

2026



EMPLOYEE BENEFITS GUIDE

#EmployeeObsessed with Benefits That Work for You

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ONLINE RESOURCES:

Click below to view important information:

- Jackson Benefits Website
JacksonBenefits.org
- Enroll Online
Jacksonbenefits.org
- View the 2026 Benefits Reference Guide
- Make an appointment at JacksonBenefits.org 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 64 for more details.

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WHAT'S HAPPENING AT JHS?



Jackson Medical Group at Plantation, a clinic exclusively for Jackson team members and their adult dependents, is **now open right in your backyard**. The clinic offers you and your loved ones family medicine services, which includes point-of-care testing like flu and COVID-19 tests, vaccines, EKGs, onsite blood collection, and more.

Jackson Medical Group at Plantation is open from 8 a.m. to 4:30 p.m., Monday through Friday, and is located at 600 S. Pine Island Road, suite 200, Plantation, FL 33324.

To make an appointment, call **305-355-6060**.



STAY CONNECTED

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

MORE CONTACT INFO

For enrollment 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. For technical issues contact: FBMC Online Technical Support: techsupport@fbmc.com

Important Dates to Remember

Your Open Enrollment dates are:
Nov. 3, 2025 through Nov. 19, 2025

Your plan year dates are:
Jan. 1, 2026 through Dec. 31, 2026

Think of
**Jackson
First**

Connect With Us



KEY THINGS TO KNOW

Open Enrollment 2026 Plan Highlights

Welcome To Your 2026 Jackson Health System Benefits Open Enrollment!

Read below to understand how benefit updates may impact you and your covered dependents, effective January 1, 2026.

- **Aetna** will be the new medical benefits administrator for plan year 2026.
- **If you don't have any changes, no action needed from you!**
- **Wellness Medical Premiums:** All employees enrolled in a medical plan had the opportunity to secure a wellness medical premium rate for the 2026 Plan Year. Employees who did not complete by September 30th, 2025 their wellness visit will see an increase of \$50 bi-weekly, for the 2026 Plan Year.

Be Mindful

- **Medical Premium:** There is no increase to the Jackson First HMO; there will be an increase of 5% to the premiums for the Select and POS.
- **Healthcare Flexible Spending Account:** Annual contribution maximum increased from \$3,200 to \$3,300.
- **Dependent Flexible Spending Account:** Annual contribution maximum increased from \$5,000 to \$7,500.
- **Flexible Spending Account (FSA):** If currently enrolled in a Flexible Spending Account (FSA), you must re-enroll during the Open Enrollment period for the 2026 plan year, as these do not rollover.
- **Coming Soon:** New Wellness Coach & Trainers! Stayed tuned for more information.

Mindful Reminders

- **Total Rewards Benefit Menu:** Offers full-time employees including non-union company code 300, AFSCME, SEIU nurses and professionals, and GSAF the flexibility and option to forego certain benefits in exchange for a pay supplement in lieu of a specific benefit with a maximum value of up to 20% of base salary.
- **Virtual Mental Health Network:** Aetna's network of virtual therapists are available via Jackson Health's medical plans, giving you options to secure unlimited and accessible mental health care through Tava and many other behavioral healthcare providers. See Page 25.

- **Jackson First Rider** - for dependents of Employees enrolled under Jackson First, who may reside outside of the tri-county area (Miami-Dade, Broward and Palm Beach) need to complete an "Away from Home" form available on JacksonBenefits.org
- An Over-age Dependent* Affidavit is **required yearly for dependents between the ages of 26-30 covered under the Medical Plans.**
- Dependent Verification Documents are required for any **newly** added dependent.
- **529 college Savings Plan** - We're excited to continue offering an opportunity to help you save for education expenses through a 529 plan. A 529 plan is a tax-advantaged savings plan designed to encourage saving for future education costs. We're offering this option through payroll deduction, which would allow you to automatically contribute a portion of your paycheck to your 529 plan account. Refer to Page 60 for more information (refer to the corebridge pages).
- **Menopause Program** Femmar's Menopause Program empowers women to learn about and manage their symptoms using the latest scientific, psychological, and medical research. Femmar is a benefit offered through the medical plan. The science-based online program offers structured guidance through weekly modules. It includes written lessons with informative videos, tools to keep you on track, expert tips, and motivational content. Everything you need to get your symptoms under control and restore your well-being. This program is covered under your medical insurance. If you are interested in joining the program, please reach out to HR-Benefits@jhsmiami.org.
- **The Ultra Human Smart Ring** is a wearable fitness device designed to monitor various health metrics such as heart rate, body temperature, sleep quality, and activity levels. By providing real-time insights and personalized data, the ring aims to help users optimize their health, performance, and recovery. You can now purchase the Ultra Human Smart Ring through payroll deductions for as little as \$10.65 a pay period, totals \$276.90 (including taxes), which is 25% discount for all JHS employees. Be sure to enroll during open enrollment.

KEY THINGS TO KNOW



Menu only available to full-time employees, including non-union company code 300, AFSCME, SEIU nurses and professionals, and GSAF. Excludes leaders (company 200 and above), physicians, and house staff residents, and fellows

BENEFIT OPTIONS	SELECTION	ANNUAL \$ AMOUNT
Health Insurance	WAIVED	\$5,850.00
Dental Insurance	WAIVED	\$400.00
Paid time off	WAIVED*	8% OF BASE SALARY
Life and disability insurance: basic and survivor benefits (employer paid coverage as applicable).	WAIVED	\$550.00
Total annual subsidy to receive	WAIVED	SUM OF ALL SECTIONS WITH A MAXIMUM VALUE OF UP TO 20% OF THEIR BASE SALARY

* Paid time off is inclusive of extended illness time for union employees. Even if paid time off is waived, 12 days of paid time off are still provided to employees annually to be used for personal leave for that calendar year. Unused days cannot be rolled over or cashed out after the corresponding calendar year.

[CLICK TO VIEW TOTAL REWARDS FAQ INFORMATION >>](#)

Meet our miracle workers

Welcome to Jackson Medical Group. Jackson Health System's physician group provides patients convenient, high-quality options close to home and work. To make it even easier to connect with the right provider, we've created this directory for patients and their doctors. Now you have world-renowned care right at your fingertips. For full physician biographies, visit JacksonMedicalGroup.org.

North Miami

Jackson Medical Group | North Miami
1801 N.E. 123rd St., suite 410
Miami, FL 33181



Nicholas Cellibas, MD

Coral Gables

Jackson Medical Group | Coral Gables
3737 S.W. 8th St., suite B
Coral Gables, FL 33134



Michael Gutierrez, MD

Miami Beach

Jackson Medical Group | South Beach
615 Collins Ave.
Miami Beach, FL 33139



Saraswati Lobst, MD

Overtown

Jefferson Reaves, Sr. Health Center
1009 N.W. 5th Ave.
Miami, FL 33136



Maurizio Sepe, MD

Doral

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



Marta D Cabrera, MD

Miami Gardens

North Dade Health Center
16555 N.W. 25th Ave.
Miami Gardens, FL 33143



Castro Bonny, MD



Saraswati lobst, MD

South Dade

Jackson Medical Group | Jackson South Medical Plaza
15155 S.W. 97th Ave., suite 200
Miami, FL 33176



Joshua Blitstein, MD

Little Havana

Dr. Rafael A. Peñalver Clinic
971 N.W. 2nd St.
Miami, FL 33128



Roberto Gonzalez, MD

Miami Health District

Jackson Medical Group | Health District
1801 N.W. 9th Ave., suite 206
Miami, FL 33136



Sergio Perez, MD



Berta Pita, MD



Luis Rizo, MD

South Miami

Rosie Lee Wesley Health Center
6601 S.W. 62nd Ave.
South Miami, FL 33143

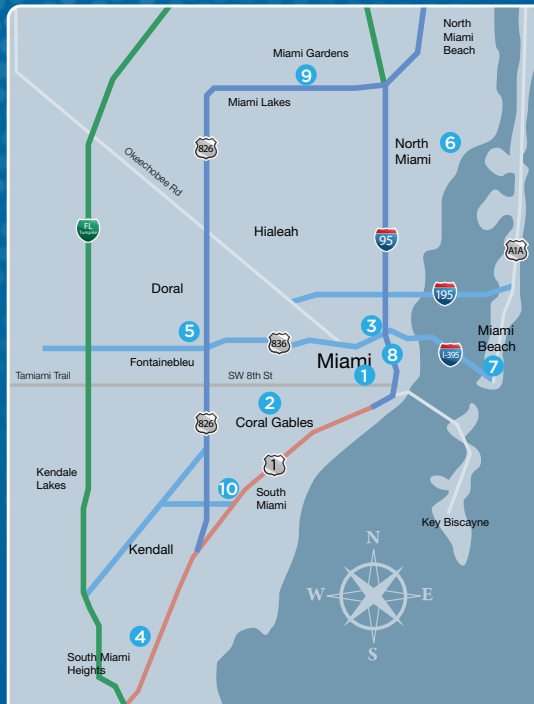


Carmen Andux, MD

JMG PHYSICIANS DIRECTORY

A network of **miracle workers**

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



- 1 Dr. Rafael A. Peñalver Clinic
- 2 Jackson Medical Group | Coral Gables
- 3 Jackson Medical Group | Health District
- 4 Jackson Medical Group | Jackson South Medical Plaza
- 5 Jackson Medical Group | Jackson West
- 6 Jackson Medical Group | North Miami
- 7 Jackson Medical Group | South Beach
- 8 Jefferson Reaves, Sr. Health Center
- 9 North Dade Health Center
- 10 Rosie Lee Wesley Health Center

Administrative Office

1611 N.W. 12th Ave.
Park Plaza West, suite 1
Miami, FL 33136
305-585-4564

JacksonMedicalGroup.org

**Jackson
Medical Group**
JACKSON HEALTH SYSTEM

Your support is important to Jackson Health System. To find out how you can get involved, contact Jackson Health Foundation today at **305-585-GIVE (4483)** or visit **JacksonHealthFoundation.org**.

JACKSON UHEALTH URGENT CARE CENTERS



UHealth Jackson Urgent Care centers

Coral Gables
3737 S.W. 8th St.
Coral Gables, FL 33134

Country Walk
13707 S.W. 152nd St.
Miami, FL 33177

Cutler Bay
18910 South Dixie Hwy.
Cutler Bay, FL 33157

Doral
7400 N.W. 104th Ave.
Doral, FL 33178

Keystone Point
13120 Biscayne Blvd.
North Miami, FL 33181

North Dade
16555 N.W. 25th Ave.
Miami Gardens, FL 33054

Quality care
close to home



UHealth Jackson
Urgent Care

UHealth Jackson
Urgent Care

What's urgent care?

At our UHealth Jackson Urgent Care centers, we provide quick, high-quality medical treatment for non-life-threatening conditions. If you're feeling sick or have a minor injury, our urgent care centers offer a faster, more affordable alternative to the emergency room.



When to visit UHealth Jackson Urgent Care

Our board-certified doctors are trained to treat patients of all ages for:

- Cold, flu, or COVID-19 symptoms
- Minor cuts, burns, or injuries
- Sprains, strains, or joint pain
- Urinary tract infections
- Allergies and skin rashes
- Dehydration
- Mild dizziness
- Fever without severe symptoms

For serious emergencies, such as chest pain, stroke symptoms, or severe injuries, call 911 or go to the emergency room.

What to expect during your visit

Walk in or check in online—no appointment needed. Once you arrive, one of our team members will evaluate you and determine the best course of treatment. Whether you need medication, testing, or expert advice, we're here to provide the care and support you need.



Why choose UHealth Jackson Urgent Care?

- **Shorter wait times:** Most visits take less than an hour.
- **Affordable care:** Lower cost than an emergency room visit.
- **On-site services:** X-rays, lab tests, and prescriptions available.
- **Compassionate staff:** Patient-centered care for all ages.
- **Autism-friendly:** We offer sensory-friendly rooms and trained staff to accommodate children with autism and related disabilities.

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 2026 benefits selection through INFOR 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. With the exception of anyone in a B5 part time as they will be waived ALL plans inclusive of Medical

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 >>](#)

[AETNA 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, 2025 to Oct. 11, 2026, can enroll in medical insurance at Open Enrollment with an effective date of January 2027.

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. Imputed income is the value of any benefits or services provided to an employee, and Employers must add imputed income to an employee’s gross wages to accurately withhold employment taxes.

[CLICK HERE FOR IMPUTED INCOME INFORMATION >>](#)

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, 2026. 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. The requested change must be consistent with the event. Visit the Home Page of your Infor portal to submit.

How to Complete a Change in Status

On the home page of your Infor portal, drop down the “Benefits” tab found on the left hand menu. Select Life Events and click on Add Life Event. Search for the life event that applies to you and click to select. Add the date your Life Event took place, please keep in mind the event would need to be within 30 days of you completing the entry. The life event has now been created and you will double click the line item to complete the enrollment application.

Follow through the prompts of the menu by clicking the “next” button on the top right after each category. The portal will first display your current benefits for reference and then prompt you to select your new choices. Make the changes to the plans as necessary, remember you are only able to modify the current plans enrolled in and will not be able to elect a different plan at this time. Attach the documents that support the reason for your change in status, such as a birth certificate for Birth or Marriage license if recently married.

You will view a Summary of selections as well as any Errors or Warnings for items selected incorrectly. Correct any errors and click Submit.

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 19th 2025, 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 Park Plaza West room L-109B 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 >>](#)

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.

ELIGIBILITY + COVERAGE

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 2025 or Spring 2026 semester school schedule or letter from the school verifying that your child is a student enrolled for Fall 2025 or Spring 2026
 - 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 2025, 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 \$0.88 per pay period for your medical, and/or dental plan premiums, Vision \$0.24, and \$2.00 per pay period for Flexible Spending Account(s). Your overall administrative fees for the Flexible Benefits Plan will not exceed \$4.00 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.

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
or via email to JHSFieldoffice@fbmc.com

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 2025 tax tables).

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, bi-weekly 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 bi-weekly 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**

“The comprehensive coverage and seamless access to quality care have been invaluable to me. From Emergency services to specialized treatments, Jackson First has exceeded my expectations, ensuring peace of mind and excellent health outcomes.”

– Ahmed Ahmed, PGY2

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 2026 (Oct. 1, 2025 - Sept. 30, 2026) 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 2027 Plan Year.

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

Jackson HEALTH SYSTEM 2026 Annual Wellness Visit PROVIDER VERIFICATION FORM
HEALTHCARE PROVIDER MUST PROVIDE CERTIFICATION BY COMPLETING THIS FORM

Employees who become benefit effective on or after August 1st of the current year, are exempt from completing the form for current fiscal.

Employee Name (Print): _____ Employee # / Badge # _____
Phone Number: _____
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: _____

***MEDICAL 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, lipid (CBC, CMP, Lipid panel, UA), immunization assessment, and Mammogram/Colonoscopy (as appropriate).
On the homepage of your later employee portal, drop down the Wellness tab found on the left-hand menu, select Annual Wellness to upload your completed form. Once uploaded, click the Submit button to finalize. You will receive an automated email notification of your submission - followed by a confirmation of approval/denial after your form has been reviewed.
When you stay up-to-date on preventive healthcare, you are taking action toward a longer, healthier, and happier life! Annual Wellness Visits are covered once every plan year (not once every 12 months).

For questions, please call 305 505 LIVE or visit HR.Benefits@jackson.org

MEDICAL PLANS

Medical Bi-weekly Rates AETNA Employee, Spouse, Domestic Partner & Child(ren)

	WELLNESS MEDICAL PREMIUM		
	JACKSON FIRST HMO PLAN	JACKSON SELECT HMO PLAN	JACKSON POS PLAN
Employee	\$0.00	\$63.67	\$191.01
Employee + Child(ren) [†]	\$105.00	\$217.64	\$485.60
Employee + Spouse/DP	\$120.00	\$256.33	\$585.28
Family [†]	\$160.00	\$364.62	\$1,011.74
Jackson First Rider	\$45.00	N/A	N/A

[†] 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 Bi-weekly Rates Medical Premium for Part-Time 24 Hours Status (B5)

	WELLNESS MEDICAL PREMIUM		
	JACKSON FIRST HMO PLAN	JACKSON SELECT HMO PLAN	JACKSON POS PLAN
Employee	\$25.00	\$113.67	\$291.01
Employee + Child(ren) [†]	\$155.00	\$292.64	\$610.60
Employee + Spouse/DP	\$195.00	\$356.33	\$735.28
Family [†]	\$260.00	\$489.62	\$1,186.74
Jackson First Rider	\$45.00	N/A	N/A

[†] 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.

"I recently signed up for the Jackson First medical plan and I can't believe the difference it has made in my life. The coverage is comprehensive, and the cost is affordable, making it the perfect choice for me and my family."

- Waqas Khan, Visitor Identification Associate

Why I Choose
**Jackson
First**

learn more about the Jackson First HMO
to enroll online, visit: JacksonBenefits.org.

MEDICAL PLANS

Understanding Your Medical Options

2026 MEDICAL PLAN CHARTS (JHS.Aetna.com)

	JACKSON FIRST HMO	JACKSON SELECT HMO
	<ul style="list-style-type: none"> 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 \$5,320.20 on annual premiums 	<p>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 Aetna contracted Jackson Health System Select HMO Network Provider.</p> <ul style="list-style-type: none"> 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; \$5 copay/visit at Uhealth Jackson Urgent Care Centers	
Emergency	\$200 copay (waived if admitted)	\$200 copay (waived if admitted)
Outpatient Surgery	\$0	\$200 Outpatient/ \$0 at JHS

MEDICAL PLANS

Understanding Your Medical Options

2026 MEDICAL PLAN CHARTS (JHS.Aetna.com)

	JACKSON POS IN NETWORK	JACKSON POS OUT OF NETWORK
	Access to an expanded network of providers in the state of Florida. In addition, Aetna 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 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	\$200 copay/\$0 at JHS for hospital	Plan Pays 70% Coinsurance, After Deductible Is Met
Urgent Care	\$100 at participating; \$5 copay/visit at Uhealth Jackson Urgent Care Centers	
Emergency	\$200 copay (waived if admitted)	\$200 copay (Waived if Admitted)
Outpatient Surgery	\$200 Outpatient/ \$0 at JHS	Plan Pays 70% Coinsurance, After Deductible Is Met

MEDICAL PLANS

Understanding Your Medical Options

2026 MEDICAL PLAN CHARTS (JHS.Aetna.com)

	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
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 by electing to buy into the away from home plans. (must complete a "Away From Home" form for approval)	All Aetna participating providers with admitting privileges at one of the covered hospitals are covered in the Select HMO. Dependents residing outside the network area may be covered.

* Formulary exclusions may apply, please refer to the summary of benefits and coverage at www.jhs.aetna.com.

MEDICAL PLANS

Understanding Your Medical Options

2026 MEDICAL PLAN CHARTS (JHS.Aetna.com)

	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
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 National network.	N/A

* Formulary exclusions may apply, please refer to the summary of benefits and coverage at www.jhs.aetna.com.

Welcome to Aetna!

We're excited to welcome Jackson Health System Employees to Aetna® beginning January 1, 2026.

While your current coverage and benefit options will largely stay the same, you'll now have access to Aetna's personalized programs and services designed to help you live your healthiest life. You'll continue to have access to plans focused on Jackson Health System and its affiliated providers, which offer quality care at a lower cost, close to home and work. In addition, you'll have the option to choose other plans that will include access to Aetna's statewide and national network. For more information and answers to frequently asked questions, visit [JHS.Aetna.com](https://www.JHS.Aetna.com).



National network strength with local expertise

We understand that change can bring uncertainty, but we are confident that the switch to Aetna® will offer significant advantages, including personalized guidance and support and access to Aetna's national network of providers. Our goal is to make this transition as smooth as possible for you and your family.

- ✓ **99% same providers** with 25,000 more local providers
- ✓ **100% of hospitals** in Florida are in-network
- ✓ **98% of hospitals nationally** are in-network
- ✓ **Students and retirees** outside of Miami-Dade and Broward counties have seamless access to Aetna's national provider network



Personalized health and wellness

Ongoing nurse support when you need it most

Your health — both physical and mental — is everything. Whether you're managing an acute issue or dealing with other complex health challenges, our nurses can help. A nurse can work with you to put together a plan, help you understand your benefit offerings, and answer your health-related questions.



Transition of care

With a 99% provider network match, your current providers are most likely already participating in our network. In rare cases where Transition of Care (TOC) coverage is needed, we ensure a smooth transition with no gaps in coverage.

If you are in the middle of care with a non-participating provider, please contact your Aetna Service Advocate Team at **1-855-755-0507** during Open Enrollment.

Aetna Onsite Team members will be available to meet with you in person in any of the different Open Enrollment sessions beginning October 27, 2025.



MEDICAL PLANS



Aetna Service Advocate Team

Elevating your service experience

Get personalized support and the answers you need

Your Aetna Service Advocate Team is here for you. They'll listen, understand your needs and find solutions that are right for you. A Service Advocate can help you:

- Get answers about a diagnosis
- Choose a doctor
- Learn about your coverage
- Plan for upcoming treatment
- Find health care solutions that fit your needs
- Learn how to use our online tools to make the right decisions
- Find network providers based on your medical needs
- Schedule appointments



Aetna Service Advocate Team • 1-855-755-0507
Available Monday through Friday, 8 AM to 6 PM



Aetna member website and mobile app

Manage your health care at home or on the go

Stay on top of your benefits

- Review your benefits and what's covered
- Track your spending
- View claims on your member website
- View your ID card online
- Get cost info before you get care

Connect to care

- Find in-network providers, including virtual care
- Locate walk-in clinics and urgent care centers near you
- See reviews for providers

Get started on 1/1/2026:

- Visit [MyAetnaWebsite.com](https://www.aetna.com) to register for your member website.
- Get the Aetna HealthSM app by texting **AETNA** to **90156** to receive a download link. Message and data rates may apply.

- OR -

Scan the QR code to download the Aetna Health app.



MEDICAL PLANS

Bringing heart and all-around support to Jackson Health System members

Here are just a few highlights of what you can expect



Urgent care from UHealth Jackson

UHealth Jackson Urgent Care provides the highest standard of care to patients of all ages. Walk-ins welcome.

With board-certified physicians on site, you'll get the treatment you need — so you can get back to being you again.

Visit [JacksonUrgentCare.com](https://www.jacksonurgentcare.com) for a full list of the conditions we treat.

Coral Gables
3737 S.W. 8th St.
Coral Gables, FL 33134
305-575-1600
8 AM – 8 PM

Doral
7400 N.W. 104th Ave.
Doral, FL 33178
305-585-9250
8 AM – 8 PM

Country Walk
13707 S.W. 152nd St.
Miami, FL 33177
305-585-9200
8 AM – 8 PM

Keystone Point
13120 Biscayne Blvd.
North Miami, FL 33181
305-585-9210
8 AM – 8 PM

Cutler Bay
18910 South Dixie Hwy.
Cutler Bay, FL 33157
305-585-9230
8 AM – 8 PM

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



24-hour nurse support

With our 24-Hour Nurse Line,* health information is a phone call away.

Members can:

- Get information on health and wellness topics
- Make better health care decisions
- Find out more about tests and procedures
- Get help preparing for a doctor's visit
- Receive emails with links to helpful videos, and more
- Get answers and guidance 24/7 by calling 1-800-556-1555 (TTY: 711)



Affordable and easy access

The care you need — in person or virtually

In addition to the UHealth Jackson Urgent Care Centers and UHealth Clinics at Walgreens, you now have access to CVS Minute Clinics, where **healthier happens together**®. This means you have even more options for when and where you get care.

- Get care 7 days a week including evenings, so you can feel better faster
- Choose from in-person and virtual care options to easily access care your way



Virtual care, anytime, anywhere

Members can get the convenient, flexible care they need through CVS Virtual Care®.



MDLIVE is being replaced by CVS Virtual Care. From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit.

- Most mental health visits are available within two weeks.
- You can access care 24/7 through our virtual clinic.

24/7 care

Virtually connect quickly and easily with a licensed provider for minor illnesses.

Mental health services

Talk with a therapist about your anxiety or stress. Or schedule with a psychiatric mental health nurse practitioner (PMHNP) for diagnosis, treatment and medication management.



Enrolled members can call 1-866-211-5678 to get started.

*While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line nurses can provide information on a variety of health topics.

Policies and plans are administered by Aetna Life Insurance Company or its affiliates (Aetna). Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health® family of companies. Subject to benefits and eligibility verification, CVS Virtual Care services are only available in the USA. Limitations may apply based on services and location. Controlled substances not prescribed. Members enrolled in qualified high-deductible health plans must meet their deductible before receiving covered non-preventive services at no cost-share. Adolescent mental health services are limited to Counseling only; Mental Health Medication Management and Psychiatry services remain available only for adults 18+. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Refer to [Aetna.com](https://www.aetna.com) for more information about Aetna® plans.

HEALTH + WELLNESS

SMARTSHOPPER

Smartshopper How AETNA SmartShopper Works

1. Your doctor recommends a qualifying procedure.
2. Call SmartShopper at 1-833-313-0145 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 **SmartShopper.com**.
3. Then, contact your doctor to schedule the service and inform Contact Aetna 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 Aetna SmartShopper, you will receive an incentive check in the mail within 60 days after your claim has been paid.

Cash Incentives on Medical Procedures and Diagnostic Tests

Aetna continues to offer SmartShopper for Plan Year 2026. 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 **SmartShopper.com** or call 1-833-313-0145 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 [JHS.Aetna.com](https://www.aetna.com/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 2027 Plan Year.

Employees have Fiscal Year 2026 (Oct. 1, 2025 – Sept. 30, 2026) to complete an annual wellness visit with their respective physician; employees who do not complete their wellness visit will see an increase of \$50 bi-weekly for the 2027 Plan Year.

* Employees who are hired within the calendar year of 2026 and have benefits effective as of August 1st will fall into the new fiscal year.

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

Jackson HEALTHSYSTEM 2026 Annual Wellness Visit PROVIDER VERIFICATION FORM

HEALTHCARE PROVIDER MUST PROVIDE CERTIFICATION BY COMPLETING THIS FORM

Employees who become benefit effective on or after August 1st of the current year, are exempt from completing the form for current fiscal year.

Employee Name (Print): _____ Employee # / Badge # _____
 Phone Number: _____

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: _____

MEDICAL 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 _____

A primary care annual wellness visit will include the vital signs, height, weight, pulse, BP, BMI, the history, physical exam, lipid (LDL-C, HDL-C, total lipids panel), UA), immunization assessment, and Mammogram/colonoscopy (as appropriate).

On the homepage of your prior employee portal, drop down the Wellness tab found on the left hand menu. Select Annual Wellness to upload your completed form. Once uploaded, click the Submit button to finalize. You will receive an automated email notification of your submission. Followed by a confirmation of approval/denial after your form has been reviewed.

When your only visit date on preventive healthcare, you are taking action toward a longer, healthier, and happier life! Annual Wellness Visits are covered once every plan year (not once every 12 months).

For questions, please call 305-585-5319 or email HRBenefits@jhs.miami.edu

Tobacco Cessation Program



Want to Quit Smoking?
 Call 305-585-5319 or
 StopSmoking@jhs.miami.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: 7:00 a.m. to 3:30 p.m.
Location: 901 NW 17th Street, Miami, FL 33136.

Park Plaza East Red Garage - 1st Floor





Get started with your online mental health benefit

Get back to feeling like you! Your psychological well-being can affect your physical health, relationships, and work performance. Tava's network of vetted therapists helps you step out of the fog and get back to a happier, more fulfilled you.

Tava is an affordable, confidential mental health benefit available to all full- and part-time employees and their eligible dependents (children 13+). The benefit provides access to therapy sessions with licensed therapists through Tava's secure, web-based technology platform. All you need for a live, video-based session is reliable internet access and a connected device with a camera (smartphone, computer, or tablet).

Covered

Tava is accessible via your employer's medical plan, giving you options to make getting care more affordable.

Convenient

Self-scheduled online video sessions means you get care whenever works best for you: days, nights, or weekends.

Confidential

Employers do not know who used the service. Your identity and anything you discuss is confidential.

Top Quality

Quality care from quality therapists. Tava's clinicians are licensed, vetted, and use evidence-based treatments.



Schedule your first appointment today at care.tavahealth.com

Whether you're feeling stressed, stuck, or burdened with something else, Tava can help. Support is available for a range of issues such as:

Addiction
Anxiety
Depression
Eating disorders
Family issues

Grief and loss
LGBTQ+ issues
Life changes
Postpartum issues
PTSD

Trauma
Relationship issues
Work pressure
Stress
and more...

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 JHS.Aetna.com



STEP 2: ANNUAL WELLNESS VISIT

Schedule your annual wellness visit and have your healthcare provider complete the 2026 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:

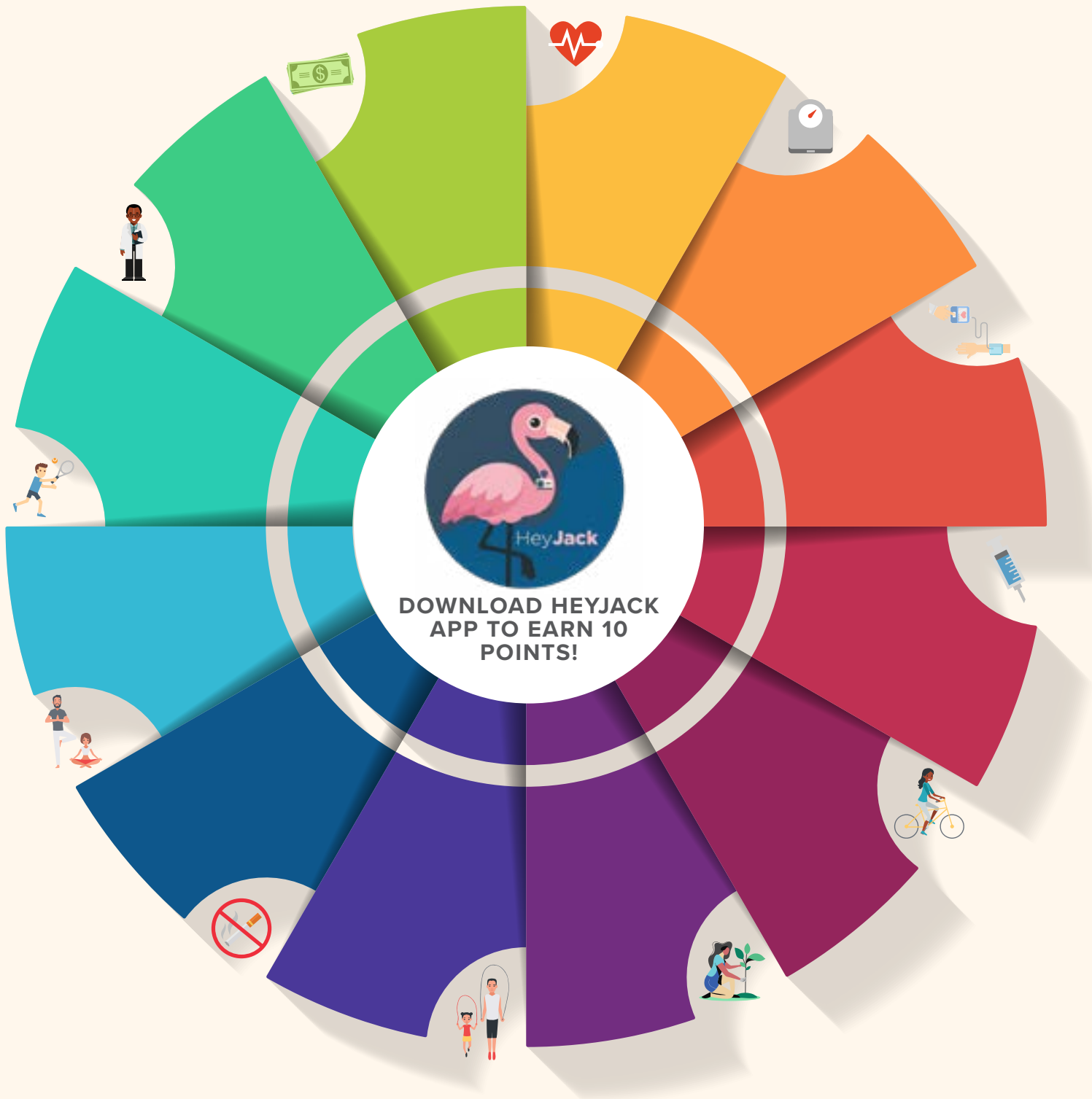
- 50 Points - \$50 • 75 Points - \$75 • 100 Points - \$150



DEADLINE

Earn your points by Dec. 1, 2026 and receive your reward in January of 2027 (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.

HEALTH + 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**

Resources for Living

To access services:

1-(786) 466-8377, TTY: 711 / resourcesforliving.com

Username: Jackson / Access code: Health



Jackson Health System

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 can access services 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 6 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, online with televideo, chat therapy or by phone. 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

Find care



It's easy to find a counselor you'd like to work with. You can:

- View provider options — images, bios, specialties and more
- Compare details — ethnicity, gender, language and more
- See which providers are open to new patients and when they're available
- Find options to schedule your first appointment online
- Get started quickly without any added steps or calls

Resources for Living

RESOURCES FOR LIVING



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
- Special needs
- Pet care
- Community resources/basic needs
- Summer programs for kids
- Household services and more

Legal services



You can get a free 30-minute consultation with a participating attorney for each new legal topic. Some of the areas of law and issues covered include:

- Family or domestic law
- Civil and criminal law
- Wills and estate planning
- Real estate and more

If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.

*Services must be related to the employee or an eligible household member. Exclusions include work-related and lack of merit issues. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial services



Simply call for a free 30-minute phone consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions

You can get a 25 percent discount on standard tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.

*Services must be for financial matters related to the employee or an eligible household member.

Online resources



Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Videos and podcasts
- Articles, blogs and self-assessments
- Mobile app
- Child and adult care provider search tool
- Live and on-demand webinars and more

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

Mind Companion Self-care

You have access to evidence-based support tools to help manage depression, anxiety, stress, substance misuse and more.

Additional services



Chat therapy — Send secure text messages to your counselor, who will respond within one working day up to five days a week. A week of texting counts as one session. You can also schedule to meet online for 30-minute televideo sessions. Each televideo session counts as one visit. Work on the same kinds of issues you'd see a counselor face-to-face to talk about.

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.



For legal disclaimers, visit rfl.com/Disclaimers.

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RFL-COM-Dist

Resources for Living®

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 Dental PPO plus Premier 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 PPO¹ network to maximize your savings². These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill³. 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.



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 Bi-weekly Rates

Delta PPO	PER PAY PERIOD	
	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.

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. Your next best option is the Delta Dental Premier 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/DEDUCTIBLE¹	\$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 0120 Periodic Oral Exam	Plan Pays (No deductible) - 100%	Plan Pays (No deductible) - 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% - limited to 12 years and older
2751 Crown Porcelain Fused To Base Metal	50% - limited to 12 years and older	50% - limited to 12 years and older
Pontics:		
6210 Full Cast	50% - are limited to 16 years and older	50% - limited to 12 years and older
6240 Porcelain Fused To Metal	50% - are limited to 16 years and older	50% - limited to 12 years and older
Prostodontics (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. The deductible does not apply to orthodontics. \$1,300 lifetime maximum benefit.
Evaluation	Not Covered	
Records	Not Covered	
Children	Not Covered	
Adult	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.

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
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	\$15.00	No Charge
2331 Two Surfaces	\$20.00	No Charge
2332 Three Surfaces	\$23.00	No Charge
2335 – Four or More Surfaces	\$25.00	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 Two Additional Every 12 Months	\$15.00 each (Twice every 12 months) \$60.00 each	\$15 each (Twice every 12 months) \$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
Prostodontics (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	You pay orthodontia as follows:	You pay orthodontia as follows:
Evaluation	Comprehensive for dependent children	Comprehensive for dependent children
Records	under age 19: \$1,500. Adults: \$2,800	under age 19: \$1,500. Adults: \$2,800
8080 Children - Normal Class II	\$200 copayment for pre and post orthodontic records.	\$200 copayment for pre and post orthodontic records.
8090 Adult - Normal Class II		
8680 Orthodontic Retention	\$300 copayment	\$300 copayment

VISION PLANS



Davis Vision Plan 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 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

Get LASIK and hearing aid discounts

With access to Quallsight and Your Hearing Network, you can save significantly on LASIK procedures and on hearing aids. To take advantage of these discounts call Quallsight at **1-877-201-3602** and/or Your Hearing Network at **1-888-494-1272**.

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

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/Ultra/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

CONTACTS² 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 ²

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)

	BASE PLAN COPAY	PREMIER PLAN COPAY
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. Certain brands are excluded and other limitations may apply

How to Access Online

Log into metlife.com/mybenefits, and enter your username and password. If you are new to the site, you will need to register online before logging in. When registering, you will need your:

Social Security number.

FLEXIBLE SPENDING ACCOUNTS



FSA Flexible Spending Account

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: \$3,300*

FOR DEPENDENT CARE FSA:

- Minimum Annual Contribution: \$260
- Maximum Annual Contribution: \$7,500



USE YOUR INSPIRA CARD®, YOUR ACCOUNT DEBIT CARD

The Inspira 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 Inspira 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. Cards are good for 5 years and will be renewed as needed. 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 \$3,750*.
- If you are single and head of household, your maximum annual contribution is \$7,500*.
- If you are married and filing jointly, your maximum annual contribution is \$7,500*.
- If either you or your spouse earn less than \$7,500* 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 \$6,000 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, 2026) after your 2025 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 2025 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:

Inspira Financial
Flex Department
PO Box 8396
Omaha, NE 68108-0396
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 Inspira

If you pay for an eligible expense with cash, check, or personal credit card, you can file a claim online at inspirafinancial.com or through the Inspira 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 Inspira. This form can be found in the Resource Center at inspirafinancial.com or you may call Inspira at 844-729-3539 to request a form.

After you log in to inspirafinancial.com, click on the **Financial Center** tab and select your account from the drop down. Click on **File a 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 inspirafinancial.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 Inspira member website. Log in to inspirafinancial.com and click on the **Link A Bank Account** 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, 210, 220, 310, 320 or 351: 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 150, 200, 300, 350 or 352: 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:

$$\frac{\text{Annual Salary}}{\text{\#Weeks}} = \text{Weekly Salary} \times \text{Benefit \%} = \text{Weekly Benefit}$$

$$\frac{\text{Weekly Benefit}}{\text{Per \$10 of Weekly Benefit}} \times \text{Rate} = \text{Monthly Rate} \times \frac{12}{12 \text{ Months}}$$

$$\frac{26}{\text{\# of Pay Periods}} = \text{Bi-weekly Premium}$$

*Note: “Annual salary is capped at \$111,429, based on the policy’s maximum benefit.”

Employees under Company Number 400, 410, 500, 600

JacksonBenefits.org

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 BI-WEEKLY 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, 150, 200, 210, 220, 300, 310, 320, 350, 351 or 352.

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 BI-WEEKLY 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. If you decide to enroll, you can keep the coverage at the same discounted rate when you leave Jackson Health System.

Optional 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 jmhinfol@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	3/12

Employer-Paid Short-Term Disability

Eligible Company Numbers	Plan
Employees under Company Numbers: 110, 210, 220, 310, 320 & 351	Elimination Period: Greater of: 6 consecutive working days (8 consecutive calendar days) or expiration of extended illness or accumulated sick leave. Maximum Benefit Duration: 110, 210, 220 & 351: 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: 150, 200, 300, 350 & 352 – Base Plan (Employer-Paid)	Benefit: 60% of weekly earnings to a maximum of \$1,000 Elimination Period: Greater of: 6 consecutive working days (8 consecutive calendar days) or expiration of extended illness or accumulated sick leave. Maximum Benefit Duration: 150, 200 & 352: 12 weeks 300 & 350: 25 weeks Pre-Existing Limitation: None
Employees under Company Numbers: 150, 200, 300, 350 & 352 – Buy-up Option (Employee-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.

Survivor Life:

Jackson Health System provides eligible employees with Group Term Survivor Life Insurance, where policy value is aligned in accordance with years of service. Survivors of employees who worked less than 10 years receive 2 weeks of pay & \$2,000; employed less than 20 years is valued at 4 weeks of pay and \$4,000; lastly 4 weeks of pay and \$6,000 if employed 20 years or more.

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

Be Protected When Legal Happens

Did you know that **3 out of 4** individuals have faced legal troubles in the past three years?¹ Most people believe legal troubles are rare, once-in-a-lifetime events, but they're **far more common** than you think.

A legal insurance plan from ARAG® covers a **wide range of legal needs** like the examples below to help you address life's legal situations.

- A contractor ghosts you mid-remodel.
- You need a contract reviewed.
- You get caught speeding.
- Your ex wants custody of your dog.
- You're being audited by the IRS.

6 Reasons to Enroll in ARAG Legal Insurance

- Work with a network attorney and attorney fees are **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 your covered legal situations with a network attorney who is **only a phone call away**.
- Your network attorney can help **throughout your legal matter**, including preparing and reviewing legal documents, offering legal advice and representing you in court.
- Use DIY Docs® to create, edit and store **state-specific legal documents**, like wills or powers of attorney.

Choose Flexible Benefit Options

Choose between two plans to get the coverage that best fits the needs of you and your family. **UltimateAdvisor®** covers most common personal legal issues.

UltimateAdvisor Plus™ includes more robust coverage plus additional services including Identity Theft Protection, financial education and counseling, tax services and services for parents/grandparents.

Bi-weekly Price	UltimateAdvisor®	UltimateAdvisor Plus™
Individual	\$6.20	\$8.34
Family	\$8.18	\$11.00

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.

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

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.

About Legal Insurance

What is Legal Insurance? Watch this video to discover how ARAG legal insurance protects you when legal happens. ARAG provides affordable coverage with more than 100+ ways to use your plan for both simple and complex legal issues.

Click to Watch Video



For specific details about your plan and to view a complete list of coverages visit:

ARAGlegal.com/myinfo
and enter Access Code: 17845jhs.

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



PERMANENT LIFE INSURANCE



Term Life Insurance Built for Today

Guaranteed Premiums¹

Life insurance premiums will never increase and are guaranteed to age 100. Thereafter no additional premium is due while the coverage can continue to age 121.

Guaranteed Benefits During Working Years

Death Benefit is guaranteed 100% when it is needed most—during your working years when your family is relying on your income. While the policy is in force, the death benefit is 100% guaranteed for the longer of 25 years or age 70.

Guaranteed Benefits After Age 70

Even after age 70, the full death benefit is designed to last through age 99 for non-tobacco users and age 95 for tobacco users based on the current interest rate and mortality assumptions. Regardless of interest rates, the death benefit after age 70 is guaranteed to always be at least 50% of the initial benefit and will likely be more given the current interest rate.

Paid-up Benefits

After 10 years, paid-up benefits begin to accrue. At any point thereafter, if you stop paying the premium, a reduced paid-up benefit is issued and can never lapse. That means when you retire, you can stop paying the premium and have a death benefit for the rest of your life—guaranteed.

Additional Benefit Options *(additional premiums required)*

Accidental Death

Doubles the death benefit if death results from an accident.

Child Term

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

Waives premium if you become totally disabled.

Payor Waiver of Premium

Waives premium of your spouse, if you become totally disabled.

Qualified Long Term Care (LTC)¹

If you need LTC, you can access your death benefit while you are living for home health care, assisted living, adult day care and nursing home care. You get 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid.

Contingent Benefit

Your contract contains a guarantee that in the event any future increase to the LTC rider premium might cause you to lapse your coverage within 120 days of an increase, you'll have the option to retain LTC benefits of a reduced amount without any increase in premium

Terminal Illness³

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.

Good things happen every day, and unfortunately hardship happens too. Let us help you protect everything you value.

1. 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. 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, Contenance, 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

LifeTime Benefit Term Features

Budget Friendly 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.

Highly Competitive Rates

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

Fully Portable and Guaranteed Renewable for Life⁴

Your coverage cannot be cancelled as long as premiums are paid as due.

Family Coverage

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

4. Except for nonpayment of premiums, coverage cannot be contested after it has been in force for 2 years for the date of issue. No statement made by an insured person shall be used in contesting the validity of coverage after it has been in force for 2 years.

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.

1. LongTermCare.gov, Feb. 18, 2020, acl.gov/ltc/basic-needs/how-much-care-will-you-need
2. Statista; March 17, 2021; www.statista.com/statistics/310446/annual-median-rate-of-long-term-care-services-in-the-us/
3. The 2021 Insurance Barometer Study, LIMRA and Life Happens, Oct. 14, 2021

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

TRUSTMARK UNIVERSAL

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.

Trustmark 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.

¹Universal LifeEvents death benefit reduces to 1/3 at age 70 or the beginning of the 15th policy year, whichever occurs last. Issue age is 18 to 64. Death benefit for issue ages 65+ won't reduce.

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** – Allows beneficiary to collect a death benefit even after long-term benefits are paid out.
- **Family coverage** – Coverage is available for employees, spouses, children, and grandchildren
- **Direct payment** - Long-Term Care Benefits paid directly to the policyholder and can be used for care services or any other personal needs.

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?

The Trustmark Universal LifeEvents and Universal Life Insurance Long-Term Care (LTC) benefit can be used to help pay for care services when you require assistance with 2 or more activities of daily living or have a cognitive impairment (like Alzheimer's). 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.

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 beginning of the 15th policy anniversary. Issue age is 18-64.

Benefit for terminal illness

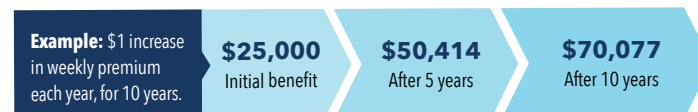
- **Use part of your death benefit** if you're diagnosed with a terminal illness to help manage costs.

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.

*This is the standard face amount of our (TMK Marketing) UL brochures.

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 3.75%.
- 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 August 10, 2023).

[CLICK HERE FOR WHOLE LIFE INSURANCE INFORMATION >>](#)

GROUP CRITICAL ILLNESS INSURANCE



Group 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.

Group 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
- Spouses are covered at 100% of the employee benefit amount and dependent children are covered at 50% of the employee benefit amount at no additional charge.
- Benefits paid regardless of any other medical or disability plan coverage
- Premiums are conveniently payroll deducted and are priced to fit most budgets.
- Coverage may be continued (with certain stipulations); refer to your certificate for more details.

Here's How it Works

You choose benefits to help 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 Group Critical Illness, you can make treatment decisions without putting your finances at risk.

Disclosure

Group Critical Illness insurance is underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers. CAIC is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. This is a brief product overview only. For complete details, please refer to the plans. Continental American Insurance Company | Columbia, SC AGC2300912R1 EXP 9/26

[CLICK HERE FOR THE GROUP CRITICAL ILLNESS BROCHURE >>](#)

GROUP ACCIDENT INSURANCE



Group Accident Insurance

Even when you live well, accidents can 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 any out-of-pocket expenses.

Key Features

- Guaranteed issue coverage (which means you may qualify for coverage without having to answer health questions).
- Coverage available for dependents
- Premiums are conveniently payroll deducted and are priced to fit most budgets.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire. Refer to your certificate for more details.

How it Works

Benefits are paid directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Group accident insurance is designed to provide you with cash benefits throughout the different stages of care, such as the following:

- Emergency treatment
- Hospital admission
- Intensive care unit
- Ambulance transportation

Disclosure

Group Accident insurance is underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers. CAIC is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. This is a brief product overview only. For complete details, please refer to the plans. Continental American Insurance Company | Columbia, SC AGC2300912R1 EXP 9/26

[CLICK HERE FOR THE GROUP ACCIDENT INSURANCE BROCHURE >>](#)

GROUP HOSPITAL INDEMNITY INSURANCE

Group Hospital Indemnity coverage pays cash benefits for covered hospital stays.

Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And even with major medical insurance, your plan may only pay a portion of your entire stay. Group Hospital Indemnity Insurance helps provide financial assistance to enhance your current coverage. Benefits can be used to help cover out-of-pocket expenses. Such as child care, groceries, or rent.

- All benefits are paid direct to insured, unless otherwise assigned
- Rates are age banded; unisex
- Four-tier coverage options include: employee only, employee + spouse, employee + children, and employee + family
- This plan is not HSA compatible

Terms of Coverage

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

Effective Date

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

Disclosure

Group Hospital Indemnity insurance is underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers. CAIC is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. This is a brief product overview only. For complete details, please refer to the plans. Continental American Insurance Company | Columbia, SC AGC2300912R1 EXP 9/26

[CLICK HERE FOR THE GROUP HOSPITAL INDEMNITY BROCHURE>>](#)



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

There are many challenges when faced with growing your family through non-traditional methods. Navigating the processes of infertility, surrogacy, and adoption can be confusing and overwhelming. Fertility, Surrogacy, and Adoption by WINFertility guides you through the challenges of a third-party journey to parenthood by providing education, resources, medical discounts, and support for your individual needs. With 24/7 access to WIN's Nurse Care Managers, you gain a personal advocate to help you understand fertility treatment and medication options and determine the best course of action for you. The Employee Adoption & ART program (EAAP) provides a comprehensive on-demand video library and live coaching to support your journey of adoption, foster care, surrogacy, and egg donation. Fertility, Surrogacy, and Adoption also gives you access to:

- Exclusive savings of up to 40% on fertility services, including IUI, IVF treatments, genetic testing, and fertility medications
- A network of top-ranked fertility specialists
- IVF treatment and Medication BundlesSM — complete packages including medical services and medications to support you on your journey to parenthood
- Genetic testing and egg-freezing services
- Behavioral Health Care Managers who provide counseling on grief associated with infertility, managing stress, and more
- Complimentary prenatal package including folic acid supplements
- Financing options available to help manage costs

- Convenient mobile app to discreetly track fertility, find an in-network doctor, and connect with a WIN nurse
- Employee Adoption & ART program, an online comprehensive service with an on-demand video library, one-on-one coaching, and resources to help navigate the best path for all non-traditional family-building options

Financial Wellness

You shouldn't have to waste hours of your life worrying about money. With Financial Wellness, you gain a helping hand to guide you through the major financial changes and challenges you'll face throughout life, from paying for college to buying a home to managing a budget. Call a financial counselor for a more hands-on approach, or tackle your financial situation independently with learning tracks through the Online Financial Wellness Center.

- Accredited or Certified Financial Counselors are accessible by phone to assess issues, discuss options, and help you determine the best course of action for your situation
- Online Financial Wellness Center does the heavy lifting for research, providing a variety of vetted articles, videos, worksheets, checklists, and more to guide your 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

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

NB 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 NB Rx. Save 10% to 85% on most prescriptions at 60,000 retail pharmacies nationwide.

- Participating retail pharmacies include Walgreens, Target, CVS, and many other independent, national, and regional chains
- 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.

Disclosure:
Financial Wellness does not provide investment, legal, or tax advice.

Alight will never share protected health information (PHI) with your employer. Alight does not provide medical advice or replace your doctor. Alight is unable to assist during medical emergencies. Alight provides unbiased recommendations and is not affiliated with anyone that we recommend.

Not available to residents in VT, UT, Wa, & KS.

Health Consumer/Fertility & Family Planning Rates

Bi-weekly
Pay Rate

Employee

\$7.00

LIFE INSURANCE WITH LTC



Aflac Group Life Term to 120

Peace of Mind that Lasts a Lifetime

Aflac Group Life Term to 120 provides affordable, guaranteed life insurance coverage designed to protect your loved ones today and far into the future. With options for you, your spouse, and your children, this plan helps secure your family's financial stability when they need it most.

What's Included:

- **Guaranteed Issue Coverage:** No medical questions required.
 - **Employee:** Up to \$150,000
 - **Spouse:** Lesser of \$50,000 or 50% of employee benefit
 - **Child:** \$25,000
- **Spouse and Child Coverage:** Automatically available for eligible dependents. Children are covered up to age 26, and coverage may continue for children with disabilities.
- **Long-Term Care Accelerated Death Benefit Rider:** Provides benefits if you are diagnosed with a chronic condition, under a doctor's plan of care, and receiving qualified long-term care services after a 90-day elimination period.
 - Choose a lump sum (50%) or monthly payments (up to 25 months at 4% each).
- **Optional Protection Rider including Extension of Long-Term Care Accelerated Death Benefit & Inflation Protection Benefit for Long-Term Care**
- **Accidental Death Benefit Rider:** Pays an additional benefit equal to your life insurance amount if death results from a covered accident.
- **Waiver of Premium Rider:** If you become totally disabled for 3 continuous months, premiums are waived for up to 24 months.

Eligibility

- Employees working at least 16 hours per week
- Issue ages: Employee and Spouse 18–70, Child under 26
- No waiting period

Portability

- You can keep your coverage even if you leave your employer. Simply continue it through direct billing with Aflac at the same premium rate.

Why Employees Value This Coverage

- No health questions or exams required
- Helps pay expenses during serious illness or chronic conditions
- Portable coverage—goes with you if you change jobs
- Financial protection for your family that lasts up to age 120

Disclosure

Group Life Term to 120 insurance is underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers. CAIC is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. This is a brief product overview only. For complete details, please refer to the plans. Continental American Insurance Company | Columbia, SC

AGC2501768

EXP 10/26

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

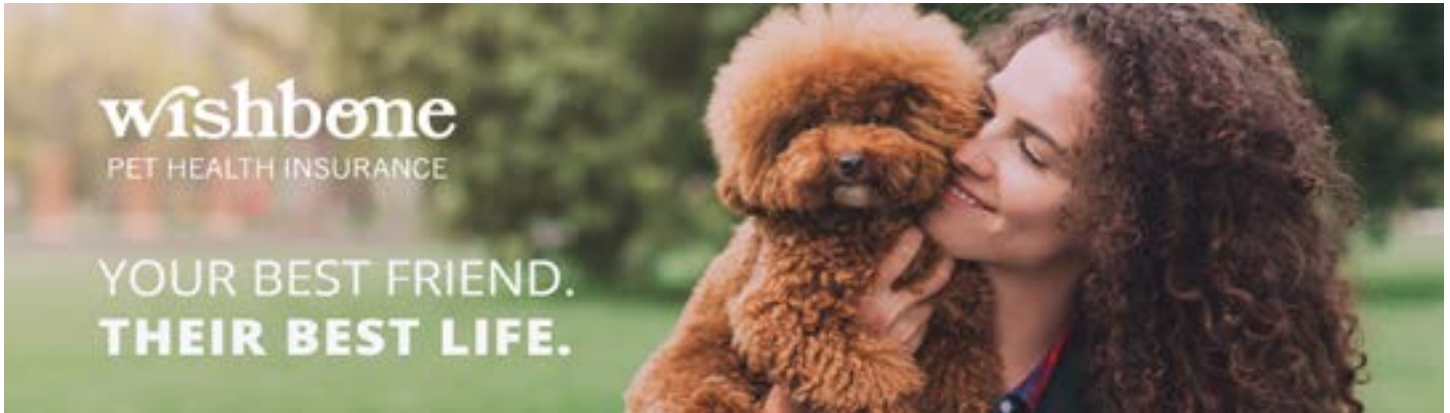
Enroll today to start saving!

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 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.

CONSTANTCREDIT & ID COMMANDER

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

These six benefits lead the way.

+ SoFi Financial Planners

Get complimentary access to credentialed financial planners who can help you navigate student loans, buying a home, retirement, and more.

👁️ Your finances at a glance

Get a 360-degree view of your finances with free credit score monitoring and the convenience of tracking all your financial accounts in one place.

💰 Student loan refinancing

Enjoy SoFi's competitive fixed rates on student loan refi*, plus employees receive an exclusive 0.25% rate discounts.

2x SoFi Checking and Savings

Open a checking and savings account, add direct deposit, and you'll gain access to the many benefits of a SoFi Plus membership, including a highly competitive savings APY.

🎓 Financial education

Financial literacy is the cornerstone of financial well-being. SoFi Learn will equip you with a library of educational resources to help you on your way.

🔧 Financial tools and calculators

With the right financial tools, you can easily manage debt, budget for a home, save on loans, and more.



Four simple steps to sign up.

Step 1: Visit [SoFi.com/JHS](https://sofi.com/JHS)

Step 2: Enter your name and company email

Step 3: Create a SoFi account (or sign in if you have one already)

Step 4: Explore your Dashboard

[Start now](#)



FINANCIAL WELLNESS

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

Jackson Health System 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.



What is the most you can contribute?

If you are eligible for certain catch-up contributions, you can save as much as \$81,000 in 2025. Check the table below to see how much you can save.

In a 403(b) plan	In a 457(b) plan
<p>Withdrawals prior to age 59½ may be subject to a 10% federal early withdrawal tax penalty, unless an exception applies.</p>	<p>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.</p>
<p>Less stringent hardship withdrawal restrictions while you are employed.</p>	<p>More stringent unforeseeable emergency withdrawal restrictions while you are employed.</p>
<p>Examples of financial hardship include:</p> <ul style="list-style-type: none"> • 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 	<p>Examples of unforeseeable emergency include:</p> <ul style="list-style-type: none"> • 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 <p>Sending a child to college or purchasing a home, two common reasons for 403(b) hardship withdrawals, generally are not considered unforeseeable emergencies.</p>

Talk it over with your Corebridge financial professional, or visit jhs.corebridgefinancial.com to enroll today.

jhs.corebridgefinancial.com 1.800.448.2542

UW@WORK - JHS FINANCIAL WELLNESS SERVICES

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.
- **How to Enroll** — Scan the QR Code



UW@WORK - JHS FINANCIAL WELLNESS SERVICES

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

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 across the Jackson Health systems. Services are available in Spanish, Kreyol, or English.

For more information,
Email: financialstability@unitedwaymiami.org
Phone: 305-646-7175
Links: [UW@Work Financial Coaching](#)



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](https://www.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](https://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [insurekidsnow.gov](https://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [askebsa.dol.gov](https://www.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.flmedicaidprecovery.com/flmedicaidprecovery.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](https://www.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](https://www.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, 2025 to Dec. 7, 2025.

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 your 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 [JHS.Aetna.com](https://www.jhs.aetna.com) Contact Aetna at 1-855-755-0507 .

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

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

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE DRUG PLANS, YOU MAY BE REQUIRED TO PROVIDE A COPY OF THIS NOTICE WHEN YOU JOIN TO SHOW WHETHER OR NOT YOU HAVE MAINTAINED CREDITABLE COVERAGE AND, THEREFORE, WHETHER OR NOT YOU ARE REQUIRED TO PAY A HIGHER PREMIUM (A PENALTY).

Last Updated: Oct. 27, 2025
Name of Entity: Jackson Health System
Contact-Position/Office: Human Resources
Health and Wellness Department
Address: 901 NW 17th Steet, 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 Aetna at 1-855-755-0507 or visit

JHS.Aetna.com. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Aetna 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 Aetna at 1-855-755-0507 or visit JHS.Aetna.com.

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 Aetna 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 Aetna 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 6-30-2025)

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. For plan years beginning in calendar year 2025, if the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.02% 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 [Aetna at \(855\) 755-0507](tel:8557550507), or view online at JHS.Aetna.com.

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.

NOTICES

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@jhs-miami.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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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 balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

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

NOTICES

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.

BENEFITS DIRECTORY

JACKSON HEALTH SYSTEM

Human Resources Capital Management

C/O HR Service Center
901 NW 17th Street Miami, FL 33136
Park Plaza East Red Garage 1st floor
of Jackson Memorial Medical Center
campus | Next to UM Bascom Palmer
Eye Institute
305-585-LIVE (5483)
AskHR@jhsmiami.org

Housestaff Office Department

East Tower, Room 1004
305-355-1122

BENEFITS ADMINISTRATOR

FBMC Benefits Management, Inc.

Benefits Service Center
Monday - Friday, 7 a.m. - 7 p.m. ET
1-855-56JHS4U (1-855-565-4748)
FBMC Online technical support:
techsupport@fbmc.com
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

Aetna

1-855-755-0507
www.jhs.aetna.com

SmartShopper

1-833-313-0145
smartshopper.com
<http://jhs.aetna.com/smartshopper>

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 by MetLife

Vision Processing Unit
PO Box 509
Troy, NY 12181
Member Service:1-833-393-5433
metlife.com/mybenefits

FLEXIBLE SPENDING ACCOUNTS

Inspira Financial

2001 Spring Road, Suite 700
Oak Brook, IL 60523
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
inspirafinancial.com

WELLNESS

Jackson Health System

1-786-466-2970
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

Group Insurance Carrier: Reliance Standard Life

Insurance Company

Claims administered by: Matrix
Absence Management, Inc.
Telephonic Intake/Customer Care:
1-877-202-0055 (24/7/365)

Electronic Intake: Online at

matrixabsence.com or via Reliance
Matrix app (24/7/365)

Fax Number: 866-683-9548

Mailing Address: 2421 W. Peoria Ave.,
Ste. 300, Phoenix, AZ 85029

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

Corebridge

Office
1800 North Military Trail, Suite #340
Boca Raton, FL 33431
Office Phone: 561-684-3775

Client Care Center:

1-800-448-2542

CorebridgeFinancial.com/RS/JHS/home

LEGAL INSURANCE

ARAG

500 Grand Avenue, Suite 100
Des Moines, IA 50309
1-800-247-4184
Access Code: 17845jhs
ARAGlegal.com/plans

CRITICAL ILLNESS INSURANCE

Aflac Group

Customer Service
1-800-433-3036
aflacgroupinsurance.com

ACCIDENT INSURANCE

Aflac Group

1-800-433-3036
aflacgroupinsurance.com

HOSPITAL INDEMNITY INSURANCE

Aflac Group

1-800-433-3036
aflacgroupinsurance.com

LIFE INSURANCE WITH LTC

Aflac Group

1-800-433-3036
aflacgroupinsurance.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
1-800-800-7616
Mon – Fri, 8 a.m. - 8 p.m. ET
Sat., 9 a.m. - 6 p.m. ET
www.newbenefits.com



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-LIVE (5483) • Fax 305-355-2324
JHSFieldOffice@fbmc.com



Contract Administrator
FBMC Benefits Management, Inc.
PO Box 1878 • Tallahassee, Florida 32302-1878
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.