2025 RETIREE UNDER 65 BENEFITS GUIDE

Health, Wealth, and More

Jackson
HEALTH SYSTEM

Miracles made daily.

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Important Dates to Remember

Your open enrollment dates are:
Oct. 28, 2024– Nov. 15, 2024

Your plan year dates are:
Jan. 1, 2025 – Dec. 31, 2025

ONLINE RESOURCES:

Click below to view important information:

- **Jackson Benefits Website: JacksonBenefits.org**

Mindful Reminders:

LISTED BELOW ARE THE CHANGES FOR THE 2025 PLAN YEAR:

- Rate increase for High Rx and High No Rx Medical Plans
- If you are currently covering Dependent Under 65 Or Children only:
- Premium Rate Increase for all Medical plans

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Open Enrollment News

- This is a CHANGES Only enrollment. **There are medical rate changes this year.** If you do not make changes during the open enrollment period, your current elected benefits will automatically continue for the 2025 Plan Year. If making changes, canceling, and/or decreasing coverage, you must complete your enrollment form and fax or mail postmarked by Nov. 22, 2024.

NOTE: 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 42 for more details.

KEY THINGS TO KNOW

2025 Plan Highlights

Core Benefits Available

Medical Plans

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

Dental Plans

- Delta Dental PPO Standard or Enriched
- DeltaCare USA DHMO Standard or Enriched

Vision Plans

- Base Plan
- Premier Plan

Mindful Reminders:

- Medical Premium Increase of 5% for all plans with the exception of the Jackson First HMO.
- Menopause Program Femmar, a new Menopause program available through Avmed medical coverage. Femmar's Menopause Program empowers women to learn about and manage their symptoms using the latest scientific, psychological, and medical research. Everything you need to get your symptoms under control and restore your well-being.

Important Enrollment Information

- You must enroll if you wish to make changes, cancel, or decrease coverage during the Open Enrollment period. You may not add coverage, add dependent coverage, or increase coverage.

You must fax/mail completed forms to:

- **FBMC Benefits Management, Inc.**
  PO Box 10789
  Attn: Mail Slot 32
  Tallahassee, FL 32302-2789
- Fax to: 1-866-836-9943

Mailed forms must be postmarked by Nov. 15, 2024, which is the last day of the enrollment.

Please direct all questions or comments to Customer Service at 855-56JHS4U (855-565-4748), Mon. – Fri., 7 a.m. – 7 p.m. ET.

Group Medical Plans

What AvMed medical plans are offered?

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

NOTE: If you are selecting health insurance, you are required to select a primary care physician. Jackson Standard HMO is a grandfathered-in plan and is only available to current participants. If you are currently enrolled in the Jackson Standard HMO, you can remain in it for 2025, unless you elect differently during Open Enrollment.

Jackson First HMO

Plan offers no referral needed to access the Jackson-only network. Employee and covered dependents must reside in Miami-Dade, Broward, and 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, and
- No coinsurance

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 charges 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 charges 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.

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MEDICAL PLANS

Medical Monthly Premiums

Jackson Retiree, Spouse/DP and Dependents

	JACKSON FIRST HMO PLAN	JACKSON SELECT HMO PLAN	JACKSON STANDARD HMO PLAN (GRANDFATHERED)	JACKSON POS PLAN
Retiree Only	$804.37	$847.61	$1034.31	$1,903.05
Retiree & Spouse/DP Under 65	$1688.33	$1779.02	$2335.98	$3,623.00
Retiree & Child(ren)†	$1563.78	$1647.84	$2147.09	$3,320.33
Retiree & Spouse/DP Under 65, plus Child(ren)†	$2058.98	$2169.64	$2892.47	$4,917.78
Retiree under 65 & Spouse/DP Over 65 on Medicare - with High HMO No Rx	N/A	$1,452.15	N/A	$2,507.59
Retiree under 65 & Spouse/DP Over 65 on Medicare Eligible - with High HMO Rx	N/A	$2,238.40	N/A	$3,293.84
Retiree under 65 & Spouse/DP Over 65 on Medicare Eligible - with High HMO No Rx, Plus Child(ren)	N/A	$2,252.38	N/A	N/A
Retiree under 65 + Child(ren) & Spouse/DP Over 65 on Medicare - with High HMO Rx	N/A	$3,038.63	N/A	N/A

† Option also applies to Adult Children (AC) between 26 through 30 years of age, children of Domestic Partners (DP) and/or eligible dependents.

† Option also applies to Adult Children (AC) between 26 through 30 years of age, children of DP and/or eligible dependents.

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MEDICAL PLANS

2025 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 Rider Wraparound: separate plan with buy-up option of $45 per pay period; designed for dependents living outside of South Florida. • Offers nationwide network for dependents residing outside of service area. • Access to a concierge appointment scheduling • Savings of up to $4868.76 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	$5 JHS PCP/ $15 All Others
Specialist Office Visits	$0	$15 JHS Specialist/$30 All Others
Preventive Services	$0	$0
Pediatrician Office Visits	$0	$5 JHS Pediatrician/$15 All Others
Routine Physical	$0	$0
Obstetrical/Gynecological	$0	$15 JHS OB-GYN/ $30 All Others
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%	$100 copay/$0 at JHS for hospital
Urgent Care	$50 participating; $100 non-participating; $5 copay/visit at Uhealth Jackson Urgent Care Centers	
Emergency	$200 copay (waived if admitted) , or $50 for ages 17 and under (Waived if Admitted)	$200 copay (waived if admitted) or $50 for ages 17 and under (Waived if Admitted)
Outpatient Surgery	$0	$200 Outpatient/ $0 at JHS

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MEDICAL PLANS

2025 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	$5 JHS PCP/ $15 All Others	Plan Pays 70% Coinsurance, After Deductible Is Met
Specialist Office Visits	$15 JHS Specialist/$30 All Others	Plan Pays 70% Coinsurance, After Deductible Is Met
Preventive Services	$0	Plan Pays 70% Coinsurance, After Deductible Is Met
Pediatrician Office Visits	$5 JHS Pediatrician/$15 All Others	Plan Pays 70% Coinsurance, After Deductible Is Met
Routine Physical	$0	Plan Pays 70% Coinsurance, After Deductible Is Met
Obstetrical/Gynecological	$15 JHS OB-GYN/ $30 All Others	Plan Pays 70% Coinsurance, After Deductible Is Met
Maternity	$30 copay for first visit. No charge for sub-sequent 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	$200 copay/$0 at JHS for hospital	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	$200 copay (waived if admitted) or $100 for ages 17 and under (Waived if Admitted)	$200 copay/$100 for age 17 and under (Waived if Admitted)
Outpatient Surgery	$200 Outpatient/ $0 at JHS	Plan Pays 70% Coinsurance, After Deductible Is Met

Chart continued on next page.

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MEDICAL PLANS

2025 MEDICAL PLAN CHARTS - avmed.org/jhs		
	JACKSON FIRST HMO	JACKSON SELECT HMO
Prescription Drugs	Includes prescription contraceptives at participating pharmacies nationwide. If member/physician selects Brand when Generic is available, member pays difference in cost plus Brand copayment. See plan literature for other participating pharmacies. No charge for generic medications under the Jackson First HMO for employees using the Jackson Pharmacy.	
Participating Network Pharmacy	$15 Generic/$35 Brand/ $50 Non-Preferred For 30-Day Supply	$15 Generic/$35 Brand/ $50 Non-Preferred For 30-Day Supply
Mail Order	$30 Generic/$60 Brand/ $90 Non-Preferred For 90-Day Supply	$30 Generic/$60 Brand/ $90 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	$0 at JHS/$100
Outpatient	$0	$5 JHS/$15
Behavioral Health		
Inpatient	$0	$0 at JHS/$100
Outpatient	$0	$5 at JHS/$15
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 for approval)	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).

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MEDICAL PLANS

2025 MEDICAL PLAN CHARTS - avmed.org/jhs

	JACKSON POS IN NETWORK	JACKSON POS OUT OF NETWORK
Prescription Drugs	Includes prescription contraceptives at participating pharmacies nationwide. If member/physician selects Brand when Generic is available, member pays difference in cost plus Brand copayment. See plan literature for other participating pharmacies.	
Participating Network Pharmacy	$15 Generic/$50 Brand/ $65 Non-Preferred For 30-Day Supply	Plan Pays 70% Coinsurance, After Deductible Is Met
Mail Order	$30 Generic/$90 Brand/$120 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	$0 at JHS/$200	Plan Pays 70% Coinsurance, After Deductible Is Met
Outpatient	$5 JHS/ $15	Plan Pays 70% Coinsurance, After Deductible Is Met
Behavioral Health		
Inpatient	$0 at JHS/$200 Inpatient	Plan Pays 70% Coinsurance, After Deductible Is Met
Outpatient	$5 JHS /$15	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

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DENTAL PLANS

Choose from the following dental plans:

- Delta Dental PPO
- DeltaCare USA (DHMO)

Retirees may 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. Retirees 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 dental plans.

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 claim 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 Dental 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.

If you visit a non-contracted provider your out-of-pocket costs may be higher. Network dentists are paid at contracted fees.

Visit a dentist in the PPO[1] network to maximize your savings[2]. These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill[3]. Find a PPO dentist at **deltadentalins.com**

If you can't find a PPO dentist, consider a Delta Dental Premiere® dentist. These dentists have agreed to set fees and offer another opportunity to save.

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

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DENTAL PLANS

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.

- 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 Plan	Monthly Rates	
DeltaCare **(DHMO)**[*]	**STANDARD**	**ENRICHED**
Retiree Only	$9.97	$18.15
Retiree + One Dependent[†]	$16.48	$30.07
Retiree + Dependents[†]	$25.17	$47.81
Delta **PPO**	**STANDARD**	**ENRICHED**
Retiree Only	$38.88	$50.90
Retiree + One Dependent[†]	$76.92	$100.63
Retiree + Dependents[†]	$123.98	$162.27

+ Option also applies to Domestic Partners and/or Children of Domestic Partners and eligible dependents.

* DeltaCare (DHMO) plans are not available outside of Florida.

On the PPO plans, Non-Delta Dental dentists are reimbursed based on the PPO Fee Schedule instead of the maximum program allowance. As a result, members visiting a non-Delta Dental dentist may see a change in out-of-pocket costs.

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DELTA DENTAL PPO CHART

Delta Dental PPO Dental Plan	STANDARD	ENRICHED
CHOICE OF DENTIST	You'll likely save most with a dentist who participates in the Delta Dental PPO network, and you'll likely save least with a non-participating dentist. 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 Dental's applicable allowances and not necessarily the dentist's actual charge.	
MAXIMUM BENEFIT/DEDUCTIBLE[1]	$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
TYPE I	**STANDARD**	**ENRICHED**
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)
1208 Fluoride Treatment (up to and not including age 19)	100%, 2x per year	100%, 2x per year
1351 Sealant- Per Tooth	100% up to and not including ages 9 or 16 depending on the tooth number.	100% to age 16
1510 Space Maintainers	100% - up to and not including age 14	100% to age 19
TYPE II	**STANDARD**	**ENRICHED**
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% - child up to and not including 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 Coronal remnants - primary 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%
TYPE III	**STANDARD**	**ENRICHED**
Crown & Bridge:		
2791 Crown Full Cast Predominately Base Metal	50% - limited to 12 years and older	50%
2751 Crown Porcelain Fused To Base Metal	50% - limited to 12 years and older	50%
Pontics:		
6210 Full Cast	50% - are limited to 16 years and older	50%
6240 Porcelain Fused To Metal	50% - are limited to 16 years and older	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 disfunction (TMJ)	50%	50%
ORTHODONTIA		Adult & Child covered at 50%. $1,300 lifetime maximum benefit Deductible does not apply to diagnostic, preventive and orthodontics.
Consultation	Not Covered	
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.

[1] The deductible does not apply to any diagnostic or preventive services, and that amounts Delta Dental pays for those services do not count towards the annual maximum.

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DELTA DENTAL DHMO CHART

DeltaCare USA (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
1206 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: (White)		
2330 One Surface	$5.00	No Charge
2331 Two Surfaces	$5.00	No Charge
2332 Three Surfaces	$10.00	No Charge
2335 – 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 - anterior	$100.00	$90.00
Extractions:		
7111 Coronal remnants - primary 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 8090 Adult 8680 Orthodontic 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. $300	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. $300

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VISION PLAN

Davis Vision by MetLife

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 plan literature.

Vision Plan	Monthly Rates
BASE PLAN	
Retiree Only	$4.14
Retiree + One	$8.30
Retiree + 2 or more	$15.23
PREMIER PLAN	
Retiree Only	$9.95
Retiree + One†	$21.39
Retiree + 2 or more†	$41.29

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VISION PLAN

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 1.67/ High Index Lenses 1.74	$60/$120	$55/$120
Polarized Lenses	$75	$75
Progressive Lenses (Standard/Premium/Ulta/ Ultimate)	$65 / $105 / $140 / $175	$0 / $90 / $140 / $175
Anti-Reflective (AR) Coating (Standard/Premium/ Ultra/Ultimate)	$40 / $55 / $69 / $85	$35 / $48 /$60 / $85
Ultraviolet Coating	$15	$12
Tinting of Plastic Lenses (Solid / Gradient)	$15	$0
Plastic Photochromic Lenses (Transitions® Signature™)	$70	$65
Standard/Premium Scratch-Resistant Coating	$0 / $30	$0 / $30
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

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

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.

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LEGAL INSURANCE FROM ARAG

Legal happens.

Legal troubles can happen to anyone. We've all been there – you get caught speeding, a contractor ghosts you mid-remodel or true love doesn't work out. And when trouble happens, ARAG® legal insurance protects. ARAG also helps with other legal needs like contract reviews or adding your newborn to your will.

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.

How legal shows up in your life.

Most consumers believe legal troubles are rare, once-in-a-lifetime events. But they're far more common than you think. 85% of individuals experienced a legal event in the past three years[1]. These events often have a considerable impact on one's finances or family.

[1]ARAG Stress Research Study, general consumers and members with known legal issues, October 2022.

Why should you get legal insurance?

- Work with a network attorney and attorney fees are **100% paid in full** for most covered legal matters.
- **Save thousands of dollars**, on average, for legal matters by avoiding costly legal fees.
- **We help connect you** with local attorneys – many who average 20+ years of experience.
- Address yousr covered legal situations with a network attorney who is only **a phone call away** for legal help and representation.
- Use DIY Docs® to create a variety of **legally valid documents**, like a will or power of attorney, including state-specific templates.

What does legal insurance cover?

The ARAG legal insurance plan covers a wide range of legal needs, like the examples on the following page, where plan options are broken down.

Choose Flexible Benefit Options

You'll have two options to choose from: UltimateAdvisor®, which features a 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 and grandparents.

For specific details about your plan, and to view a complete list of coverages, visit:
ARAGlegal.com/myinfo
and enter Access Code:
17845ret.

To talk with someone, call ARAG at **800-247-4184**.

	UltimateAdvisor®	UltimateAdvisor Plus™
Retiree	$13.43	$18.07
Family	$17.73	$23.84

Any legal matter that occurs or is initiated prior to the effective date of your legal plan 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, in-office benefits are 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 rate if you have not previously hired an attorney.

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.

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

LEGAL INSURANCE FROM ARAG

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

Legal Insurance

800-247-4184

ARAGlegal.com/plans, access code 17845ret

You may be eligible to receive a minimum 25% reduced fee off a network attorney's normal 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.

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2023 Standard Plan Design Rev 1/22 200365jhsret

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PET ASSURE AND PETPLUS

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 **petbenefits.com/search**

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, or visit 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	Monthly Rates
Pet Assure Unlimited Plan	$8.00
PetPlus Single Pet Plan	$4.50
PetPlus Unlimited Plan	$8.50
Pet Assure Unlimited + PetPlus Single Pet	$12.50
Pet Assure Unlimited + PetPlus Unlimited	$16.50

Unlimited plans covers all pets in your household.

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CONSTANT CREDIT

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 first 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	Monthly Rate
Retiree	$11.50
Retiree + Spouse	$23.00

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 Monthly Rates	Ultimate
Retiree	$10.50
Family	$22.50

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 from your Plan Administrator free of charge upon request.

HIPAA SPECIAL ENROLLMENT NOTICE

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Plan Administrator.

NOTE: This assumes that the retiree plan is not a separate, standalone retiree plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 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 lymphedemas. Call your Plan Administrator for more information.

COBRA OVERVIEW

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage 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." Your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. This is not a complete account of all COBRA terms and conditions. Please contact your Plan Administrator for more information.

Note: This is optional and not required. It doesn't really satisfy any rule. This is just alerting the retiree that his or her dependents may have a COBRA right. The retiree no longer has COBRA rights if he or she has elected the retiree plan.

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.

NEWBORN AND MOTHER'S HEALTH PROTECTION ACT

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.
The length of stay may not be limited to less than: 48 hours following a vaginal delivery OR 96 hours following a cesarean section.
Determination of when the hospital stay begins is based on the following:

- For an in the hospital delivery: The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.
Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew

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- coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.

These rules do not mandate hospital stay benefits on a plan that does not provide that coverage. The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

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.

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. 15th to Dec. 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? 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

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

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, 2024
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

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Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

You're protected from balance billing for:

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

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

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up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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

In the state of Florida, there are comprehensive balance billing protections in addition to those provided by the federal No Surprises Act. Florida law states that insurance companies are not allowed to bill you for amounts beyond your plan's in-network cost-sharing amount. That protection applies to HMO and PPO insurance plans for emergency services by out-of-network providers and facilities, as well as non-emergency services provided by out-of-network providers at in-network facilities. For PPOs, the state payment standard applies to emergency services and non-emergency services provided by out-of-network providers at in-network facilities. For HMOs, the state payment standard only applies to emergency services but the state also has a claim dispute resolution program in place. Under Florida law, these protections do not apply to ground ambulance services for PPO insurance plans, patients enrolled in PPO insurance plans who consent to non-emergency out-of-network services, and patients with self-funded insurance plans. The laws put in place by the state of Florida work together with the requirements of the No Surprises Act to ensure that you are protected from surprise medical bills.

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

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

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ONLINE RESOURCES

DOWNLOAD AN FRS, PHT, OR ACH FORM AT JACKSONBENEFITS.ORG

FAX IN OR MAIL TO:

FBMC Benefits Management, Inc.
Retiree and Direct Bill Department
PO Box 10789 Att: Mail Slot 32
Tallahassee, FL 32302-2789
Fax: 1-866-836-9943

Forms are only required if you are adding any NEW benefits.

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JHS NURSE EMERITUS PROGRAM

The JHS Nurse Emeritus Program is our way of supporting our new to practice nurses as they integrate into the workforce, and ensure that their experience is a positive one. Our nurses will gain real time experiences with our retired nurses, called Nurse Emeriti, to help them navigate the ups and downs of their new profession. The JHS Nurse Emeritus program will help us to fulfill our mission to retain the brightest and the best for the care of our patients. So, if you have retired from JHS with in the last 3 years and would like to give back, while being paid, to this fine organization that helped you to retire comfortably.

PLEASE CONTACT US AT THE JHS CENTER FOR ACADEMIC PARTNERSHIPS:

Beverly Fray, PhD, APRN-CNS-BC
Manager, bfray2@jhsmiami.org
Office: 305-585-6684
Cell: 305-586-6753

Anabel Perez, Specialist
Anabel.perez@jhsmiami.org
Office: 305-585-7158
Cell: 305-505-5238

Andrea Socorro Sardi
andrea.socorrosardi@jhsmiami.org
Office: 305-585-3491

JACKSON VOLUNTEER PROGRAM OPPORTUNITIES

Share your time and continue your caring commitment to Jackson Health System by volunteering with us. To learn about opportunities to offer non-clinical support through the volunteer program, please contact **Volunteer.Resources@jhsmiami.org** or call:

Jackson Memorial Medical Center Volunteer Services: 305-585-6541

Jackson North Medical Center Volunteer Services: 305-654-5060

Jackson South Medical Center Volunteer Services: 305-256-5159

Jackson West Medical Center Volunteer Services: 786-466-1076

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BENEFITS DIRECTORY

CONTRACT ADMINISTRATOR

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

FBMC On-Site Service Center
1140 NW 16 Street
Park Plaza West L-109B
Miami, FL 33136-1096
1-305-585-6512

MEDICAL PROVIDER

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

Jackson First Concierge
(Jackson First HMO and Jackson Select HMO Participants for services at JHS)
305-585-2727

Social Security
1-800-772-1213
Social Security On Campus:
305-585-2559
ssa.gov

OVER 65 MEDICARE
Advantage Plans

AVMED
1-800-453-4564
Mon – Fri, 8 a.m. – 8 p.m. EST
Medicare Post enrollment:
1-800-782-8633(TTY 711)
Oct. 1 - March 31:
Mon. – Sun., 8 a.m. – 8 p.m. EST
April 1 - Sept. 30:
Mon. - Fri., 8 a.m. - 8 p.m.
and Sat., 8 a.m. - 1 p.m. EST

HUMANA
1-800-824-8242 (TTY 711)
Mon – Fri, 8 a.m. – 8 p.m. EST
Post enrollment: 1-866-396-8810
(TTY 711)

OVER 65 MEDICARE
Part B Supplemental Options

Humana
Antonio Cruz
Senior Manager, Humana
6101 Blue Lagoon Dr. Suite 199
Miami, FL 33126
acruz2@humana.com
Toll Free: 1-800-824-8242
Fax: 305-698-3169
AvMed
Christian Munoz
Field Benefits Consultant - Medicare
Christian.munoz@avmed.org
Mobile: 305-903-4775
Office: 1-800-453-4564
avmed.org

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 by MetLife
Vision Care Processing Unit
PO Box 1525
Latham, NY 12110
Member Service:1-833-393-5433
metlife.com/mybenefits

LEGAL INSURANCE

ARAG
500 Grand Avenue, Suite 100
Des Moines, IA 50309
1-800-247-4184
ARAGlegal.com/myinfo
Access Code 17845ret

OTHER PROVIDERS

Pet Benefit Solutions
1-800-891-2565
customercare@petbenefits.com
www.petbenefits.com/land/jacksonhealthretirees

ID Commander
Membership Services
1-855-592-7941
Mon - Fri, 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

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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.