Pays 70% Coinsurance, After Deductible Is Met
Specialty Rx	$100 For 30-Day Supply Through Specialty Pharmacy	Plan Pays 70% Coinsurance, After Deductible Is Met
Substance Abuse Treatment		
Inpatient	Benefits Paid At 100%, After $200 Copayment	Plan Pays 70% Coinsurance, After Deductible Is Met
Outpatient	$15 per visit	Plan Pays 70% Coinsurance, After Deductible Is Met
Behavioral Health		
Inpatient	Benefits Paid At 100%, After $200 Copayment	Plan Pays 70% Coinsurance, After Deductible Is Met
Outpatient	$15 per visit	Plan Pays 70% Coinsurance, After Deductible Is Met
Durable Medical Equipment (DME)	DME And Orthotic Covered At 100%. External Prosthetic Appliance - No Charge After $200 Deductible Per Contract Year.	Plan Pays 70% Coinsurance, After Deductible In MET For DME and Orthotic. External Prosthetic Appliance Not Covered Out Of Network.
Coverage Area	Covers hospitals excluded on the Select Plan. Dependents residing outside the network area may be covered through the PHCS network (Must complete "Away From Home" form for approval).	N/A

HEALTH + WELLNESS

Additional AvMed Features MDLive

VIRTUAL VISITS ANYWHERE, ANYTIME. 24/7/365 ACCESS TO HEALTHCARE PROVIDERS

AvMed Virtual Visits, powered by MDLIVE®, are available to all Jackson employees and dependents covered under any of the AvMed medical plans. It provides remote access to board-certified doctors from your home, office, or on the go. All you have to do is register online. Members can speak with a doctor about non-emergency medical issues by phone or by secure video using a computer, tablet, or smartphone, for only a $10 copay. Virtual Visits can be used to treat minor illnesses and injuries, including but, not limited to:

- Acne
- Headache
- Constipation
- UTI
- Pink eye
- Cough
- Fever
- Sore throats
- Insect bites
- Cold/flu
- Earache
- Rash
- Allergies
- Respiratory problems
- Nausea/ Indigestion

Register online: bit.ly/Avmedvirtualvisits **or** by phone: 1-888-834-1532 or by downloading the "MDLIVE" app
Employer Code: AvMed

Smartshopper

How AvMed SmartShopper Works

1. Your doctor recommends a qualifying procedure.
2. Call SmartShopper at 1-866-285-7453 and a Health Cost Adviser will provide cost-effective locations in your area for your doctor's recommended service. Have your member ID for verification. You may also shop online at AvMed.VitalsSmartShopper.com.
3. Then, contact your doctor to schedule the service and inform Contact AvMed SmartShopper AT LEAST 24 hours before the procedure to qualify for the incentive.
4. If you choose to use a cost-effective location, as identified by AvMed SmartShopper, you will receive an incentive check in the mail within 60 days after your claim has been paid.

CLICK TO VIEW THE SMARTSHOPPER FLYER >>

CASH INCENTIVES ON MEDICAL PROCEDURES AND DIAGNOSTIC TESTS

AvMed continues to offer SmartShopper for Plan Year 2023. When enrolling in Jackson Select HMO and Jackson POS Plan, you have a chance to earn cash back while saving on healthcare costs. **Please note that Jackson First medical plan does not qualify for Smartshopper services.**

- Medical procedures or diagnostic tests can qualify you or your dependents for a $25-$500 CASH BACK when you shop with SmartShopper!
- To access SmartShopper, go to AvMed.VitalsSmartShopper.com or call 1-866-285-7453 to shop healthcare services in your area.

Reduced Copays When Using Jackson

Jackson Health System is dedicated to providing quality and cost-effective healthcare benefits that meet the needs of our employees and their dependents. All employees, regardless of the plan you enroll in, will be eligible for lower copayments for most services received at Jackson Providers. To access the Jackson Providers, go to avmed.org/jhs.

	ENROLLED IN JACKSON SELECT HMO		ENROLLED IN JACKSON POS IN NETWORK	
	USE A JACKSON PROVIDER AND PAY	OTHER JACKSON SELECT HMO NETWORK PROVIDERS YOU PAY	USE A JACKSON PROVIDER AND PAY	OTHER JACKSON POS IN NETWORK PROVIDERS YOU PAY
PCP Office Visit	$5	$15	$5	$15
Specialist Office Visit	$15	$30	$15	$30
Pediatrician Office Visit	$5	$15	$5	$15
Maternity Office Visits (1st visit only. No charge for subsequent visits)	$15	$30	$15	$30
Inpatient Facility	$0	$100	$0	$200
Outpatient Surgery	$0	$200	$0	$200
Behavioral Health Outpatient	$5	$15	$5	$15
Substance Abuse Outpatient	$5	$15	$5	$15
Behavioral Health Inpatient	$0	$100	$0	$200
Substance Abuse Inpatient	$0	$100	$0	$200

HEALTH + WELLNESS

Annual Wellness Visit

When you have an annual wellness visit with your healthcare provider, you are taking steps to achieve the best possible health status. Creating a continuing, trusting relationship with a healthcare provider has immense value. They know you and your history, allowing them to recognize changes in your health. By completing your annual wellness visit, you will have an opportunity to secure a wellness rate for the 2024 Plan Year.

Employees have Fiscal Year 2023 (Oct. 1, 2022 – Sept. 30, 2023) to complete an annual wellness visit with their respective physician; employees who do not complete their wellness visit will see an increase of $50 biweekly for the 2024 Plan Year.

CLICK TO DOWNLOAD THE ANNUAL WELLNESS VISIT - PROVIDER VERIFICATION FORM >>


Jackson HEALTH SYSTEM

2023 Annual Wellness Visit
PROVIDER VERIFICATION FORM

HEALTHCARE PROVIDER MUST PROVIDE CERTIFICATION BY COMPLETING THIS FORM

Employee Name (Print): _____

Phone Number: _____ Lawson # / Badge # _____

I attest that all information is true and accurate. If document is falsified I will be responsible for paying retroactive surcharges and may face disciplinary action up to and including termination of employment.

Signature of Employee: _____

PHYSICAL PROVIDER MUST SIGN AND DATE THE BELOW

SCREENING COMPLETED BY:

Date of Visit: ____ / ____ / ____

Healthcare Provider Name (Print): _____

Healthcare Provider's Signature: _____

Healthcare Provider's Phone Number: _____

Healthcare Provider's Address: _____

Street Address _____

City, State, & Zip _____

MD Office Stamp

A primary care annual wellness visit will include the vital signs, (height, weight, pulse, BP, BMI), the history, physical exam, labs ((CBC, CMP, Lipid panel, UA), immunization assessment, and Mammogram/Colonoscopy (as appropriate)).

The provider verification form can be found and submitted on Lawson Employee Self-Service under the "Wellness" section and "Annual Wellness Visit." To find a primary care physician near you, visit AvMed.org/jhs. Please note: Wellness visits are 100 percent covered when using one of Jackson's health plans at any location of your choosing.

When you stay up-to-date on preventive healthcare, you are taking action toward a longer, healthier, and happier life!

For questions, please call 305 585 LIVE or email HR-Benefits@jhsmiami.org

Tobacco Cessation Program

Want to Quit Smoking?
Call **305-585-5319** or
StopSmoking@jhsmiami.org

Open to all JHS employees, patients and family members

Jackson and UM medical facilities and properties are smoke-free.

Wellness Clinic

Jackson is committed to providing an environment protecting the safety and well-being of employees while offering healthcare opportunities for better health. The new Employee Wellness Clinic will cater to all employees' healthcare needs while at work and support healthy behaviors.

Hours of Operation: 7:30 a.m. to 4 p.m.
Location: Jackson Medical East Towers 1103
Contact: 305-585 WELL (9355)

HEALTH + WELLNESS

BE Jackson-FIT

This program is an annual, voluntary wellness program designed to motivate you to maintain and improve your well-being by offering a cash incentive for the completion of eligible activities. Employees enrolled in any of the Jackson insurance plans are eligible to participate.

We encourage you to get started by following the steps below:

STEP 1: COMPLETE YOUR PERSONAL HEALTH ASSESSMENT (PHA)

Complete the REQUIRED online Personal Health Assessment (PHA) by visiting avmed.org/JHS

STEP 2: ANNUAL WELLNESS VISIT

Schedule your annual wellness visit and have your healthcare provider complete the 2023 Annual Wellness Visit - Provider Verification Form to certify your visit.

CLICK HERE FOR THE ANNUAL WELLNESS VISIT - PROVIDER VERIFICATION FORM >>

STEP 3: COMPLETE THE WHEEL OF WELLNESS TO EARN YOUR CASH INCENTIVE

Reward Scale:

- **50 Points - $50**
- **75 Points - $75**
- **100 Points - $150**

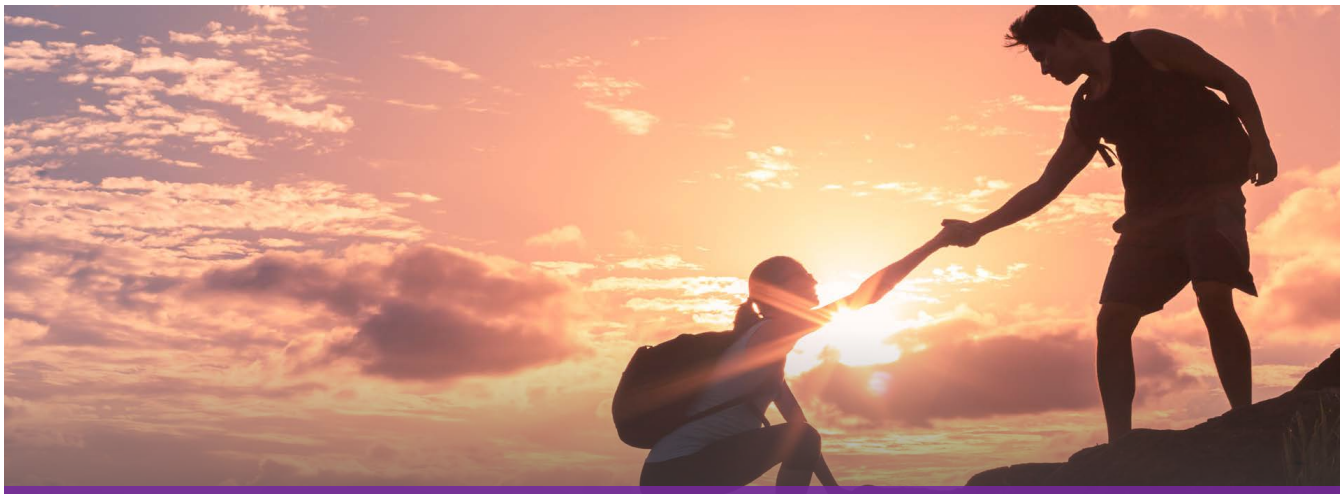
DEADLINE

Earn your points by Dec. 1, 2023 and receive your reward in January of 2024 (Employees must be in active pay status at the time of payment)! For certain activities, there are requirements that must be met in order to earn points. If you have any questions, contact Employee Benefits at HR-Benefits@jhsmiami.org.

WHEEL OF WELLNESS

WHEEL OF WELLNESS - Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at HR-benefits@jhsmiami.org and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

RESOURCES FOR LIVING



Anytime support

Employee Assistance Program
To access services:
(786) 466-8377, TTY: 711
resourcesforliving.com
Username: Jackson
Password: Health

Jackson Health System

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. Children living away from home are covered up to age 26.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional wellbeing support

You can access up to 5 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face to face, via televideo or chat therapy. Services are free and confidential. We're always here to help with a wide range of issues including:

- Anxiety
- Relationship support
- Depression
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Self-esteem and personal development
- Substance misuse and more

Daily life assistance

Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Care for older adults
- Caregiver support
- School and financial aid research
- Special needs
- Pet care
- Community resources/ basic needs
- Home repair and improvement
- Summer programs for kids
- Household services and more

Resources *for* Living®

74.03.962.1-RFL F (6/21)

DENTAL PLANS

Choose from the following dental plans:

- Delta Dental PPO
- DeltaCare USA DHMO

Employees can select coverage in a PPO or a DHMO dental program. Choices include standard or enriched dental PPO plans offered by Delta Dental, and standard or enriched DHMO dental plans offered by Delta Dental. Employees with dental PPO coverage may also choose a dentist not participating in their program and will receive applicable benefits.

DHMO dental plans provide preventive, diagnostic, and many other services free of charge to members. Other services, including major procedures, such as crowns, have fixed copayments established by the plan. Claim forms are not required. Members must choose one of the plan's participating dentists to receive benefits. There is no annual dollar maximum under the prepaid dental programs.

Delta Dental PPO

With Delta Dental PPO, you can select between two plan options, the Standard or Enriched. When you're covered under either of the Delta Dental PPO plans, you and your family members:

- Can visit any licensed dentist, including the dental specialist of your choice. We highly encourage you to find a provider in the Delta Dental PPO network to save the most in out-of-pocket costs.
- Can visit different dentists.
- May change dentists any time without notifying Delta Dental.
- Can receive dental care anywhere in the world (out-of-network benefits apply outside the U.S.).
- Will never have to pay more than the patient's share at the time of treatment or file claims forms when you visit a Delta Dental PPO network dentist.

Under either of the Delta Dental PPO Plans (Standard or Enriched), you have access to the Delta PPO network.

The Delta Dental network provides access to the largest network of its kind nationwide. Delta Dental PPO network dentists agree to accept the Delta Dental PPO contracted fees as full payment when treating PPO patients. This means your out-of-pocket costs are usually lower than when you visit a non-Delta Dental dentist.

Depending on the type of services being performed, benefits are payable at various coinsurance levels. A dental deductible is applied for services other than preventive and diagnostic. The Standard plan has an annual dollar maximum of $1,000. The Enriched plan includes an orthodontia benefit not provided under the Standard plan. The annual dollar maximum is $2,000 under the Enriched plan, and $1,300 lifetime max for orthodontia.

Note: Non-Delta Dental dentists will be reimbursed based on the 90th percentile of usual and customary. As a result, members visiting a non-Delta Dental dentist may see a change in out-of-pocket costs.

When you enroll in the DeltaCare USA DHMO, you and your covered family members can access the dental care you need through DeltaCare USA's network of quality dentists.

Each covered family member can choose their own general dentist from the network. Split family option allows up to three assigned providers. You will need a referral from your general dentist to see any specialist, such as an endodontist, oral surgeon, pediatric dentist or orthodontist.

DeltaCare USA DHMO

When you enroll in the DeltaCare USA DHMO, you and your covered family members can access the dental care you need through DeltaCare USA's network of quality dentists.

Each covered family member can choose their own general dentist from the network. Split family option allows up to three assigned providers. You will need a referral from your general dentist to see any specialist, such as an endodontist, oral surgeon, pediatric dentist, or orthodontist.

DENTAL PLANS

DHMO Features and Benefits (continued from previous page)

- No deductible. No dollar maximums. No claim forms to file. No waiting periods for coverage.
- Reduced rates on all covered services.
- Coverage for most preventive services at no charge.
- The first two cleanings are in any 12 month period at no charge. The member is able to have one additional cleaning at a charge.
- Discounts on complex procedures.
- Specialty care provided at the same fee as general care with an approved referral.
- Orthodontic benefits for adults and children.
- Teeth whitening covered.

See copay schedule for details.

Dental Biweekly Rates

	PER PAY PERIOD	
Delta **PPO**	**STANDARD**	**ENRICHED**
Employee Only	$0.00	$4.90
Employee + One†	$17.05	$27.70
Employee + 2 or More†	$38.15	$55.32
DeltaCare **DHMO**	**STANDARD**	**ENRICHED**
Employee Only	$0.00	$2.54
Employee + One†	$2.93	$7.89
Employee + 2 or More†	$6.82	$16.09

+ Option also applies to Domestic Partners and/or Children of Domestic Partners and eligible dependents.
* DeltaCare USA DHMO plans are not available outside of Florida.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at deltadentalins.com.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care5, you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

DENTAL PLANS

Delta PPO Dental Plan	STANDARD	ENRICHED
CHOICE OF DENTIST	You'll likely save most with a dentist who participates in the Delta PPO network.. Services provided by out-of-network providers will be reimbursed at the maximum plan allowance of usual and customary charges. Percentages below are based on Delta's applicable allowances and not necessarily the dentist's actual charge.	
MAXIMUM BENEFIT/DEDUCTIBLE	$1,000 per year per person, $50 deductible per year per person; $150 family maximum	$2,000 per year per person, $50 deductible per year per person; $150 family maximum
	STANDARD	**ENRICHED**
TYPE I		
0150 Comprehensive Oral Evaluation - New or Established	Plan Pays (No deductible) - 100%	Plan Pays (No deductible) - 100%
0120 Periodic Oral Exam	100%	100%
X-RAYS	100%	100%
1110/20 Prophylaxis	100% (Twice per calendar year)	100% (Twice per calendar year)
1203 Fluoride Treatment (Children Up To The Age 19)	100%, 2x per year	100%, 2x per year
1351 Sealant- Per Tooth	100% to age 16	100% to age 16
1510 Space Maintainers	100% to age 19	100% to age 19
	STANDARD	**ENRICHED**
TYPE II		
Fillings: (Silver And White)		
2330 One Surface	100% (In PPO Network) / 75% (Out of PPO Network)	100% (In PPO Network) / 75% (Out of PPO Network)
2331 Two Surfaces	100% (In PPO Network) / 75% (Out of PPO Network)	100% (In PPO Network) / 75% (Out of PPO Network)
2332 Three Surfaces	100% (In PPO Network) / 75% (Out of PPO Network)	100% (In PPO Network) / 75% (Out of PPO Network)
2334 Four Or More Surfaces	100% (In PPO Network) / 75% (Out of PPO Network)	100% (In PPO Network) / 75% (Out of PPO Network)
Restorative Services:		
2930 Prefabricated Stainless Steel Primary Tooth	75% for children to age 16	75% for children to age 16
Root Canals:		
3310 Anterior	75%	75%
3320 Bicuspid	75%	75%
3330 Molar	75%	75%
3410 Apicoectomy	75%	75%
Extractions:		
7111 Single Tooth	75%	75%
7140 Extraction, Erupted Tooth Or Exposed Tooth	75%	75%
7210 Surgical Extraction Of Erupted Tooth	75%	75%
Periodontics: (Gum Treatment)		
4341 Periodontal Scaling & Root Planing- Per Quadrant	75%	75%
4210 Gingivectomy/Gingivoplasty - Per Quadrant	75%	75%
4910 Periodontal Maintenance Procedures	75%	75%
	STANDARD	**ENRICHED**
TYPE III		
Crown & Bridge:		
2791 Crown Full Cast Predominately Base Metal	50%	50%
2751 Crown Porcelain Fused To Base Metal	50%	50%
Pontics:		
6210 Full Cast	50%	50%
6240 Porcelain Fused To Metal	50%	50%
Prosthodontics (Dentures):		
5110 Complete Upper	50%	50%
5120 Complete Lower	50%	50%
5213/14 Partial Upper Or Lower - Cast Metal Base	50%	50%
Implants	50%	50%
Temporomandibular joint (TMJ)	50%	50%
ORTHODONTIA		
Consultation	Not Covered	Adult & Child covered at 50% after a one time deductible of $50 per person. $1,300 lifetime maximum benefit
Evaluation	Not Covered	
Records	Not Covered	
Children - Normal Class II	Not Covered	
Adult - Normal Class II	Not Covered	
8750 Retention	Not Covered	

*All Type II and III charges subject to annual deductible.

DENTAL PLANS

DeltaCare DHMO Dental Plan

	STANDARD	ENRICHED
CHOICE OF DENTIST	Limited to providers participating in the DeltaCare USA network.	
MAXIMUM BENEFIT/DEDUCTIBLE	No Maximum, No Deductible	
TYPE I	**STANDARD - YOU PAY**	**ENRICHED - YOU PAY**
1110/20 Prophylaxis	No Charge	No Charge
0120 Periodic Oral Exam	No Charge	No Charge
0150 Comprehensive Oral Evaluation - New Or Established	No Charge	No Charge
1203 Fluoride Treatment (Children Up To The Age 19)	No Charge	No Charge
1351 Sealant - Per Tooth	$5.00	No Charge
1510 Space Maintainers	$30.00	No Charge
TYPE II	**STANDARD**	**ENRICHED**
Fillings: (Silver)		
2140 One Surface	$5.00	No Charge
2150 Two Surfaces	$5.00	No Charge
2160 Three Surfaces	$10.00	No Charge
2161 Four Or More Surfaces	$13.00	No charge
Root Canals		
3310 Anterior	$75.00	$70.00
3320 Bicuspid	$85.00	$80.00
3330 Molar	$150.00	$140.00
3410 Apicoectomy	$100.00	$90.00
Extractions:		
7111 Single Tooth	$10.00	$10.00
7140 Extraction, Erupted Tooth Or Exposed Tooth	$10.00	$10.00
7210 Surgical Extraction Of Erupted Tooth	$30.00	$35.00
Periodontics: (Gum Treatment)		
4210 Gingivectomy/Gingivoplasty - Per Quadrant	$75.00	$60.00
4341 Periodontal Scaling & Root Planing- Per Quadrant	$30.00	$25.00
4910 Periodontal Maintenance Procedures	$15.00 each (Twice every 12 months)	$15 each (Twice every 12 months)
Two Additional Every 12 Months	$60.00 each	$60.00 each
TYPE III	**STANDARD**	**ENRICHED**
Crown & Bridge:		
2751 Crown Porcelain Fused To Base Metal	$180.00	$95.00
2791 Crown Full Cast Predominately Base Metal	$180.00	$95.00
2930 Prefabricated Stainless Steel	$15.00	$10.00
Prosthodontics (Dentures):		
5110 Complete Upper	$190.00	$110.00
5120 Complete Lower	$190.00	$110.00
5213/14 Partial Upper Or Lower - Cast Metal Base	$220.00	$130.00
ORTHODONTIA		
Consultation Evaluation Records 8080 Children - Normal Class II 8090 Adult - Normal Class II 8680 Retention	You pay orthodontia as follows: Comprehensive for dependent children under age 19: $1,500. Adults: $2,800 $200 copayment for pre and post orthodontic records.	You pay orthodontia as follows: Comprehensive for dependent children under age 19: $1,500. Adults: $2,800 $200 copayment for pre and post orthodontic records.

VISION PLANS

Davis Vision Plan

The out of-network-benefit allows you to select any out of-network provider and reimburses a fixed dollar amount based on the schedule shown for the out of-network services. The following chart indicates the benefits the plan pays for the services you receive. For more information, see the Davis Covered Vision Services on the following pages.

Vision Plan Rates	PER PAY PERIOD
BASE PLAN	
Employee Only	$1.91
Employee + One	$3.83
Employee + 2 or more	$7.03
PREMIER PLAN	
Employee Only	$4.59
Employee + One	$9.87
Employee + 2 or more	$19.06

VISION PLANS

Covered Vision Services	BASE PLAN COPAY	PREMIER PLAN COPAY
FREQUENCY		
Exam	Once Every Calendar Year	Once Every Calendar Year
Lenses & Lens Upgrades	Once Every Calendar Year	Once Every Calendar Year
Frame	Once Every Other Calendar Year	Once Every Calendar Year
Contacts Evaluation & Fitting	Once Every Calendar Year	Once Every Calendar Year
EXAMS & SERVICES		
Eye Exam	$25	$10
CONTACTS EVALUATION, FITTING:		
Standard Lens & Specialty Lens	15% Discount[1]	15% Discount[1]
GLASSES		
FRAMES		
Other Locations	$100	$160
Visionworks[4]	$150	Covered In Full
Any Overages	Additional 20% Off Any Overage[1]	Additional 20% Off Any Overage[1]
THE EXCLUSIVE COLLECTION:		
Fashion/Designer/Premier	Covered in Full/$15/$40	Covered In Full
LENSES	$25	$0
COPAYS FOR OPTIONS & UPGRADES		
LENS OPTIONS		
Clear Plastic Single-Vision, Bifocal, Trifocal or Lenticular Lenses (any RX)	$0	$0
Oversized Lenses	$0	$0
Plastic Lenses	$0	$0
Polycarbonate Lenses (Children/Adults)	$0/$35	$0/$30
High-Index Lenses	$60	$55
Polarized Lenses	$75	$75
Progressive Lenses (Standard/Premium/Ultra)	$65 / $105 / $140	$0 / $90 / $140
Anti-Reflective (AR) Coating (Standard/Premium/Ultra)	$40 / $55 / $69	$35 / $48 / $60
Ultraviolet Coating	$15	$12
Tinting of Plastic Lenses (Solid / Gradient)	$15	$0
Plastic Photochromic Lenses (Transitions® Signature™)	$70	$65
Scratch-Resistant Coating	$0	$0
Scratch-Protection Plan (Single-Vision | Multifocal)	$20 | $40	$20 | $40
ADDITIONAL SAVINGS		
Retinal Imaging (Member charge)	$39	$39
Additional Pairs of Eyeglasses	30% Discount[1]	30% Discount[1]
CONTACTS[2] IN LIEU OF GLASSES		
Contact Allowance	$100	$120
Any Overages	Additional 15% Off Any Overage[1]	Additional 15% Off Any Overage[1]
THE EXCLUSIVE COLLECTION OF CONTACT LENSES: [3]	N/A	Covered In Full

VISION PLANS

Covered Vision Services Continued	BASE PLAN COPAY	PREMIER PLAN COPAY
OUT-OF-NETWORK BENEFITS		
You will receive the greatest value and maximize benefit dollars if you select a provider who participates in the network, however, you may receive services from an out-of-network provider.		
OUT-OF-NETWORK REIMBURSEMENT SCHEDULE (UP TO)		
Eye Examination	$40	$40
Frame	$50	$50
Single-Vision Lenses	$40	$40
Bifocal / Progressive Lenses	$60	$60
Trifocal Lenses	$80	$80
Lenticular Lenses	$116	$116
Elective Contact Lenses	$100	$120
Visually Required Contacts	$210	$210

1. Some limitations apply to additional discounts; Discounts not applicable at all in-network providers.
2. Contact lens coverage varies by product selection. Visually required contacts are covered in full with prior approval.
3. The Davis Vision Exclusive Collection of Contact Lenses is available at participating independent providers. Evaluation, fitting, and follow-up care for Collection contacts are covered in full.
4. Excludes Maui Jim® Eyewear. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

How to Accesss Online

Log into davisvision.com/member, and enter your username and password or your client code. If you are new to the site, you will need to register online before logging in. When registering, you will need your: **Member ID number** or **Social Security number**.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts

A Flexible Spending Account (FSA) lets you pay for eligible expenses with tax-free money. You contribute to an FSA with pretax money from your paycheck. This, in turn, may help lower your taxable income. There are two types of FSAs – Healthcare FSA and Dependent Care FSA.

Healthcare FSA

A Healthcare FSA is used to pay for eligible medical expenses that are not covered by your insurance or other plan. These expenses can be incurred by you, your spouse, or a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses, such as: before and after school care, day time baby-sitting fees, elder care services, nursery, and preschool costs. Eligible dependents include your qualifying child up to age 13, spouse, and/or relative.

You can request reimbursement from your Dependent Care FSA after your dependent receives day care services. Unlike the Healthcare FSA, your full annual contribution is not available at the beginning of the plan year. You can only get reimbursed up to the amount that is available in your account at that time.

Annual Contribution Limits

FOR HEALTHCARE FSA:

- Minimum Annual Contribution: $260
- Maximum Annual Contribution: $2,850*

FOR DEPENDENT CARE FSA:

- Minimum Annual Contribution: $260

USE YOUR PAYFLEX CARD®, YOUR ACCOUNT DEBIT CARD

The PayFlex debit card is a convenient way to pay for eligible healthcare expenses. The card knows when the expense is eligible and whether you have funds available. When you use the card, save your Explanation of Benefits, itemized statements and detailed receipts. There may be times when PayFlex asks you to provide documentation to verify you used your card for an eligible expense. If you're a new healthcare FSA member, you'll automatically receive one card in the mail before the beginning of the plan year. The card is not available for the dependent care FSA.

The maximum contribution depends on your tax filing status:

- If you are married and filing separately, your maximum annual contribution is $2,500*.
- If you are single and head of household, your maximum annual contribution is $5,000*.
- If you are married and filing jointly, your maximum annual contribution is $5,000*.
- If either you or your spouse earn less than $5,000* a year, your maximum annual contribution is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual contribution is $3,000* a year for one dependent and $5,000 a year for two or more dependents.

*Including administrative fees

FLEXIBLE SPENDING ACCOUNTS

Run Out Period and Grace Period

You have a 120-day run-out period (ending April 30, 2023) after your 2022 Plan Year ends to submit reimbursement requests for all eligible FSA expenses incurred DURING your plan year.

You may, however, continue using only your Healthcare FSA during the grace period, which is two months and 15 days after the end of your 2022 Plan Year (March 15th). Be sure to submit your grace period claims before the end of your 120-day run-out period (April 30th).

FSA Appeals and Managing Your FSA Online

Appeals Process

If you have an FSA reimbursement claim denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to:

PayFlex Systems USA, Inc.
Flex Department
PO Box 3039
Omaha, Ne 68103-3039

or **Fax** to: 402-231-4310

Your appeal must include:

- The name of your employer;
- The date of the services for which your request was denied;
- A copy of the denied request;
- The denial letter you received;
- Why you think your request should not have been denied; and
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal and supporting documentation will be reviewed upon receipt. You will be notified of the results within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's, and the IRS' regulations governing the plan.

Filing a Claim with PayFlex

If you pay for an eligible expense with cash, check, or personal credit card, you can file a claim online at payflex.com or through the PayFlex Mobile® app to pay yourself back for your out-of-pocket expenses OR you can fill out a paper claim form and fax or mail it to PayFlex. This form can be found in the Resource Center at payflex.com or you may call PayFlex at 844-PAYFLEX to request a form.

After you log in to payflex.com, click on the **Financial Center** tab and select your account from the drop down. Click on **File a Spending Account Claim** to get started.

When you submit a claim, you need to include supporting documentation that shows the following:

- Merchant or service provider name
- Name of patient (if applicable)
- Date of service
- Amount you were required to pay
- Description of item or service

How to Register Online

- Go to payflex.com
- Click on CREATE YOUR PROFILE and follow the online instructions.
- After successfully registering your account, "My Dashboard" will be displayed and you will be able to access your account information.
- To receive electronic account notifications, select "My Settings" at the top of the page and
  - Select the notifications link,
  - Enter your email address and then re-enter to confirm, and
  - Then select the notifications you wish to receive and click "Submit."

Enroll in Direct Deposit

To receive your claim payments quickly, sign up for direct deposit through the PayFlex member website. Log in to payflex.com and click on the **Financial Center** tab. Select your account from the drop down menu and click on **Enroll in Direct Deposit** to get started.

DISABILITY INCOME PROTECTION

Short-Term Disability Income Protection

A Short-Term Disability does not have to put your life or income on hold. Short-Term Disability insurance can provide a stable income source to carry you and your family through a temporary disability if you are unable to work due to a covered injury or sickness.

Short-Term Disability benefits begin after you meet the definition of disability and satisfy the elimination period. Benefit payments are issued in arrears on a weekly basis and can continue while you are disabled up to the maximum benefit duration. Please refer to the Short-Term Disability Plan Document for the full plan and exclusion details.

Eligibility for Coverage

To receive coverage under this plan, you must be an active employee with benefits status.

Employees under Company Number 100, 110, 200, 210, 220, 300, 310 or 320: Jackson Health System provides employer-paid Short-Term Disability. Please refer to the Short-Term Disability Plan Document for full plan and eligibility details.

Employees under Company Number 200 or 300: Jackson Health System provides a "base" Short-Term Disability plan that is employer-paid. Employees have the opportunity to apply for additional income protection under a "buy-up" plan. Please refer to the Short-Term Disability Plan Document for full plan and eligibility details.

Example of Short -Term Disability Buy-Up Calculation:

_____ / 52 = _____ X .70 = _____
Annual Salary* | #Weeks | Weekly Salary | Benefit % | Weekly Benefit

_____ / 10 = _____ X $.12 = _____ X 12 /
Weekly Benefit | Per $10 of Weekly Benefit | Rate | Monthly Rate | 12 Months

26 = _____
# of Pay Periods | Biweekly Premium

*Note: "Annual salary is capped at $111,429, based on the policy's maximum benefit."

Employees under Company Number 400, 410, 500, 600 or 710: Jackson Health System provides a voluntary Short-Term Disability option. The cost of this Short-Term Disability is paid for by you. Please refer to the Short-Term Disability Plan Document for full plan and eligibility details. Use the chart below to determine the premium for your age group.

SHORT-TERM BIWEEKLY RATES

ATTAINED AGE	Option I Rate ($425 maximum)	Option II Rate ($700 maximum)
Age 18 – 29	$7.51	$9.78
Age 30 – 39	$9.41	$12.25
Age 40 – 49	$12.26	$15.95
Age 50 – 59	$15.23	$19.80
Age 60 and over	$18.30	$23.80

Is coverage guaranteed?

Employees who elect coverage as a new hire, during annual enrollment, or within 30 days of a Qualifying Life Event are guaranteed coverage. However, coverage is subject to pre-existing condition limitations. Benefits will not be paid for a Total Disability:

1. Caused by;
2. Contributed to by; or
3. Resulting from;

A pre-existing Condition unless the Insured has been actively at work for one (1) full day following the end of twelve (12) consecutive months from the date he/she became an Insured.

Pre-existing Condition means any sickness or injury for which the Insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately prior to the Insured's effective date of insurance.

Please note that pre-ex only applies to the Voluntary STD plan, it does not apply to those in company codes 100, 110, 200, 210, 220, 300, 310, 320.

DISABILITY INCOME PROTECTION

Long-Term Disability Income Protection

How long are my benefits payable?

If you are disabled before age 62, you can receive monthly payments up to age 65. For disabilities that commence between ages 62 and 69, you can receive payments on a decreasing scale, with a maximum one year benefit period for disabilities that commence at age 69 or older.

Is coverage guaranteed?

Employees who elect coverage as a new hire, during annual enrollment, or within 30 days of a Qualifying Life Event are guaranteed coverage. A claim is subject to a pre-existing condition review during an employee's first 12 months of coverage.

How do I report a Long-Term Disability claim?

Claim forms can be obtained by calling 1-800-866-2301.

What rates will I pay for these plans? Long-Term Disability

The cost of this insurance program is paid for by you. Use the chart below to determine the amount for your age group.

LONG-TERM DISABILITY BIWEEKLY RATES

ATTAINED AGE	Option I Rate ($2,500 maximum)	Option II Rate ($6,000 maximum)
Age 18 – 29	$2.47	$3.70
Age 30 – 39	$4.58	$6.88
Age 40 – 49	$11.18	$16.77
Age 50 – 59	$22.27	$33.40
Age 60 and over	$18.25	$27.38

This information is a brief description of the important features of the plan. It is not the contract. Terms and conditions of coverage are set forth in Reliance Standard group policy number LTD 669887. The group policy is subject to its laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

Important facts about Long-Term Disability

Work Incentive Benefits are designed to allow a disabled employee to return to work while considered disabled and to continue to receive monthly benefits. During the first 12 months you return to work, if, for any month during this period, the sum of your Long-Term Disability benefit, current earnings and any additional other income benefits exceeds 100% of your covered earnings, your disability benefit will be reduced by the excess amount.

If an Insured is receiving a Monthly Benefit because he/she is considered Totally Disabled after 12 months and is able to perform Rehabilitative Employment, you will continue to receive the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

Rehabilitation During Disability – An Insured will be considered able to perform Rehabilitative Employment if a Physician or licensed or certified rehabilitation specialist determines that he/she can perform such employment. If an insured refuses such Rehabilitative Employment, benefits will terminate.

Reasonable Accommodation Benefits – The insurance carrier may reimburse your employer for expenses incurred in making a reasonable accommodation to return the disabled employee to any occupation for your employer. The maximum reimbursement will not exceed $2,000.

What is the Elimination Period and Interruption Period?

Elimination Period - The period of consecutive days of total disability for which no benefit is payable. It begins on the first day of total disability.

Interruption Period - If, during the Elimination Period, an Insured returns to active work for less than 30 days, then the same or related total disability will be treated as continuous. Days that the Insured is actively at work during this Interruption Period will not count toward the Elimination Period. This interruption of the Elimination Period will not apply to an Insured who becomes eligible under any other group long term disability insurance plan.

DISABILITY INCOME PROTECTION

Covered Earnings

Covered Earnings, as used in the Schedule of Benefits, means the Insured's monthly salary as reported by the Employer on the day just before the date of disability. Earnings does not include commissions, overtime pay, bonuses, or any other special compensation not received as basic salary. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of change, provided the Insured is actively at work on the effective date of the change. If the Insured is not actively at work on that date, the effective date of the change will be deferred until the date the Insured returns to active work.

How do I file a claim?

- Call Matrix Absence Management at the toll-free hotline as soon as possible 1-877-202-0055 (24/7 for telephonic claims filing)
- You may also file your claim online, 24 hours a day, seven days a week at: **matrixabsence.com**
- Short-Term Disability or FMLA claims may be filed by using the mobile app. Search for "Matrix eServices" in your smartphone or tablet's app store.
- All filing options are available 24/7/365.

For Housestaff Members:

Group Long-Term Disability

Jackson Health System provides eligible Housestaff Residents and Fellows with Group Long-Term Disability Income Protection while they are employed by JHS. The amount of coverage is 60% of salary to a maximum of $3,500. Long-Term Disability benefits start after you are disabled for the 90-day elimination period. Benefits continue for each period of total disability until Social Security Normal Retirement Age (SSNRA).

You are considered disabled if as a result of illness or injury you are unable to perform the material duties of your regular occupation. If you return to work and are earning less than your pre-disability earnings, a proportionate benefit may be payable.

Optional Long-Term Disability Income Protection

Additional Disability Income Insurance, called Optional Long-Term Disability Income Protection is available. You are guaranteed coverage if you decide to enroll and you can keep the coverage at the same discounted rate when you leave Jackson Health System.

Long-Term Disability benefits are available up to $3,500 per month. The benefits start after you have been disabled for the 90-day elimination period and are tax free. The plan covers you in your Own Specialty. The level premiums will be determined by your age and specialty at enrollment time.

For more information on your policy or if you wish to enroll in the optional disability, please contact The Lawrence D. Share Company at 305-577-3937 or email **jmhinfo@ldshare.com**

DISABILITY INCOME PROTECTION

Voluntary Short-Term Disability

Weekly Benefit Amount	60% of earnings to a maximum of: Option 1: $425 Option 2: $700
Elimination Period	Greater of 14 consecutive days Accident and Sickness or expiration of extended illness or accumulated sick leave.
Benefit Duration	Maximum of 24 weeks
Pre-Existing Limitation clause applies	

Employer-Paid Short-Term Disability

Eligible Company Numbers	Plan
Employees under Company Numbers: 110, 210, 220, 310, 320	Elimination Period: Greater of: 6 working days (8 calendar days) or expiration of extended illness or accumulated sick leave Benefit Duration: Maximum of: -110, 210, 220: 12 weeks - 310, 320: 25 weeks Pre-Existing Limitation: None

Employer-Paid Short Term Disability with Employee-Paid Buy-up Option

Eligible Company Numbers	Plan
Employees under Company Numbers: 200 & 300 – **Base Plan (Employer-Paid)**	Benefit: 60% of weekly earnings to a maximum of $1,000 Elimination Period: Greater of: 6 working days (8 calendar days) or expiration of extended illness or accumulated sick leave Benefit Duration: Maximum of: -200: 12 weeks - 300: 25 weeks Pre-Existing Limitation: None
Employees under Company Numbers: 200 & 300 – **Base Plan (Employer-Paid)**	Benefit: 70% of weekly earnings to a maximum of $1,500

Voluntary Long-Term Disability

Monthly Benefit Amount	60% of earnings to a maximum of: Option 1: $2,500 Option 2: $6,000
Elimination Period	180 Days
Benefit Duration	SSNRA or ADEA – B Age
Pre-Existing Limitation	3/12
Workplace Modification	100% up to $2,000
Survivor Income Benefit	3x monthly benefit
Social Security Integration	Direct with Family SS offset
Own Occupation Coverage	Yes, 24 months
Spouse Benefit	None
Conversion	Yes

GROUP BASIC & OPTIONAL TERM LIFE INSURANCE & ADDITIONAL BENEFITS

For Active Employees

What life insurance benefits are available?

Group Term Basic Life and Accidental Death and Dismemberment Insurance:
Jackson Health System provides eligible employees with Group Term Basic Life Insurance in the amount of one times the employee's annual base salary. In addition, Jackson Health System provides Group Accidental Death and Dismemberment Insurance (AD&D) with a value equivalent to the employee's annual base salary in the event of death resulting from accidental injuries sustained whether on or off duty. Dismemberment benefits are payable for loss of hand, foot, or sight of eye resulting from an accident.

Premiums for the Group Term Basic Life and AD&D coverages are paid in full by Jackson Health System.

Group Term Optional Life Insurance:
Jackson Health System also offers additional life insurance, called Optional Life, at the employee's expense. You may elect to purchase between one and five times your annual base salary for a maximum coverage of $2 million. You may obtain up to three times your basic annual salary without being subject to medical approval during your initial eligibility period. If you choose not to enroll during your initial eligibility period, you may apply during the current Open Enrollment period. You may submit an application at this time; however, you will be subject to medical approval.

Premiums for Optional Life are based on your age and the amount of coverage you are purchasing and will be payroll deducted. Contact your HR Service Center office for further details.

Imputed Income:
Jackson Health System provides one times your annual salary of basic group term life insurance. If the amount of life insurance exceeds $50,000, Jackson Health System is required to withhold taxes on the amount above $50,000.

NOTE: You can cancel or decrease coverage at any time, but you can only increase coverage during Open Enrollment. Your premiums are affected by salary and age changes (in five year increments). Beneficiaries for Life Insurance may be changed at any time.

Conversion:
If your Basic Life and Optional Life Insurance ceases due to termination of employment or membership in an eligible class, you may have the option to continue coverage through the Conversion option. Contact Reliance Standard Customer Service at 1-800-351-7500 to obtain the application.

CLICK HERE FOR EVIDENCE OF INSURABILITY >>

For Housestaff

What life insurance benefits are available?

Term Life Insurance
Jackson Health System provides eligible House Staff Residents and Fellows with $50,000 of personal Life Insurance. You must complete a beneficiary designation form during Open Enrollment. Beneficiary designations may be updated at any time.

Optional Term Life Insurance
Additional life insurance, called Optional Life, is available during Open Enrollment at the employee's expense. You may elect to purchase an additional $50,000 of coverage for $60 per year. You are guaranteed coverage if you enroll during your initial eligibility period. However, if you enroll more than 6 months after becoming eligible, you will be subject to medical approval. Contributory insurance will be deferred until the date the insurer approves the employee's written evidence of insurability.

CLICK HERE FOR HOUSESTAFF EVIDENCE OF INSURABILITY>>

ARAG® LEGAL INSURANCE

Protect yourself and your family with legal insurance.

Life is full of legal situations. Some you plan for — like creating a will or buying a home. Others are more unexpected — like fighting a traffic ticket or getting your deposit back from a difficult landlord.

At Jackson Health System, we are excited to offer you a benefit that is there for the legal ups and downs: legal insurance from ARAG®. You'll have access to a nationwide network of attorneys when you need help with legal issues at any stage in life. Plus, attorney fees are 100% paid in full for most covered matters when you work with a network attorney who can offer legal guidance, review personal documents, and represent you, if needed.

Rely on legal insurance benefits from ARAG.

Legal fees are expensive — averaging $368 per hour for attorneys with 11 to 15 years of experience.[1] With legal insurance from ARAG:

- Save thousands of dollars on average, for legal matters by avoiding costly legal fees.[1]
- Avoid the hassle of finding a local network attorney easily in ARAG's network — many who average 20+ years of experience.
- Use DIY Docs® to create, edit and store legally valid, state-specific documents, such as a will or powers of attorney.

Choose Flexible Benefit Options

You'll have two options to choose from: UltimateAdvisor®, which features a wide variety of legal coverages and services, and UltimateAdvisor Plus™, which offers more comprehensive legal coverage and additional services, like Identity Theft Protection, tax services, and services for parents/grandparents.

Any legal matter that occurs or is initiated prior to the effective date of an Insured will be considered excluded and no benefits will apply. ARAG defines this as an event covered by this policy whose initiation date will be considered the earlier of the date (a) written notice of a legal dispute is sent or filed by you or received by you; or (b) a ticket or citation is issued; or (c) an attorney is hired. If your matter is considered pre-existing, paid-in-full office visit or representation coverage is not available; however, as long as the matter is not listed under "Exclusions" in the plan, you are able to receive advice from a network attorney under the telephone legal access services benefit. You can also receive a reduced fee benefit of at least 25% off the network attorney's normal hourly rate if you have not previously hired an attorney.

VISIT ARAGLEGAL.COM/MYINFO AND ENTER ACCESS CODE 17845JHS TO LEARN MORE ABOUT YOUR ULTIMATEADVISOR® AND ULTIMATE ADVISOR PLUS™ PLANS!

SEE THE PLAN OPTIONS ON THE FOLLOWING PAGE.

Biweekly Price	UltimateAdvisor®	UltimateAdvisor Plus™
Individual	$6.20	$8.34
Family	$8.18	$11.00

Call for Questions or Plan Coverage Details

Get assistance from professionals and ARAG's award-winning Customer Care team, with dedicated specialists who can review your plan coverage and offer steps. Call 800-247-4184 when you are ready to address your legal issue or have a quick question about your coverage.

1 Based on $368 Average hourly attorney rate for attorneys with 11 to 15 years' experience according to The Survey of Law Firm Economics: 2018 Edition, The National Law Journal and ALM Legal Intelligence, October 2018.

Limitations and exclusions apply. Depending upon a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, call 800-247-4184.

About Legal Insurance

What is legal insurance? Learn how ARAG legal insurance can help you save money, time, and stress.

ARAG® LEGAL INSURANCE

Compare Your Legal Insurance Plan Options from ARAG®

Plan Options	Ultimate Advisor®	Ultimate AdvisorPlus™
Consumer Protection		
Auto Repairs, Buy/Sell a Car, Consumer Fraud, Contractors and More	●	●
Insurance Disputes	●	●
Estate Planning		
Wills and Powers of Attorney	●	●
Revocable Living Trusts	●	●
Irrevocable Living Trusts	●	●
Protection of Inheritance Rights	●	●
Estate Administration & Closing (9 Hours)	●	●
Family		
Adoption	●	●
Alimony/Child Custody/Visitation/Child Support (8 Hours)		●
Initial Child Custody/Child Support Agreements (8 Hours)		●
Contested Divorce (10 Hours)	●	
Contested Divorce (15 Hours)		●
Uncontested Divorce	●	●
Domestic Partnership Agreement	●	●
Domestic Violence Protection	●	●
Restraining/Protective Order	●	●
Elder Law - Member Support	●	●
Funeral Directive	●	●
Gender Identifier Change	●	●
Guardianship/Conservatorship	●	●
Hospital Visitation Authorization	●	●
Mental Incompetency or Infirmity	●	●
Name Change	●	●
Postnuptial Agreements	●	●
Prenuptial Agreements	●	●
School Administrative Hearings		●
Real Estate — Primary and Secondary Residence		
Buy/Sell	●	●
Home Equity Loan	●	●
Refinance	●	●
Foreclosure	●	●
Real Estate Disputes	●	●
Neighbor Disputes	●	●
Easements	●	●
Zoning and Variances	●	●
Building Codes	●	●
Traffic and Vehicle (Excluding DWI)		
Driving Privilege Protection	●	●
Driving Privilege Restoration	●	●
Minor Traffic	●	●
Services for Tenants		
Disputes with a Landlord — Contracts, Lease, Eviction, Deposits	●	●

Plan Options	Ultimate Advisor®	Ultimate AdvisorPlus™
Financial Services		
Financial Education and Counseling Services	●	●
Immigration		
Immigration Services	●	●
Government Benefits		
Social Security/Veterans/Medicare	●	●
Identity Theft		
Identity Theft Services	●	●
Full-Service Identity Restoration		●
$1 Million Theft Insurance[1]		●
Single-Bureau Credit Monitoring		●
Internet Surveillance		●
Change of Address Monitoring		●
Child Identity Monitoring		●
Lost Wallet Services		●
Taxes		
Tax Services		●
IRS Audit Protection	●	●
IRS Collection Defense	●	●
Property Tax — Primary and Secondary Residence		●
Debt		
Bankruptcy	●	●
Defense of Debt Collection	●	●
Defense of Garnishment	●	●
Mechanic's Lien	●	●
Student Loan Debt Collection	●	●
Services for Parents/Grandparents		
Annual Legal Checkup, Advice and Caregiving Services		●
Criminal		
Criminal Misdemeanor Defense		●
Habeas Corpus	●	●
Parental Responsibilities	●	●
Juvenile Court	●	●
Civil Damage Defense		
Libel/Slander, Pet-Related Matters and More	●	●
General Coverages		
Credit Record Correction		●
Small Claims Court	●	●
Miscellaneous Services (4 Hours per Year)		●
Document Preparation and Review	●	●
Personal Property Protection	●	●
Premium Rate		
Family bi-weekly	**$8.18**	**$11.00**
Individual bi-weekly	**$6.20**	**$8.34**

ARAG Legal Insurance

800-247-4184

ARAGlegal.com/plans, access code 17845jhs

You may be eligible to receive a minimum 25% reduced fee off a network attorney's normal hourly rate for any other non-covered and non-excluded issues.

[1]The Identity Theft Insurance is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Please see the plan summary document for details.
Limitations and exclusions apply. Depending upon a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, contact us.

PERMANENT LIFE INSURANCE

Combined Insurance Company of America, a Chubb company

LifeTime Benefit Term Provides You with the Protection Your Family Needs

LifeTime Benefit Term helps protect you and your family if you were no longer able to provide for them. Your family can receive cash benefits paid directly to them upon your death that they can use to help cover expenses like mortgage payments, credit card debt, childcare, college tuition and other household expenses.

Cash benefits can also be paid directly to you while you are living for long term care expenses.

You Decide How You Want to Use LifeTime Benefit Term Benefits

When you make the promise to protect your family with LifeTime Benefit Term, there are several ways it can work.

As Life Insurance
LifeTime Benefit Term protects your family with money that can be used any way they choose. It is most often used to pay for mortgage or rent, education for children and grandchildren, retirement, family debt, and final expenses.

For Qualified Long Term Care[1] (LTC)
If you become chronically ill[2], LifeTime Benefit Term will pay you 4% of your death benefit each month you receive Long Term Care. You can use this money any way you choose, and your life insurance premiums will be waived.

- Your death benefit will reduce proportionately each month as you receive benefit payments for Long Term Care. After 25 months of receiving Long Term Care Benefits, your death benefit will reduce to zero.

Restoration of Your Death Benefit
Ordinarily, accelerating your life coverage for Long Term Care benefits can reduce your death benefit to $0. While in force, this rider restores your life coverage to not less than 50% of the death benefit on which your LTC benefits were based, not to exceed $50,000. This rider assures there will be a death benefit available for your beneficiary until you reach age 121.

For Terminal Illness[3]
After your coverage has been in force for two years, you can receive 50% of your death benefit, up to $100,000, if you are diagnosed as terminally ill.

LifeTime Benefit Term Features

Affordable Financial Security
Lifelong protection with premiums beginning as low as $3 per week.

Dependable Guarantees
Guaranteed life insurance premium and Death Benefits last a lifetime.

Fully Portable and Guaranteed Renewable for Life
Your coverage cannot be cancelled as long as premiums are paid as due.

Highly Competitive Rates
For the same premium, LifeTime Benefit Term provides higher benefits than permanent life insurance and lasts to age 121.

Family Coverage
Coverage is available for your spouse, children and dependent grandchildren.

This product is underwritten by Combined Insurance Company of America, a Chubb company.

1. LTC and Extension of Benefits premiums may be adjusted based upon the experience of the group or other group characteristics that may affect results. Premiums will not be increased solely because of an independent claim. New premiums will be based on the insured's age and premium class on the rider's coverage date.
2. Chronically ill means certified by a licensed health care practitioner as: being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or requiring substantial supervision for protection from threats to health and safety due to severe cognitive impairment. Activities of daily living include Bathing, Continence, Dressing, Eating, Toileting and Transferring.
3. Terminally Ill means that the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.

PERMANENT LIFE INSURANCE

How LifeTime Benefit Term can be Used					
Three options	Life Situation	Death Benefit	Long Term Care	Long Term Care Extension	Total Benefits
1. Life Insurance	You lead a full life and do not need Long Term Care (LTC)	$100,000	–––	–––	$100,000
2. Long Term Care (LTC)* insurance	You lead a full life and need assisted living or nursing home care	–––	$100,000	–––	
3. Split your Death Benefit for LTC & life insurance	You lead a full life but also need some LTC funds (Example: 4% of $100,000 for 12 months)	$52,000	$48,000	–––	
				Option 1, 2 or 3 = **TOTAL COVERAGE**	**$100,000**

* LTC premiums may be adjusted based upon the experience of the group or other group characteristics that may affect results. Premiums will not be increased solely because of an independent claim.

Additional Benefit Options

Accidental Death Benefit Doubles the death benefit if death results from an accident.

Child Term Benefit Death Benefits available up to $25,000. Guaranteed conversion to individual coverage at age 26–up to 5 times the benefit amount.

Waiver of Premium Benefit Waives premium if you become totally disabled.

Payor Waiver of Premium Benefit Waives premium of your spouse, if you become totally disabled.

LifeTime Benefit Term Exclusions

If the insured commits suicide, while sane or insane, within two years from the Date of Issue, and while this Coverage is in force, We will pay in one sum to the Beneficiary, the amount of premiums paid for this Coverage.

Long Term Care Exclusions

We will not pay Long Term Care benefits for care that is received or loss incurred as a result of: 1) Any Pre-Existing Conditions; 2) Mental or nervous conditions except Alzheimer's Disease; 3) Alcoholism and drug addiction; 4) Illness, treatment or medical conditions arising out of: War or act of war (whether declared or undeclared); Participation in a felony, riot or insurrection; Service in the armed forces or units auxiliary thereto; Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or Aviation (non-fare-paying passengers); 5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other Governmental program (except Medicaid), any state or federal workers' compensation, employers' liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance. 6) Expenses for services or items available or paid under another long term care insurance or health insurance policy. 7) In the case of a long term care contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount; or 8) Care or services received outside the United States or its territories.

Pre-Existing Condition Limitation LTC benefits are not payable for care received in the first 6 months after the coverage issue date if a Pre-Existing Condition causes an insured to be Chronically Ill. Care received 6 months or more after the issue date caused by a Pre-Existing Condition will be covered. Pre-Existing Conditions means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the date of issue.

If you have questions about this product contact (855) 241-9891.

This document is a brief description of Certificate Form No. C34544FL. Benefits, rates, exclusions and limitations may apply. Refer to your certificate of insurance for specific details. Lifetime Benefit Term is a group life insurance policy that can provide benefits to help pay for qualified long term care expenses through the addition of the Accelerated Death Benefit for Qualified Long-Term Care Insurance Rider Form No. 34553FL and the Extended Accelerated Death Benefit for Qualified Long-Term Care Insurance Rider Form No. 34554FL.

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. This insurance product is underwritten by Combined Insurance Company of America, Chicago, IL, a Chubb company.

TRUSTMARK UNIVERSAL LIFE EVENTS®

Financial Security Even After a Loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, survivors can face – not only grief – but costly expenses, debt, and loss of income.

Universal LifeEvents insurance can mean those left behind can still pursue their own dreams, and help ensure that the ending of one story won't stop the beginning of another.

Universal LifeEvents provides a higher death benefit during your working years, when your needs and responsibilities are the greatest. You can choose a benefit amount that provides the right protection for you.

Great Benefits:

- **Long-Term Care** – Provides up to 25 months of benefits for home healthcare, assisted living, adult day care, and nursing home care
- **Benefit restoration** – Restores the benefit paid out by LTC
- **Family coverage** – Coverage is available for employees, spouses, children, and grandchildren
- **Direct payment** - Benefits paid directly to the policyholder enabling choices in care

Great Features:

- **Portability** – Coverage is completely portable, regardless of job changes or retirement
- **Streamlined Underwriting** - Simple and efficient underwriting process
- **EZ Value option** – Automatically increases benefits to keep pace with an employee's growing needs, without additional underwriting
- **Accelerated Death Benefit** - Accelerates up to 75% of the death benefit if a doctor determines the policyholder's life expectancy is 24 months or less

Solving the Long-Term Care Issue

At any point in your life, you may need Long-Term Care services, which could cost hundreds of dollars per day. Universal LifeEvents includes an accelerated death benefit that can help pay for these services at any age. This benefit never reduces due to age, so the full amount is always available when you most need it.

How does it work?

You can collect 4% of the face amount of your Universal LifeEvents policy per month for up to 25 months to help pay for Long-Term Care services.

Additionally, if you collect an accelerated benefit for LTC, your full death benefit is still available for your beneficiaries, as much as doubling your benefit.

Plan form GUL.205/IUL.205 and applicable cs are underwritten by Trustmark Insurance Company, Lake Forest, Illinois. Universal LifeEvents death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary; issue age is 18-64. Employees over age 65, up to a certain age, may select traditional Universal Life with a benefit that does not reduce due to age. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Your policy will contain complete information. Trustmark® and LifeEvents® are registered trademarks of Trustmark Insurance Company.

Examples of How Universal LifeEvents Works:

How Universal LifeEvents Works

- A **higher death benefit** during working years.
- **Full LTC benefits** when you're most likely to need them.

Example: $25,000 policy

Before age 70	
Death benefit	**$25,000**
LTC benefits	**$25,000**

After age 70	
Death benefit	**$8,333**
LTC benefits	**$25,000**

Death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary. Issue age is 18-64.

Benefit for terminal illness

- **Use part of your death benefit** if you're diagnosed with a terminal illness to help manage costs.

Additional advantages

- **Keep your coverage** at the same price and benefits if you change jobs or retire.
- **Apply for coverage for family members:** spouse, children and grandchildren.
- **Convenient payroll deduction;** pay via direct bill, bank draft or credit card if you leave your employer.

Plus: grow your benefit with EZ Value

The EZ Value option can automatically **increase your benefit amount** over time – without any medical questions.

Example is for age 40, employee only, non-smoker coverage, with accelerated death benefit and no additional features. Actual values will vary by age, smoking status, benefits selected and interest rates. Increases may be available for a maximum of 5 or 10 years, depending on employer selection.

WHOLE LIFE INSURANCE W/LTC

How would your family get by if something happened to you suddenly and they could no longer rely on your paycheck? With Unum's Permanent Whole Life Insurance, you can help give your family the added financial protection they may need in the event something unexpected happens.

Plan Features

- Voluntary, individual coverage is for employees, with multiple family coverage options available.
- No physical exams are required to apply for coverage. Policy issue may depend upon answers to health questions contained in the application.
- Premiums are guaranteed based on your age at the time of policy issue and do not increase due to age.
- Cash value is based on a tabular rate of 4.5%.
- The policy contains a reduced paid-up provision, which allows you to use your accumulated cash value to purchase a smaller, paid-up policy with no further premiums due.
- Coverage may be continued as long as sufficient premiums are paid.
- A Living Benefit Option rider is automatically included at no extra premium on all policies. This feature allows the policy owner to request 100% of the death benefit (to a maximum of $150,000) if the insured is diagnosed with a medical condition that limits life expectancy to 12 months or less. Any payout reduces the death benefit.
- A Long-Term Care rider is automatically included at the initial offering to employees and spouses ages 15 to 70 who have policies with face amounts of at least $10,000.
- All Whole Life policies are individually owned, which means you can take the policy with you – should you retire or leave the hospital.

Employee Weekly Premium Limits

Guaranteed Issue*	Simplified Issue
$3 - $30	$31 - $40

Spouse Weekly Premium Limits

Conditional Guaranteed Issue*	Simplified Issue
$3 - $5	$6 - $10

Additional Coverage Options

- Accidental Death Benefit Rider
- Waiver of Premium
- Long-Term Care Rider

Plan Provider

Provident Life and Accident Insurance Company, a subsidiary of Unum Corporation, underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates Unum "A" Excellent (rating effective as of May 7, 2021).

CLICK HERE FOR WHOLE LIFE INSURANCE INFORMATION >>

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance

No one is ever really prepared for a life-altering critical illness diagnosis. The treatment to recovery is vital, but it can also be expensive. Your medical coverage may only cover some of the costs associated with treatment. You're still responsible for deductibles and coinsurance. If treatment keeps you out of work, the financial worries can grow quickly and stress levels may rise.

Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness. With the expense of treatment often high, seeking the treatment you need could seem like a financial burden. When a diagnosis occurs, you need to be focused on getting better and taking control of your health, not stressing over financial worries.

Key Features

- Guaranteed issue coverage without a Pre-Existing Condition Limitation*
- Coverage available for dependents
- Covered dependents receive 50% of your basic-benefit amount
- Benefits paid regardless of any other medical or disability plan coverage
- Premiums are affordable and conveniently payroll deducted
- Coverage may be continued; refer to your certificate for more details

* Please refer to the Exclusions and Limitations section of your brochure.

Here's How it Works

You choose benefits to protect yourself and any family members, if diagnosed with a critical illness. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

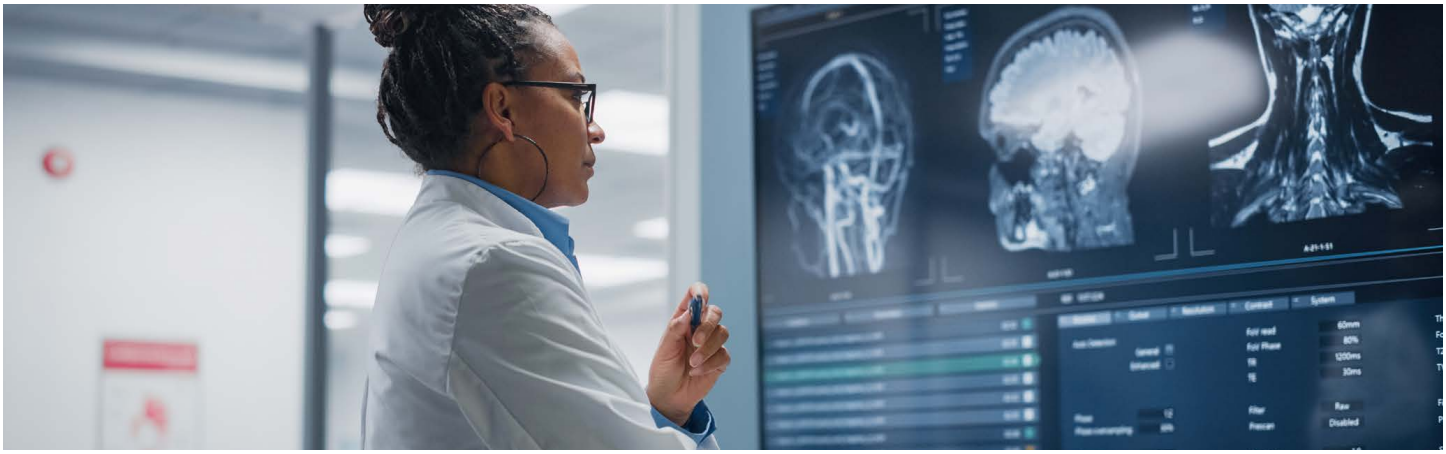
With Allstate Benefits, you can make treatment decisions without putting your finances at risk. Are you in good hands? You can be.

Disclosure

The coverage is provided under forms GVCIP4, or state variations thereof. The coverage has exclusions and limitations. Contact your benefits representative for full details. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

CLICK HERE FOR THE ALLSTATE BENEFITS CRITICAL ILLNESS BROCHURE >>

ACCIDENT INSURANCE



Accident Insurance

Even when you live well, accidents happen. Treatment can be vital to recovery, but it can also be expensive. And if an accident keeps you away from work during recovery, the financial worries can grow quickly.

Most major medical insurance plans only pay a portion of the bills. Our coverage can help pick up where other insurance leaves off and provide cash to help cover the expenses.

With Allstate Benefits accident insurance, cash benefits are paid to help you gain financial protection. You also gain the financial empowerment to seek the treatment needed to be on the mend.

Key Features

- Guaranteed issue coverage, subject to exclusions and limitations*
- Coverage available for dependents
- Premiums are affordable and are conveniently payroll deducted
- Coverage may be continued; refer to your certificate for more details

* Please refer to the Exclusions and Limitations section of your brochure.

How it Works

Our coverage pays you cash benefits that correspond with hospital and intensive care confinement. Your plan may also include coverage for a variety of occurrences, such as: dismemberment; dislocation or fracture; ambulance services; physical therapy and more. The cash benefits can be used to help pay for deductibles, treatment, rent, and more.

With Allstate Benefits, you can protect your finances against life's slips and falls. YOU DECIDE how to use the cash benefits. Our cash benefits provide you with greater coverage options because you get to determine how to use them.

Disclosure

The coverage is provided under forms GVAP6, or state variations thereof. The coverage has exclusions and limitations. Contact your benefits representative for full details. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

CLICK HERE FOR THE ALLSTATE BENEFITS ACCIDENT INSURANCE BROCHURE >>

HOSPITAL INDEMNITY PROTECTION

Group Hospital Indemnity coverage from Allstate Benefits pays cash benefits for expenses associated with hospital and emergency room visits.

Being hospitalized is something everyone could experience in their lifetime. If it happens, having the right supplemental hospitalization coverage in place can help offer peace of mind. Most major medical insurance plans only pay a portion of the hospital bills. Our coverage helps pick up where other insurance leaves off and provides cash to help cover the expenses.

- All benefits are paid direct to insured, unless assigned
- Benefits increase 5% after the first coverage year and each coverage year thereafter, for the next 5 years the policy remains in force at no corresponding increase in premium
- Rates are age banded; unisex
- Four-tier coverage options include: employee only, employee + spouse, employee + children, and employee + family
- Eligible to full-time and permanent part-time employees; excludes temporary and seasonal employees
- This plan is not HSA compatible

Terms of Coverage

Family plan coverage may include employee/member, spouse and dependent children as defined in the policy. Individual and spouse coverage includes employee/member and spouse. Individual and children coverage includes employee/member and eligible children as defined in the policy.

Effective Date

The effective date of coverage will be the policy date assigned by the home office and shown on the certificate specification page, not the application date.

Disclosure

The coverage is provided under forms GVSP1, or state variations thereof. The coverage has exclusions and limitations. Contact your benefits representative for full details. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

CLICK HERE FOR THE ALLSTATE BENEFITS HOSPITAL INDEMNITY BROCHURE>>

LOW BIWEEKLY PREMIUM PLAN - 1 Unit Hospital Benefits, 1 Unit Surgery & Related Benefits, 1 Unit Outpatient Benefit

Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	$9.86	$18.86	$16.56	$25.06
36-49	$11.48	$22.02	$19.00	$29.02
50-59	$14.04	$27.64	$21.80	$34.80
60-64	$18.36	$36.72	$26.34	$44.00
65+	$24.18	$48.36	$32.90	$56.26

MEDIUM BIWEEKLY PREMIUM PLAN - 3 Units Hospital Benefits, 1 Units Surgery & Related Benefits, 1 Units Outpatient Benefit

Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	$19.66	$36.82	$31.10	$47.74
36-49	$23.10	$43.46	$36.04	$55.86
50-59	$29.00	$56.62	$41.24	$68.28
60-64	$39.14	$78.26	$49.78	$88.20
65+	$52.84	$105.68	$62.82	$114.82

HIGH BIWEEKLY PREMIUM PLAN - 5 Units Hospital Benefits, 1 Units Surgery & Related Benefits, 1 Units Outpatient Benefit

Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	$29.46	$54.76	$45.64	$70.42
36-49	$34.74	$64.90	$53.08	$82.68
50-59	$43.96	$85.62	$60.68	$101.76
60-64	$59.90	$119.80	$73.20	$132.40
65+	$81.50	$163.00	$92.72	$173.40

HEALTH CONSUMER/FERTILITY & FAMILY PLANNING

You may now sign up for or register for the Health Consumer/Fertility & Family Planning for membership discounts on the following plans:

Fertility Advocacy

Infertility affects one in eight couples, and employees struggling to build a family face higher rates of depression, absenteeism, and turnover in the workplace. Fertility Advocacy by WINFertility provides employees with personalized guidance and support through their fertility treatment journey, improving clinical outcomes in a cost-efficient manner while keeping employees happy and productive. The benefit gives employees a highly experienced Nurse Care Manager as their advocate to explore treatment options, access to a network of top-ranked fertility specialists, IVF treatment and fertility medication discount bundles, access to genetic testing and egg freezing services, financing options, and more.

- Guides you every step of the way through your fertility treatment journey, providing education, resources, medical discounts, and emotional support for your individual needs
- Highly trained Nurse Care Managers serve a personal advocate to help you understand treatment and medication options and determine the best course of action for you
- Receive access to a network of top-ranked fertility specialists, IVF treatment and fertility medication discount bundles, genetic testing and egg freezing services, financing options, and more

Financial Wellness

One in three employees admit to being less productive at work due to financial stress, costing businesses nearly one month of productive work days every year. Financial Wellness guides members through the major financial changes they'll face throughout life, from paying for college to buying a home to navigating the loss of a spouse. Members can achieve financial wellness with live, one-on-one coaching from accredited financial counselors and independent learning through online resources.

- Accredited or Certified Financial Counselors are accessible by phone to assess issues, discuss options, and help members determine the best course of action for their situation
- Online Financial Wellness Center does the heavy lifting for research, providing a variety of vetted articles, videos, worksheets, checklists, and more to guide the member's financial wellness journey
- Established learning tracks include resources for major life events, like getting married or having a child, and general financial goals, like developing a budget and eliminating student debt

Financial wellness disclosure: Financial Wellness does not provide investment, legal, or tax advice

Health Consumer/Fertility & Family Planning Rates	Bi-weekly Pay Rate
Employee	$7.00

HEALTH CONSUMER/FERTILITY & FAMILY PLANNING

Health Navigation

Health benefits can be confusing, medical costs are rising, and finding the right care solutions can be frustrating and time consuming. Alight Navigator simplifies the healthcare experience. A dedicated team of highly trained Health Pros:

- Helps you understand insurance benefits
- Provide guidance related to plan selection
- Explain care options
- Review medical bills and resolve errors
- Assist with scheduling appointments
- Help with issues related to dental and vision benefits
- Respond to most requests by the next business day
- Have passed rigorous credentialing and completed extensive training

New Benefits Rx

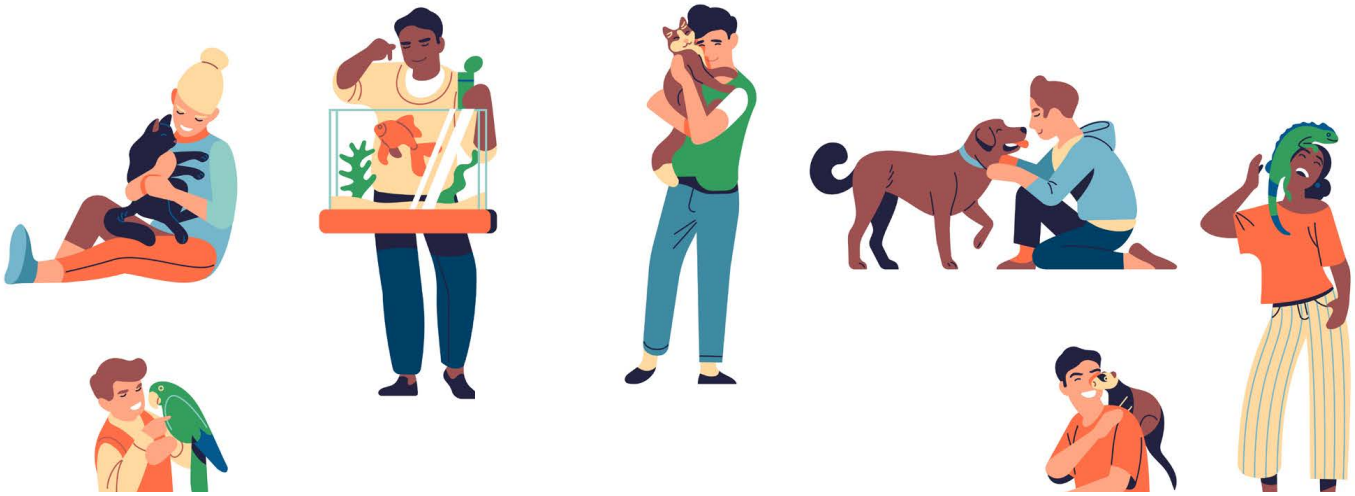
Healthcare keeps getting more expensive, but you shouldn't have to choose between your prescription medications and other essential expenses. Make sure you're always getting the best deal on your prescriptions with deep discounts through New Benefits Rx. Save 10% to 85% on most prescriptions at 60,000 retail pharmacies nationwide and through home delivery.

- Participating retail pharmacies include Walgreens, Target, CVS, and many other independent, national, and regional chains
- Save time and money through home delivery, powered by GeniusRx, delivering discounted medication directly to your door with free shipping
- Find the best deal by comparing prescription prices at participating pharmacies through your mobile app or web portal; then text or email the prescription price to easily cash in your savings at the pharmacy
- My Medicine Cabinet feature allows you to save your prescription search so you can easily refresh pricing for your next refill
- Even if you have insurance, you can present both cards at the pharmacy or research online to receive the lowest price
- Savings are available for your whole family, including certain medications for pets!

Health Consumer/Fertility & Family Planning program disclosure: **This program is NOT insurance coverage** and does not meet the minimum creditable coverage requirements under the Affordable Care Act or Massachusetts M.G.L. c. 111M and 956 CMR 5.00. **It contains a 30 day cancellation period**, provides discounts only at the offices of contracted health care providers, and each member is obligated to pay the discounted medical charges in full at the point of service. The range of discounts for medical or ancillary services provided under the program will vary depending on the type of provider and medical or ancillary service received. Member shall receive a reimbursement of all periodic membership fees if membership is canceled within the first 30 days after the effective date. Discount Plan Organization:

New Benefits, Ltd., Attn: Compliance Department, PO Box 803475, Dallas, TX 75380-3475, 800-800-7616. Website to obtain participating providers: MyBenefitsWork.com.

PET BENEFITS



Pet Assure Veterinary Discount Plan

Pet Assure is a post-tax employee benefit program that enables members to receive discounts on all in-house medical services provided by network veterinarians.

You will save hundreds on your pets' medical care for only $8/month. Pet Assure is the nation's oldest and largest veterinary discount plan and has been saving pet caretakers money on pet expenses since 1995.

Here's what your membership includes:

- **25% off all in-house medical services** every time you visit a network veterinarian. With Pet Assure, you'll receive your discount right at the vet's office. This plan is not insurance so there are no hassles, no claim forms, and no deductibles. Savings are instant!
- **Any type of pet,** with absolutely no exclusions, can receive the discounts. There are no exclusions based on type, breed, age, past medical history, or pre-existing conditions.
- Do you have one dog, five cats, a lazy iguana and a donkey? One Pet Assure membership covers them all.
- ThePetTag Lost Pet Recovery Service. Every pet that joins can register in ThePetTag, Pet Assure's Lost Pet Recovery Service.

There are dozens of network providers in Miami and the surrounding areas. For a complete list of participating veterinary practices, visit Pet Assure online at **petassure.com**

Pet Assure and PetPlus are brought to you by Pet Benefit Solutions. If you have any questions, please call Pet Benefit Solutions at: 800-891-2565. petbenefits.com**.**

PetPlus Prescription Discount Plan

With PetPlus, members receive up to 40% off their pet's prescriptions, preventatives, food, treats, and more. It's instant savings without any paperwork, and no exclusions based on pre-existing conditions. All dogs and cats are covered!

You will get up to 40% off on:

- Flea and Tick Preventatives
- Heartworm Preventatives
- Rx Medications
- Vitamins and Supplements
- Food (Rx & Non-Rx)
- Treats and Toys

Additional Benefits:

- Free shipping on all orders from PetCareRx.com
- Pickup human-grade Rx from participating pharmacies, including CVS, Walmart and other independent CVS Caremark® pharmacies
- 24/7 Pet Telehealth powered by AskVet

Enroll today to start saving!

Pet Assure & PetPlus Rates	Bi-weekly Pay Rate
Pet Assure Unlimited Plan	$3.69
PetPlus Single Pet Plan	$2.08
PetPlus Unlimited Plan	$3.92
Pet Assure Unlimited + PetPlus Single Pet	$5.77
Pet Assure Unlimited + PetPlus Unlimited	$7.61

Unlimited plans covers all pets in your household.

PET BENEFITS

Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

Jackson Health System is offering Wishbone Pet Insurance to employees.

Nobody wants to imagine their pet getting sick or injured - but when it comes to your pet's health, it's best to expect the unexpected.

Enroll in pet health insurance from Wishbone and receive 90% reimbursement on your pet's veterinary care. With a low deductible of $250, protecting your pet's health and your finances has never been easier!

Wishbone Pet Insurance is accepted at any vet in the U.S., including emergency hospitals. Once you file a claim, expect to be reimbursed via direct deposit or mailed check in 5 business days or less. It's that easy!

POLICYHOLDERS ENJOY:

- Optional Routine Care Plans
- Fast Claims Processing
- Easy-to-Use Member Account
- No Waiting Periods on Accidents or Illnesses
- Lost Pet Recovery Service from **ThePetTag**
- 24/7 Pet Telehealth from **AskVet**

Get a quote & enroll at www.wishboneinsurance.com/jacksonhealthsystem

Wishbone Pet Insurance is program managed by Odie Pet Insurance Marketing, Inc. and is underwritten by Clear Blue Insurance Group. Please visit www.getodie.com for more information.

Pet Benefit Solutions | petbenefits.com | info@petbenefits.com | (800) 891-2565

pet BENEFIT SOLUTIONS

CONSTANTCREDIT

It's YOUR credit. Keep it that way with ConstantCredit.

ConstantCredit monitors your credit report for any changes that may indicate suspicious activity or possible fraud. With ConstantCredit, you can be more aware of your credit health by receiving alerts when changes are reported. You will also receive information on your credit score, and access to tools that allow you to keep track of how your current and future activities may affect your credit score.

Features and Benefits:

LEVEL 3 (L3) VERIFICATION
You will verify your identity before monitoring begins. This ensures you are the only person to have access to your personal information through ConstantCredit.

FULL ACCESS TO CREDIT REPORTS
With ConstantCredit, you have access to your full credit report at any time, regardless of what level of plan you have.

CREDIT MONITORING
ConstantCredit monitors bureau activity and alerts you to any reported changes on your credit report. The sooner you find out if someone is acting on your behalf, the sooner you can act to mitigate the damage.

SCORE TRACKER
Score Tracker is a monthly report based on four credit factors, showing you graphically how your credit score changes over time.

SCORE SIMULATOR
Score simulator is a tool that helps you determine how certain actions will affect your credit, such as opening a new line of credit or paying off a loan.

RESOURCE CENTER
At the Resource Center, you can find recent news and articles on issues related to financial health and other information to educate you on the importance of a healthy credit record.

Have Questions? Need Help? Call ConstantCredit at 855-592-7940.

ConstantCredit Rates	Bi-weekly Pay Rate
Employee	$5.31
Employee + Spouse	$10.62

ID COMMANDER

Identity theft is the fastest growing crime in America, with an identity stolen once every four seconds. ID Commander, a leader in proactive identity theft protection, uses a variety of industry-leading tools to help protect you from the growing crime of identity theft:

- Advanced Identity Monitoring and Alerts
- $1 Million Identity Theft Insurance Policy, with $0 deductible
- Full-service Identity Restoration
- 24/7 Lost Wallet Assistance
- Award-winning Computer Protection Software

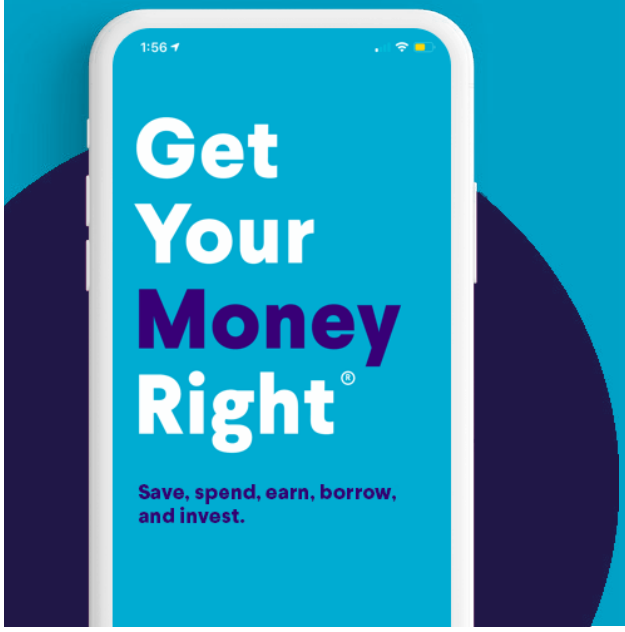
ID Commander's comprehensive identity theft protection plans are available to both individuals and families, with complete access to benefits the moment membership begins. The ID Commander Family Protection Plan provides a truly managed household program and empowers individual family members with the tools and data they need to proactively manage the health and well-being of their identities.

If the worst happens, and you become the victim of identity theft while covered by ID Commander, we will restore your identity and any related credit accounts to pre-theft status. No limits, no fine print, no "service guarantee." In addition, if you suffer any covered out-of-pocket expenses as a result of a breach, you're covered by a real insurance policy that will put money in your hands for qualified losses.

Take command of your future with ID Commander – sign up today!

ID Commander Bi-Weekly Rates	Ultimate
Individual	$4.85
Family	$10.38

FINANCIAL WELLNESS



Choose your own path.

Learn
Read up on a wide variety of financial content.

Manage
Keep an eye on your credit score, set financial goals, and track your spending.

Organize
Securely connect your student loans and have an organized picture of them in one spot.

Explore
Use financial tools to help manage student debt, learn how to invest, and more.

Areas to explore

Your benefits: Receive special offers on SoFi products like a 0.25% rate discount* for student loan refinancing

Your finances: Monitor your credit, save for life milestones, and track your spending.

Insights: Check out fresh content on current events, including SoFi's Daily Pod.

Resources: Visit and explore a full library of financial content, covering a range of topics.

Tools: See a complete picture of your student debt and get recommendations–whether it's around managing your student loans, or picking the right 529 college savings plan.

Access your dashboard today.

1. Visit SoFi.com/JHS
2. Enter your last name and work email.
3. Create a SoFi account or log in to your existing account.
4. Land on your dashboard and explore.

*1Terms and conditions apply. Offer good for new student loan refinancing customers only and subject to lender approval. To receive the offer, you must: (1) register and/or apply through the referral link you were given; (2) complete a loan application with SoFi within 90 days of your application start date; (3) and meet SoFi's underwriting criteria. Once conditions are met the interest rate shown in the Final Disclosure Statement will include an additional 0.25% rate discount because of your involvement with a SoFi partner company at the time of loan origination. Cannot be combined with other rate discounts, with the exception of the 0.25% autopay rate discount. Autopay is not required to receive a loan from SoFi. SoFi reserves the right to change or terminate the Rate Discount Program to unenrolled participants at any time with or without notice.

NOTICE: Recent legislative changes have suspended all federal student loan payments and waived interest charges on federally held loans until 09/30/21. Please carefully consider these changes before refinancing federally held loans with SoFi, as in doing so you will no longer qualify for these changes or other current or future benefits applicable to federally held loans.

SoFi's Relay tool offers users the ability to connect both in-house accounts and external accounts using Plaid, Inc's service. The credit score provided to you is a Vantage Score® based on TransUnion™ (the "Processing Agent") data. Licensed by the Department of Financial Protection and Innovation under the California Financing Law, license #6054612. NMLS #1121636 (nmlsconsumeraccess.org). The Student Debt Navigator tool and 529 Savings and Selection tool are provided by SoFi Wealth, LLC, an SEC Registered Investment Advisor.
2750 E. Cottonwood Parkway #300 Cottonwood Heights, UT 84121. ©2020 Social Finance, Inc. All rights reserved. Information as of October 2020 and is subject to change. AW20-250289

Double your tax-deferred retirement savings

Contribute to both: 403(b) plan and 457(b) deferred compensation plan

Take advantage of this powerful way to save

Your employer offers you the opportunity to save in a 403(b), a 457(b) deferred compensation plan or both. Because you can choose to contribute to one or both, you can select the plan with features that best suit your situation.

Double your tax-deferred retirement savings

How do the plans differ?

There are some significant differences between the plans, especially when it comes to withdrawals. Consider these differences when deciding which plan will suit you best.

403(b)	457(b)
Withdrawals prior to age 59½ may be subject to a 10% federal early withdrawal tax penalty, unless an exception applies.	Unlike the 403(b) plan, the 10% federal early withdrawal tax penalty for withdrawals prior to age 59½ does not apply to distributions from 457(b) plans except on amounts rolled into the plan from non-457(b) plans — including IRAs.
Less stringent hardship withdrawal restrictions while you are employed.	More stringent unforeseeable emergency withdrawal restrictions while you are employed.
Examples of financial hardship include: • Certain unreimbursed medical expenses • Payments to purchase a principal residence • Qualifying expenses for higher education • Payments to prevent eviction from or foreclosure of a mortgage on a principal residence	Examples of unforeseeable emergency include: • You or a dependent suffer an accident or unexpected illness • Loss of property due to casualty • Other similar extraordinary circumstances arising as a result of events beyond your control Sending a child to college or purchasing a home, two common reasons for 403(b) hardship withdrawals, generally are not considered unforeseeable emergencies.

If this sounds complicated, don't be dismayed. You don't have to make the decision by yourself! The information in this flyer can help you get started, and then you can talk it over with your local financial advisor.

FINANCIAL WELLNESS

Save With CollegeAmerica.®

With tuition costs rising faster than inflation, many students need assistance paying for their education. To help you save for this important goal, your employer, working alongside a financial advisor, is offering you a CollegeAmerica 529 plan as part of your benefits package.

Powered through Valic: You Get Some Great Benefits

- **Tax-advantaged investing** — Earnings in a 529 account grow free from federal tax. This can help you accumulate more over the long term.
- **Flexibility** — You can use the assets in your account to fund qualified, educational expenses for eligible K-12 school (up to $10,000 per year per student for K-12 tuition), public or private college — undergraduate, graduate, professional, or vocational. Qualified expenses include tuition, fees, room and board, and many more.
- **Investing for any beneficiary** — You can save for anyone — your children, grandchildren, nieces, nephews, friends, etc. You can even save for yourself. In addition, there are no age or income limits.
- **Convenience of automatic investing** — You easily invest on a regular basis through deductions from your personal bank account or payroll deductions (if available). For details, talk to your employer.
- **Low plan costs** — You never pay a sales commission, and you benefit from low operating expenses. That way more of your money goes toward pursuing your goal.
- **Control over your account** — Unlike other education funding vehicles, you always control the assets in a 529, even when your beneficiary reaches the age of enrollment.

UW@WORK - JHS FINANCIAL WELLNESS SERVICES

Learn about FREE Financial Coaching at a Jackson UW@Work Event Near You

Earlier this year, Jackson partnered with United Way of Miami-Dade's Center for financial stability to bring the UW@WORK program to the health system. UW@WORK is an HR financial initiative that gives employees who make up to $60,000 a year access to a team of experts that can help them jumpstart their finances and achieve their goals.

To learn more about what UW@WORK has to offer, visit one of their upcoming events at Jackson Memorial Hospital, Jackson North Medical Center, and Jackson South Medical Center. Services are available in Spanish, Kreyol, or English.

For more information,
Email: UWWork@UnitedWayMiami.org
Phone: 305-646-7175
Links: UW@Work Financial Coaching

NOTICES

COBRA Q&A

Overview

COBRA is a continuation of Plan coverage when it would otherwise end because of a life event, also called a "qualifying event." 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 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 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; or
- 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 after the qualifying event occurs. You must provide this notice to Jackson Health Systems.

Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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 **Healthcare.gov**.

More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer.

Keep Address Updated

To protect your family's rights, let your 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.

NOTICES

TAXABLE BENEFITS AND THE IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pretax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pretax and after-tax dollars, then any payments received under the plan will be taxed on a pro-rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual Healthcare expenses you incur, if these premiums were paid with pretax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

LIFE INSURANCE PREMIUMS AND THE IRS

According to IRS regulations, you can pay premiums on a pretax basis for the first $50,000 of life insurance coverage under a group term life insurance, a group term life insurance plan, covering your life. However, you must pay tax on such coverage exceeding $50,000.

SOCIAL SECURITY

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through a cafeteria plan may generally outweigh the Social Security reduction. Call the service center at 1-855-569-3262 for an approximation.

DISCLAIMER - HEALTH INSURANCE BENEFITS PROVIDED UNDER HEALTH INSURANCE PLAN(S)

Health Insurance benefits will be provided not by your employer's flexible benefits plan, but by the health insurance plan(s). The types and amounts of health insurance benefits available under the health insurance plan(s), the requirements for participating in the health insurance plan(s) and the other terms and conditions of coverage and benefits of the health insurance plan(s) are set forth from time to time in the health insurance plan(s). All claims to receive benefits under the health insurance plan(s) shall be subject to and governed by the terms and conditions of the health insurance plan(s) and the rules, regulations, policies and procedures from time to time adopted.

NOTICE OF FBMC'S CAPACITY

FBMC Benefits Management, Inc. (FBMC) has been authorized by your employer to provide certain administrative services for some the insurance plans offered within your employer's benefit program. Importantly, FBMC is not the policyholder or an insurance company. The policyholder is the entity to whom the insurance policy has been issued; the employer is the policyholder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate. The insurance companies noted in this guide have been selected by your employer and are liable for the funds to pay your insurance claims.

NOTICES

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **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 **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 **askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in Florida, you may be eligible for assistance paying your employer health plan premiums.

If you reside outside of Florida, view the entire CHIP Model Notice online at

https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.doc

Contact your state for more information on eligibility.

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

To locate the list of states, current as of July 31, 2021, or to view states that have recently added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

NOTICES

CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM JACKSON HEALTH SYSTEM 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 Health System 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 Health System has determined that the prescription drug coverage offered by the Jackson First HMO, Jackson Select HMO and Jackson POS plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are 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.
3. 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 Oct. 15, 2021 to Dec. 7, 2021.

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? Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of you current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Jackson Health System coverage, be aware that you and your dependents will 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 Health System 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...Refer to your certificate of coverage issued by your medical insurance plan or visit avmed.org/jhs. Contact AvMed at 844-439-5378.

You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

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 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 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).

Last Updated: Oct. 27, 2021
Name of Entity: Jackson Health System
Contact-Position/Office: Human Resources
Health and Wellness Department
Address: 1500 NW 12 Ave, Suite 106 W., Miami, FL 33136
Phone Number: 786-466-8378

NOTICES

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

HIPAA 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). However, you must request enrollment within "30 days" or any longer period that applies under the plan after your 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:

FBMC On-site Service Center
1611 NW 12 Ave, Park Plaza West, L-109B
Miami, FL 33136
Phone: 305-585-6512
JHSFieldOffice@fbmc.com

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including: all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 855-56JHS4U (855-565-4748) for more information.

Designation of Primary Care Physician

JHS generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, JHS designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care

providers, contact the AvMed at 1-844-439-5378 or visit **avmed.org/jhs**. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from AvMed or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the AvMed at 1-844-439-5378 or visit **avmed.org/jhs**

JHS Wellness Program Notice of Reasonable Alternative

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact JHS at we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice Regarding Wellness Program

JHS's Wellness Program is 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.

As part of the Wellness Program for JHS's AvMed members, employees have the opportunity to complete a voluntary Health Risk Assessment or "HRA." The HRA consists of a biometric screening and brief health questionnaire. The health questionnaire is a series of questions about health-related activities and behaviors and personal history of certain medical conditions (e.g., cancer, diabetes, or heart disease). The biometric screening includes a blood finger stick to obtain a sample of blood to test Total Cholesterol, HDL, Total Cholesterol to HDL Ratio, and Blood Glucose. You are not required to complete the HRA or participate in the blood test or other medical examinations. Employees who complete the HRA will receive a $50 incentive.

The information from your HRA 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, such as participating in a Tobacco Cessation or Better You program, getting involved in on-site exercise or making an appointment with your primary care physician. You also are encouraged to share your results or concerns with your own doctor.

JHS's AvMed members who choose to participate in voluntary aspects of the wellness program will receive an incentive of up to $200 per school year. These voluntary health activities include participating in a race, having an Annual Physical by a Primary Care Physician, attending a health lecture, having dental cleanings and much more. If you are unable to participate in any of the health-related activities to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting JHS.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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.[1]

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.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact AvMed at 844-439-5378, or view online at www.avmed.org/jhs.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Jackson Health System		4. Employer Identification Number (EIN) 59-171-3947
5. Employer address 1611 NW 12th ave		6. Employer phone number 305-585-1111
7. City Miami	8. State FL	9. ZIP code 33136
10. Who can we contact about employee health coverage at this job? The Benefits Department		
11. Phone number (if different from above) 305-585-6512	12. Email address hr-benefits@jhsmiami.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:

☒ Some employees. Eligible employees are:

Any Full time regular employee, house staff employee, or part– time employee with benefits status.

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

Spouse/Domestic Partner, Dependent Children to age 26 (or age 30 if special eligibility conditions are met)

☐ We do not offer coverage.

☒ 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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

BENEFITS DIRECTORY

JACKSON HEALTH SYSTEM

Human Resources Capital Management
C/O HR Service Center
Jackson Medical Towers
1500 NW 12th Avenue, Suite 106W
Miami, FL 33136
305-585-6771

Housestaff Office Department
East Tower, Room 1004
305-355-1122

BENEFITS ADMINISTRATOR

FBMC Benefits Management, Inc.
Service Center
Monday - Friday, 7 a.m. - 7 p.m. ET
1-855-56JHS4U (1-855-565-4748)
myfbmc.com

FBMC On-Site Service Center
1611 N.W. 12th Avenue
Park Plaza West L-109B
Miami, FL 33136-1096
305-585-6512
JHSFieldOffice@fbmc.com

MEDICAL PROVIDER

AvMed
1-844-439-5378
avmed.org/jhs

SmartShopper
1-800-824-9127
AvMed.VitalsSmartShopper.com

Jackson First Concierge
305-585-2727

DENTAL PROVIDERS

Delta Dental
Delta Dental PPO - 800-521-2651
DeltaCare USA - 800-422-4234
PO Box 1809
Alpharetta, GA 30023-1809
PPO Group Number – 19083
DHMO Group Number – 78933
deltadentalins.com

VISION PROVIDER

Davis Vision
Vision Care Processing Unit
PO Box 1525
Latham, NY 12110
Member Service: 1-877-393-7363
davisvision.com

FLEXIBLE SPENDING ACCOUNTS

PayFlex
11819 Miami Street Suite 200
Omaha, NE 68164
Monday - Friday, 8 a.m. - 8 p.m. ET
Sat., 10 a.m. - 3 p.m. ET
1-800-284-4885

Toll-Free Claims Fax
1-855-703-5305

General Account Info - Voice Response
24 hours a day
1-800-284-4885
payflex.com

WELLNESS

Jackson Health System
1-786-466-8378
HR-Benefits@jhsmiami.org

EMPLOYEE ASSISTANCE PROGRAM

Resources for Living, LLC
55 Lane Road
Fairfield, NJ 07004
24/7 Access for Jackson Health System employees:
786-466-8377, Option 2

DISABILITY PROVIDER

Reliance Standard Life Insurance Company
Matrix Absence Management, Inc.
1-877-202-0055
24/7 for Telephonic Claims Filing or file online at matrixabsence.com

Reliance Standard Life Insurance Company
Matrix Absence Management, Inc.
PO Box 13498
Philadelphia, PA 19101
1-800-866-2301
Fax 602-866-9707

HOUSESTAFF DISABILITY AND LIFE INSURANCE PROVIDER

The Hartford/The Lawrence D. Share Company, Inc.
8211 West Broward Blvd Suite 400
Plantation FL 33324
305-577-3937
jmhinfo@ldshare.com

BENEFITS DIRECTORY

LIFE INSURANCE PROVIDERS

Chubb
Customer Service
1-866-445-8874
Monday - Friday, 7:30 a.m. - 6 p.m. CST
chubbworkplacebenefits.com

Reliance Standard Life Insurance Company
Customer Service
1-800-351-7500
reliancestandard.com

ReliaStar Life Insurance Company
A Member of the Voya® Family of Companies Customer Service
1-800-537-5024
PO Box 122
Minneapolis, MN 55440-0122
1-800-537-5024
voya.com

Transamerica Life Insurance Company
Customer Service
1-888-763-7474
transamerica.com

Unum Life Insurance Company of America
Customer Service
1-800-331-1538
unum.com

Unum Whole Life Insurance with Long-Term Care
Customer Service
Monday - Friday, 8 a.m. - 8 p.m. ET
1-800-635-5597
unum.com

Trustmark
Customer Care
1-800-918-8877
Customer Care Email
customercare@trustmarkbenefits.com

Claims Phone
1-877-201-9373
TrustmarkVB.com

TAX SHELTER ANNUITY PROVIDERS

AIG/VALIC
Miami District Office
701 Brickell Avenue, Suite 1950
Miami, FL 33131
Office Phone: 305-817-2250
Office Fax: 786-777-7626

VALIC Client Care Center:

1-800-448-2542
valic.com

LEGAL INSURANCE

ARAG®
500 Grand Avenue, Suite 100
Des Moines, IA 50309
1-800-247-4184
ARAGLegal.com/myinfo
Access Code: 17845jhs
ARAGLegalCenter.com

CRITICAL ILLNESS INSURANCE

Allstate Benefits
Customer Service
1-800-521-3535
allstatebenefits.com

ACCIDENT INSURANCE

Allstate Benefits
1-800-521-3535
allstatebenefits.com

HOSPITAL INDEMNITY INSURANCE

Allstate Benefits
1-800-348-4489
allstatebenefits.com

OTHER PROVIDERS

Pet Benefit Solutions
1-800-891-2565
customercare@petbenefits.com
petbenefits.com

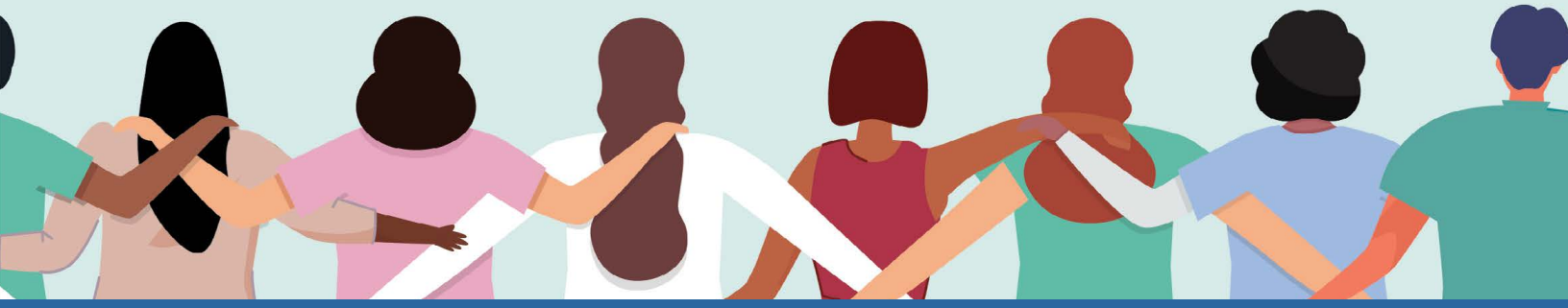
ID Commander
Membership Services
1-855-592-7941
Monday - Friday, 9 a.m. - 6 p.m. ET
idcommander.com

ConstantCredit
Membership Services
1-855-592-7940
Mon – Fri, 9 a.m. - 6 p.m. ET
constantcredit.com

Health Consumer/Fertility & Family Planning
Membership Services
1-800-800-8304
Mon – Fri, 8 a.m. - 8 p.m. ET
Sat., 9 a.m. - 6 p.m. ET
www.newbenefits.com

NOTES

Jackson
HEALTH SYSTEM



Jackson
HEALTH SYSTEM

Office Hours: 7:30 a.m. - 5 p.m. Monday - Friday ET

On-site FBMC Service Center
Jackson Memorial Hospital
1611 NW 12th Avenue, Park Plaza West, L-109B
Miami, FL 33136-1096
305-585-6512 • Fax 305-355-2324
JHSFieldOffice@fbmc.com

FBMC
BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
PO Box 1878 • Tallahassee, Florida 32302-1878
FBMC Service Center 855-56JHS4U (855-565-4748)
myFBMC.com

Disclaimer: This guide does not contain an exhaustive list of the terms and conditions of each benefit. Please refer to the policy, certificate of coverage, or the carrier for more information. Information contained herein does not constitute an insurance certificate or policy. Certificates or policies will be provided to participants following the start of the plan year, if applicable.