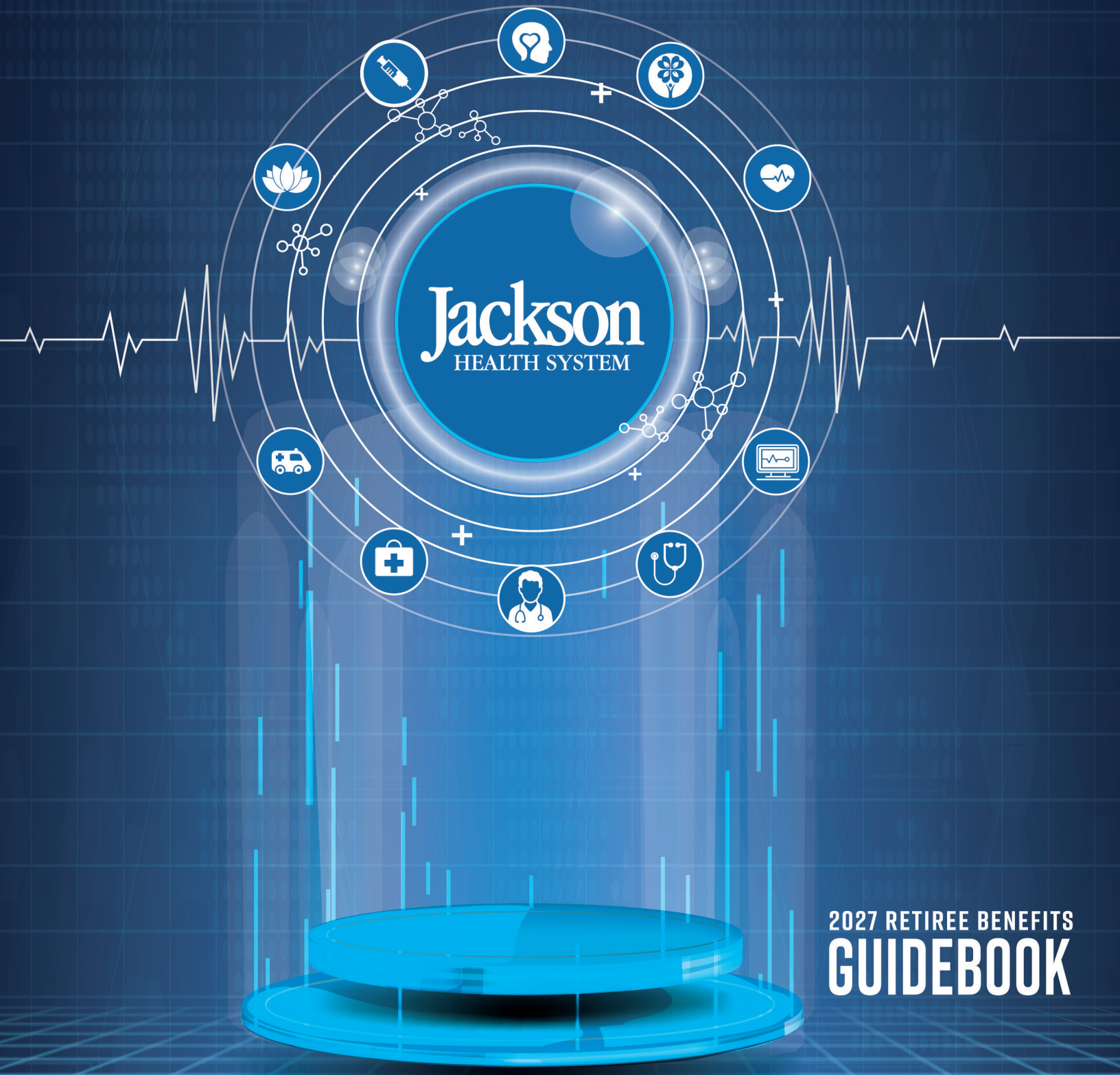
THINK OF JACKSON FIRST

THE FUTURE OF YOUR CARE STARTS WITH YOU



2027 RETIREE BENEFITS

GUIDEBOOK

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ONLINE RESOURCES:

Click below to view important information:

JHS Website: JacksonBenefits.org

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

Please see page 48 for more details.

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Retirement Dept. #786-466-2974
PHTRetirement@jhsmiami.org

Jackson HEALTH SYSTEM

Retirement Information Session

This special invitation is being extended to those employees who are retiring in the upcoming months. This session aims to equip you with useful information prior to retirement and enlightens on a variety of issues relating your pension and benefits.



Discussion Topics:

- How to obtain an appointment
- The array of benefits available to you
- DROPs program
- The required documents for the day of your one on one session
- Medicare Part B contact for enrollment information, if applicable.

FRS Sessions Every 1st Monday of the Month @10:00am Zoom Link: https://jhsmiami.zoom.us/j/84488178053

PHT Sessions Every 1st Monday of the Month @11:00am Zoom Link: https://jhsmiami.zoom.us/j/86918962329



CONTRACT ADMINISTRATOR

FBMC Benefits Management, Inc.
Service Center
Mon - Fri, 7 a.m. - 7 p.m. ET
1-855-56JHS4U (855-565-4748)

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

Retirement Department
Jackson Memorial Hospital
786-466-2974
Fax: 305-355-5011
Phtretirement@jhsmiami.org

Florida Retirement System
Enter Drop Estimate
1-844-377-1888
For Appointment to Process Enter Drop
Raymond Montalvo 786-466-2970
Raymond.montalvo@jhsmaimi.org

MEDICAL PROVIDER

Aetna (Under 65 and/or Dependent Coverage)
1-855-755-0507
JHS.Aetna.com

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

Social Security
1-800-772-1213
ssa.gov

OVER 65 MEDICARE ADVANTAGE PLANS

Humana Medicare Advantage Options
Antonio Cruz
Senior Manager, Humana
6101 Blue Lagoon Dr. Suite 199
Miami, FL 33126
acruz2@humana.com
Toll Free: 1-800-824-8242
Direct line: 305-458-3513
Fax: 305-698-3169

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

OVER 65 MEDICARE SUPPLEMENTAL PLANS

AETNA (Grandfathered in Plans only)
1-855-755-0507
www.jhs.aetna.com

DENTAL PROVIDERS

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

VISION PROVIDER

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

LIFE INSURANCE PROVIDER

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

LEGAL INSURANCE

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

Provider Contact Directory

The following Voluntary Benefits provide insurance portability coverage and are available for continuance upon retirement or separation of employment at the same rates with no change in coverage or benefits. For more details regarding your plan, please contact the provider company at:

OTHER PROVIDERS

Wishbone
1-800-887-5708
customercare@petbenefits.com
help@wishbone.pet
https://www.wishbone.pet/

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

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

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

GROUP ACCIDENT INSURANCE:

AFLAC Group
1-800-433-3036
aflacgroupinsurance.com

GROUP CRITICAL ILLNESS INSURANCE:

AFLAC Group
1-800-433-3036
aflacgroupinsurance.com

GROUP HOSPITAL INDEMNITY INSURANCE

AFLAC Group
1-800-433-3036
aflacgroupinsurance.com

LIFE INSURANCE WITH LTC

AFLAC Group
1-800-433-3036
aflacgroupinsurance.com

UNIVERSAL LIFE INSURANCE

Trustmark
Customer Care
1-800-918-8877
Customer Care Email
customercare@trustmarksolutions.com
Claims Phone
1-877-201-9373
trustmarksolutions.com

TRANSAMERICA LIFE INSURANCE COMPANY

1-888-763-7474
transamerica.com

RELIASTAR UNIVERSAL LIFE INSURANCE (VOYA)

1-800-537-5024
voya.com

TERM LIFE INSURANCE

Chubb
1-855-241-9891 Ext 3
Customer Service at email: csmail@visfin.com

WHOLE LIFE INSURANCE

UNUM Whole Life Insurance with Long Term Care
1-800-635-5597
unum.com

LONG TERM CARE INSURANCE

UNUM Long Term Care
1-800-331-1538
unum.com

INDIVIDUAL CRITICAL ILLNESS INSURANCE

CRITICAL ILLNESS & HEART/ STROKE INSURANCE
American Heritage Life Insurance Company
1-800-521-3535
allstatebenefits.com

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



2027 PLAN HIGHLIGHTS

Core Benefits Available:

Under 65 Dependents Medical Plans

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

Dental Plans

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

Vision Plans

- Base Plan
- Premier Plan

Over 65 Medicare Plans

- Humana LPPO 079/187 RX 412
- Humana RPPO 079/632 RX 417
- Humana HMO 076/135 Rx 288

Please direct all questions or comments to the JHS Retirement Services Department by email Phtretirement@jhsmiami.org or calling 786-466-2974, Mon. – Fri., 7 a.m. – 5 p.m. ET.

If you are age 65 and over, you may enroll in the Over 65 Medicare Advantage plan options being offered through Humana. Enrollment is done DIRECTLY through the carriers.
For benefits information or to enroll in any of these plans, please contact:

Humana
1-800-824-8242 (TTY 711)
Mon – Fri, 8 a.m. – 8 p.m. EST
Post enrollment: 1-866-396-8810 (TTY 711)
Mon – Fri, 8 a.m. – 9 p.m. EST

Important Information

- In addition to this 2027 New Retiree Reference guide, you have been provided an enrollment form. When completing the enrollment form, please be sure to note all benefits you would like to continue into retirement.
- Please remember when electing your retiree benefits: After retiring, you may not increase your coverage elections, you may only cancel coverages. You may not add coverage, add dependent coverage, or increase coverage.
- For all of your eligible dependents, please record their Social Security number(s) and date(s) of birth on your enrollment form.

Core Benefits Available:

Medical	Dental	Vision	Life

Choosing the Right Enrollment Form — Under age 65 or 65 and Over
The New Retiree Reference Guide explains your available benefits in separate sections based on whether you are under 65 or 65 and over, including any eligible dependents. The benefits (except life insurance) for 65 and over also apply if you and/or your eligible dependent are under 65, but Medicare eligible.

If you wish to elect retiree coverage, please complete and return the correct enrollment form:

- Under 65 and/or not Medicare A and B eligible
- 65 and Over an d/or Medicare Eligible

You are eligible to continue coverage under the retiree group if you retire from Jackson Health System/Public Health Trust – provided you transition as an active employee into retirement. You will have 30 days from your separation date to make or change your election.

Please note: you may not elect continuation of medical coverage under COBRA if you are entitled/enrolled in Medicare Part A & B.

Leave of Absence

The same election process applies to employees on leave of absence (or no-pay status) who terminate Jackson Health System employment without physically returning to work. Group insurance coverage will end as of the last day of the pay period in which the separation of employment date falls, assuming premiums were paid through that date. If coverage is canceled for non-payment of premiums, while on leave status, you will not have the opportunity to continue coverage under the Retiree Group or COBRA.

Coverage Available

JHS doesn't contribute the employer portion on your behalf; consequently, you will pay the full monthly premium cost. Your dependent spouse or domestic partner (DP) and/or children including the children of a DP, currently covered under your medical and/or dental/vision plan as of the date you retire, may continue under your coverage at retirement.

Changing Health Plans

At the time of retirement and within 30 days of your separation date, you will have a one-time opportunity to change plans or enroll in the retiree insurance plan offered that you previously declined.
Once you submit your election form, you cannot change plans until the annual retiree open enrollment period, unless you move out of the plan's geographic service area.

Electing Health Coverage Under Your Spouse/DP's Plan

If your spouse/DP is a JHS employee, you have the option of enrolling as a dependent under your spouse/DP's JHS medical and/or dental/vision plan. Your spouse/DP must submit the Change in Status forms (CIS) within 30 days of your separation date. You can transfer your medical/dental/vision coverage to the Retiree Group at a later date as a CIS, as long as you have been continuously covered under a JHS-sponsored medical/dental/vision plan without a break, since your retirement.

Important Note: Continuation of basic life insurance cannot be postponed. You must elect the coverage at retirement otherwise you forfeit the coverage.

Remember to ensure that your beneficiary designations are current. A new beneficiary may be named at any time. To update your beneficiary call the FBMC On-site Service Center at 305-585-6512 and request a life insurance beneficiary update form. Make sure your beneficiary designation form is legible and contains no erasures or cross-out marks. Specify the percentage of benefits for each named beneficiary to receive. The total percent allocation among the beneficiaries must add up to 100 percent. Please be sure your beneficiary is aware of the benefit and knows how to contact our office in the event of your death.

Retirees must elect health insurance coverage within 30 days of retirement. Following the 30 day window, there is no change in the status or eligibility opportunity for the retiree to elect health insurance coverage under Jackson's plan. The only exception to this policy would be if the employee's spouse is an Jackson (not MDC or external) employee and the employee will be covered dependent under his/her plan. Any waive or cancellation of health insurance coverage for retirees is irrevocable.

How to Complete a Change in Status

Read below to learn how to complete a change in status, such as Marriage, Birth or removing a dependent from the plans if said dependent gain coverage elsewhere.
If you experience a qualifying event—such as a change in marital status, loss of other health coverage, or any other significant life change—we advise you to contact our Third-Party Administrator (TPA), FBMC benefits promptly (within 30 days). They can assist you in understanding your options and ensuring that your benefits are adjusted accordingly.

Please reach out via email at **JHSRetiree@fbmc.com**. Make sure to include your full name, contact information, and a brief description of the qualifying event.



PHT Drop Benefits

PROGRAM FEATURE	ALTERNATIVES INCLUDED IN PRICING
Eligibility	Within 12 months of attaining Age-based Normal Retirement 62 or 65 (not available upon retirement at 30 years of service)
Length of Drop Period	3 years
Employer & Employee Contributions	Contributions will continue to be made during the DROP period; employees will receive contributions made during the DROP period after retirement/ separation from service at end of DROP period
Cost of Living Increases During the DROP Period	None; COLA increases would first apply after retirement/ separation from service and commencement of benefits (after the DROP period)
Interest credited to Accumulated DROP Payments and employee contributions during DROP period	None
Form of payment accumulated during the DROP period	Single life annuity (“Option 1”)
Form of payment after retirement/ separation from service at end of DROP period	All options available upon retirement
Death Benefit payable during DROP period	Same as for an active employee who has not entered the DROP

If you would like to enroll in the PHT Drop, please email PHTretirement@jhsmiami.org for more information.

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



Group Medical Plans

What Aetna medical plans are offered?

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

NOTE: If you are selecting health insurance, you are required to select a primary care physician.

Jackson First HMO

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

- No deductibles
- No copays, and
- No coinsurance

Jackson Select HMO

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

Jackson Point of Service (POS)

In-network
Plan offers no referral needed to access an expanded network of providers. The plan provides 100% of benefits for covered charges after the applicable copayments.

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

Medical Monthly Premiums

Jackson Retiree, Spouse/DP and Dependents	JACKSON FIRST HMO PLAN	JACKSON SELECT HMO PLAN	JACKSON POS PLAN
Retiree Only	$824.48	$868.80	$1,950.63
Retiree & Spouse/DP Under 65	$1,730.54	$1,823.50	$3,713.58
Retiree & Child(ren)†	$1,602.87	$1,689.04	$3,403.34
Retiree & Spouse/DP Under 65, plus Child(ren)†	$2,110.45	$2,223.88	$5,040.72

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

2027 MEDICAL PLAN CHARTS (JHS.Aetna.com)		
	JACKSON FIRST HMO	**JACKSON SELECT HMO**
	• Freedom to choose from a variety of JHS and UM healthcare professionals. • Access to a concierge appointment scheduling	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. • Offers nationwide network for dependents residing outside of service area.
Concierge Services	Concierge Services Available	Concierge Services 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	$15 JHS Specialist	$30 All Others. 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

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

Under 65 Medical Plans

2027 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	Concierge Services Available	Concierge Services 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	$15 JHS OB-GYN	$30 All Others. No charge for subsequent visits.
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

2027 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	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.

Under 65 Medical Plans

2027 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

Group Medicare Plans

The medical chart pages are intended to highlight the plans available and do not constitute a contract. Precise benefits will be governed by the contracts and not by these charts. Please review details of any modification in benefits in the plan literature, or seek clarification through the health plan.

Health Plans are continually negotiating contracts with affiliated providers (doctors, hospitals etc.). As a result, providers may be added to or deleted from the participating provider listing of the various plans during the plan year. We highly recommend verifying if the provider of your preference still participates in the program prior to making an appointment.



Over 65 Medicare Plans

- Humana LPPO 079/187 RX 412
- Humana RPPO 079/632 RX 417
- Humana HMO 076/135 RX 288

If you are age 65 and over, you may enroll in the Over 65 Medicare Advantage plan options being offered through Humana. Enrollment is done DIRECTLY through the carriers. For benefits information or to enroll in any of these plans, please contact:

Humana

1-800-824-8242 (TTY 711)

Mon – Fri, 8 a.m. – 8 p.m. EST
Post enrollment: 1-866-396-8810 (TTY 711)
Mon – Fri, 8 a.m. – 9 p.m. EST

Aetna Dependent Coverage

Retiree 65 and Over	JACKSON FIRST HMO PLAN	JACKSON SELECT HMO PLAN	JACKSON POS PLAN
Spouse/DP Under 65†	$906.05	$954.70	$1,950.63
Child(ren)†	$778.40	$820.24	$1,456.10
Spouse/DP Under 65 and Child(ren)†	$1,285.97	$1,355.08	$3,170.97

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

Over 65 Medical Plans

More benefits are ready for you!

A plan designed to fit your lifestyle and deliver the coverage you need.



We're excited to let you know that you may be eligible for a $0 monthly premium Medicare Advantage and prescription drug (MAPD) plan that gives you more benefits than Original Medicare.

The Humana Medicare Employer preferred provider organization (PPO) is a Medicare Advantage plan (Medicare Part C). This plan combines Medicare Part A (hospital), Part B (other medical services) and Part D (prescription drugs) in one package of benefits.

We're here to help you get ready

We'll assist you along the way to help you feel confident about managing your costs—and your well-being.

Humana offers you a Medicare Employer PPO plan with:

- All the benefits of Original Medicare—plus extra benefits
- Maximum out-of-pocket protection
- Worldwide emergency coverage
- Programs to help improve health and well-being
- Dedicated Customer Care team

Extra benefits and resources

The Centers for Medicare & Medicaid Services (CMS) requires all private carriers to provide the same basic medical coverage for all members. It's the extra services and resources provided by Humana that move us past a relationship built on paid bills toward a partnership focused on helping you achieve lifelong well-being.

SilverSneakers® fitness program
A health and physical activity program that offers membership at fitness locations nationwide.

Humana Well Dine®
After your inpatient stay in a hospital or nursing facility, you're eligible for 10 nutritious meals delivered to your door at no additional cost to you.

SmartSummary®
Personalized monthly updates after you've had a claim. These updates show how you're using your healthcare plan and prescription drug plan and what you've spent.

MyHumana
Your secure online account at **Humana.com**.

Enroll today!

To request an enrollment kit or for more information, contact our licensed Humana sales agents today.
1-800-824-8242 (TTY: 711)
Monday – Friday, 8 a.m. – 8 p.m., Eastern time.
Or call Ruben Veliz, Humana Sales Manager
305-698-3114 (TTY: 711)

Humana. | Jackson HEALTH SYSTEM | PUBLIC HEALTH TRUST

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

2027 Over 65 Medicare Plans Comparison Chart

Service	HUMANA LPPO 079/082 RX 413		HUMANA RPPO 079/623 RX 417		HUMANA HMO 076/135 RX 288
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
	Retiree Cost		Retiree Cost		Retiree Cost
Medical Plan Type	PPO		PPO		HMO
Drug Plan Type	100%		100%		100%
PCP Required	N/A		N/A		N/A
Annual Deductible	N/A		N/A		N/A
Annual Maximum Out-of-Pocket (OOP)	$4,900	$8,950	$6,500	$8,950	$500
OOP Exclusions	Pharmacy, Dental (Routine), Hearing Services (Routine), OTC Drugs and supplies, Vision (Routine)		Part D Pharmacy, Dental Services (Routine), Hearing Services (Routine) , OTC Drugs and Supplies, Vision Services (Routine)		Part D Pharmacy, Acupuncture (Routine), Dental Services (Routine), Hearing Services (Routine), Hyperbaric Oxygen Treatment, OTC Drugs and Supplies, Podiatry Services (Routine), Sleep Study (Home Based), Sleep Study (Facility Based), Transportation (Routine), Vision Services (Routine), Wound Care
Medical Benefits					
Inpatient Hospital Care	100% after $290 Co-Payment per day (days 1-5)	100% after $490 Co-Payment per day (days 1-27)	100% after $325 copayment per day (days 1-5)	60% per admission	$0
Inpatient Mental Health Care	100% after $290 Co-Payment per day (days 1-5)	100% after $490 Co-Payment per day (days 1-27)	100% after $325 copayment per day (1-5)	60% per admission	$0
Skilled Nursing Facility (SNF)	$0 for days 1-20; 100% after $160 copayment per day (days 21-100) • Plan pays $0 after 100 days	100% after $250 copayment per day (days 1-58); $0 Co-payment per day (days 59-100) • Plan pays $0 after 100 days	$0 per day (days 1-20); $150 copayment per day (days 21-100) • Plan pays $0 after 100 days	60% per day (days 1-100) Plan pays $0 after 100 days	$0 days 1-20; $50 per day (days 21-100) Plan pays $0 after 100 days.
Home Health Care	$0 (Excludes Personal Home Care)	50% (Excludes Personal Home Care)	$0 (Excludes Personal Home Care)	40% (Excludes Personal Home Care)	$0 (Excludes Personal Home Care)
Doctor Office Visits - Primary Care	$0	$65	$5	100% after $65 copayment	$0
Doctor Office Visits - Specialist	$40	$65	$45	100% after $65 copayment	$0
Emergency Care	$90 copayment; waived if admitted within 24 hours		$90 copayment; waived if admitted within 24 hours		$40 copayment, waived if admitted within 24 hours

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2027 Over 65 Medicare Plans Comparison Chart

Service	HUMANA LPPO 079/082 RX 413		HUMANA RPPO 079/623 RX 417		HUMANA HMO 076/135 RX 288
Urgently Needed Care	$0	40	$0	40%	$0
Chiropractic Services	$15	$65	$15	$65	$0
Podiatry Services	$40	$65	$45	$65	$0
Outpatient Mental Health Care	20%	50%	$40	40%	$0
Outpatient Substance Abuse	20%	50%	$40	40%	$0
Outpatient Surgery - Outpatient Hospital	$225	50%	$195	40%	$0-$25
Outpatient Surgery - Ambulatory Surgical Center	$150	50%	$150	40%	$0
Professional Fees for Outpatient Surgeries - Outpatient Hospital	$0	50%	$0	40%	$0
Ambulance Services	$240 (Limited to Medicare-covered transportation)		$240 (Limited to Medicare-covered transportation)		$75 (Limited to Medicare-covered transportation)
Outpatient Rehabilitation	$10	$65	$15	$65	now pay at 100%
Durable Medical Equipment	18%	25%	20%	30%	$0
Prosthetic Devices	20%	25%	20%	25%	$0
Diabetes Monitoring Supplies	18%	75%	20%	30%	$0
Diagnostic - Basic Outpatient Hospital	$225 or 20%	50%	$80-$195	0-40%	$0-$25
Diagnostic - Basic Freestanding Facility	$40	50%	$50-$100	40%	$0
Diagnostic Radiology Services	$40	50%	$65-$195	40%	$0-$25
Lab Services	$0	50%	$0	$0	$0

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2027 Over 65 Medicare Plans Comparison Chart

Service	HUMANA LPPO 079/082 RX 413		HUMANA RPPO 079/623 RX 417		HUMANA HMO 076/135 RX 288
Medicare Part B Drugs	20%	20%	10%	20%	$0
Preventive Services	$0	$0-50%	$0	$0 to 40% coinsurance for Medicare-covered preventive services.	$0
Wellness Visits	$0	50%	$0	40%	$0
Wellness Services	$0	50%	$0	40%	$0
Dental Services (Medicare Covered Services)	$40	$65	$45	$65	100% ($6,000 annual allowance for preventive and comprehensive service. Some restrictions apply.)
- Exam	$0 (1 per year)	$0 (1 per year)	$0 (1 per year)	$0 (1 per year)	Dental Benefits are: • Up to $6,000 annual allowance for covered preventive, basic, and comprehensive dental services. • Includes services such as exams, cleanings, fillings, extractions, crowns, dentures, root canals, bridges, and periodontal scaling. • You are responsible for any costs exceeding the annual allowance. Unused amounts expire at year-end. • **Note:** Coverage does not include fluoride treatments, cosmetic services, or implants. Frequency limits may apply.
- Cleaning	$0 (1 per year)	$0 (1 per year)	$0 (1 per year)	$0 (1 per year)	Dental Benefits are: • Up to $6,000 annual allowance for non-Medicare covered preventive, basic, and major dental services. • Includes services such as exams, cleanings, fillings, extractions, crowns, dentures, root canals, bridges, and periodontal scaling. • **Note:** Frequency limits may apply. Fluoride, cosmetic services, and implants are not covered. Unused allowance expires at year-end, and you are responsible for charges above the annual allowance.

2027 Over 65 Medicare Plans Comparison Chart

Service	HUMANA LPPO 079/082 RX 413		HUMANA RPPO 079/623 RX 417		HUMANA HMO 076/135 RX 288
- X-Ray	$0 (1 per year)	$0 (1 per year)	$0 (1 per year)	$0 (1 per year)	Dental Benefits are: • $6,000 maximum annual allowance for non-Medicare covered preventive, basic, and major dental services. • Includes exams, cleanings, fillings, extractions, crowns, dentures, root canals, bridges, and periodontal services. • **Note:** Frequency limits may apply. Fluoride treatments, cosmetic services, and implants are not covered. You are responsible for costs exceeding the annual allowance, and unused amounts expire at year-end.
Hearing Services (Hearing Loss Exam)	$0 copayment for routine hearing exams up to 1 per year	$0 copayment for routine hearing exams up to 1 per year	$0 copayment for routine hearing exams up to 1 per year	$0 copayment for routine hearing exams up to 1 per year	Routine Benefits are: $0 copay for fitting/evaluation, routine hearing exams up to 1 per year. • $1000 maximum benefit coverage amount for hearing aids (all types) up to 1 per ear per year. • **Note:** Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty.

2027 Over 65 Medicare Plans Comparison Chart

Service	HUMANA LPPO 079/082 RX 413		HUMANA RPPO 079/623 RX 417		HUMANA HMO 076/135 RX 288
Vision Services (Medicare Covered Eye Exam)	•100% after $40 copayment for routine exam (includes refraction) up to 1 per year. •$100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).	$65 •$135 combined maximum benefit coverage amount per year for routine exam (includes refraction). •100% after $40 copayment for routine exam (includes refraction) up to 1 per year. •$100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).	$40 •$40 combined maximum benefit coverage amount per year for routine exam (includes refraction) up to 1 per year. •$100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frame)	•$135 combined maximum benefit coverage amount per year for routine exam (includes refraction). •100% after $40 copayment for routine exam (includes refraction) up to 1 per year. •$100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).	$0 • 100% for routine exam up to 1 per year. • $350 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames plus fitting. • Eyeglasses include polycarbonate lenses with ultraviolet protection and scratch-resistant coating.
Pharmacy Benefits					
	N/A	N/A	N/A	N/A	N/A
Deductible	$100 (Tier 1 is excluded from the deductible)	N/A	$100 (Tier 1 is excluded from the deductible)	N/A	N/A
Network	Major Chains	N/A	Major Chains	N/A	Major Chains
Drug Usage Management	Yes	N/A	Yes	N/A	Yes

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2027 Over 65 Medicare Plans Comparison Chart

Service	HUMANA LPPO 079/082 RX 413		HUMANA RPPO 079/623 RX 417		HUMANA HMO 076/135 RX 288
Initial Coverage Period*	30 Day Retail	90 Day Mail Order	30 Day Retail	90 Day Mail Order	30 Day Mail Order
Initial Coverage	$2,400	N/A	$2,400	N/A	$2,400
Tier 1	$0	$0	$5	N/A	$0
Tier 2	$47	$131	$45	$125	$0
Tier 3	$160	$470	$95	$275	40%
Tier 4	30%	N/A	31%	N/A	30%
Tier 5	N/A	N/A	N/A	N/A	N/A
Tier 6	N/A	N/A	N/A	N/A	N/A
Catastrophic					
OOP threshold	$2,400	N/A	$2,400	N/A	$2,400
Tier 1	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay	N/A	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay	N/A	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay
Tier 2	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay	N/A	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay	N/A	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay
Tier 3	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay	N/A	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay	N/A	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay

2027 Over 65 Medicare Plans Comparison Chart

Service	HUMANA LPPO 079/082 RX 413		HUMANA RPPO 079/623 RX 417		HUMANA HMO 076/135 RX 288
Tier 4	Once the member reaches the $2,100 moop or coverage limit, they are covered at 100%. $0 copay	N/A	Once the member reaches the $2,100 moop or coverage limit, they are covered at 100%. $0 copay	N/A	Once the member reaches the $2,400 moop or coverage limit, they are covered at 100%. $0 copay
Tier 5	N/A	N/A	N/A	N/A	N/A
Tier 6	N/A	N/A	N/A	N/A	N/A
Mail Order	90 Day	N/A	90 Day	N/A	90 Day
Tier 1	$0	N/A	$0	N/A	$0
Tier 2	$141	N/A	$125	N/A	$0
Tier 3	$470	N/A	$275	N/A	40%
Tier 4	N/A	N/A	N/A	N/A	N/A
Tier 5	N/A	N/A	N/A	N/A	N/A
Tier 6	$0	$0	$0	$0	$0
Premium					
Monthly Premium	**$0**	**$0**	**$149**	**$149**	**$0**

*This plan has a deductible of $100 that applies to tiers 2, 3 and 4.

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Choose from the following dental plans:

- Delta Dental PPO
- DeltaCare USA (DHMO)

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

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

Delta Dental PPO

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

- Can visit any licensed dentist, including the dental specialist of your choice.
- 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 PPO network dentist.

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

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

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

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

Visit a dentist in the 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.

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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'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.

DHMO Features and Benefits

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

See copay schedule for details.

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

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

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



Delta PPO Dental Plan

	STANDARD	ENRICHED
Choice Of Dentist	You'll likely save most with a dentist who participates in the Delta PPO network.. Services provided by out-of-network providers will be reimbursed at the maximum plan allowance of usual and customary charges. Percentages below are based on Delta's applicable allowances and not necessarily the dentist's actual charge.	
Maximum Benefit/Deductible[1]	$1,000 per year per person, $50 deductible per year per person; $150 family maximum	$2,000 per year per person, $50 deductible per year per person; $150 family maximum
Type I	**STANDARD**	**ENRICHED**
0150 Comprehensive Oral Evaluation - New or Established	Plan Pays (No deductible) - 100%	Plan Pays (No deductible) - 100%
0120 Periodic Oral Exam	100%	100%
X-Rays	100%	100%
1110/20 Prophylaxis	100% (Twice per calendar year)	100% (Twice per calendar year)
1208 Fluoride Treatment (up to and not including age 19)	100%, 2x per year	100%, 2x per year
1351 Sealant- Per Tooth	100% - up to and not including ages 9 or 16 depending on the tooth number.	100% to age 16
1510 Space Maintainers	100% - up to and not including age 14	100% to age 19
Type II	**STANDARD**	**ENRICHED**
Fillings: (Silver And White)	100% (In PPO Network) / 75% (Out of PPO Network)	100% (In PPO Network) / 75% (Out of PPO Network)
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	75% - child up to and not including age 16	75% for children to age 16
Restorative Services:		
2930 Prefabricated Stainless Steel Primary Tooth	75%	75%
Root Canals:	75%	75%
3310 Anterior	75%	75%
3320 Bicuspid	75%	75%
3330 Molar		
3410 Apicoectomy	75%	75%
Extractions:	75%	75%
7111 Coronal remnants - primary tooth	75%	75%
7140 Extraction, Erupted Tooth Or Exposed Tooth	75%	75%
7210 Surgical Extraction Of Erupted Tooth		
Periodontics: (Gum Treatment)	75%	75%
4341 Periodontal Scaling & Root Planing- Per Quadrant	75%	75%
4210 Gingivectomy/Gingivoplasty - Per Quadrant	75%	75%
4910 Periodontal Maintenance Procedures		
	75%	75%
	75%	75%
	75%	75%
Type III	**STANDARD**	**ENRICHED**
Crown & Bridge:	50% - limited to 12 years and older	50%
2791 Crown Full Cast Predominately Base Metal	50% - limited to 12 years and older	50%
2751 Crown Porcelain Fused To Base Metal		
Pontics:	50% - are limited to 16 years and older	50%
6210 Full Cast	50% - are limited to 16 years and older	50%
6240 Porcelain Fused To Metal		
Prosthodontics (Dentures):	50%	50%
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)		
Orthodontia		
Consultation	Not Covered	
Evaluation	Not Covered	Adult & Child covered at 50% after
Records	Not Covered	a one time deductible of $50 per person.
Children	Not Covered	$1,300 lifetime maximum benefit
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.

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DeltaCare USA (DHMO) Plan	STANDARD	ENRICHED
Choice of Dentist	Limited to providers participating in the DeltaCare USA network.	
Maximum Benefit/Deductible	No Maximum, No Deductible	
	STANDARD - You pay	**ENRICHED - You pay**
Type I		
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	$15.00 each (Twice every 12 months)	$15 each (Twice every 12 months)
Two Additional Every 12 Months	$60.00 each	$60.00 each
	STANDARD	**ENRICHED**
Type III		
Crown & Bridge:		
2751 Crown Porcelain Fused To Base Metal	$180.00	$95.00
2791 Crown Full Cast Predominately Base Metal	$180.00	$95.00
2930 Prefabricated Stainless Steel	$15.00	$10.00
Prosthodontics (Dentures):		
5110 Complete Upper	$190.00	$110.00
5120 Complete Lower	$190.00	$110.00
5213/14 Partial Upper Or Lower - Cast Metal Base	$220.00	$130.00
Orthodontia	You pay orthodontia as follows: Comprehensive for dependent children under age 19: $1,500. Adults: $2,800 $200 copayment for pre and post orthodontic records. $300 copayment	You pay orthodontia as follows: Comprehensive for dependent children under age 19: $1,500. Adults: $2,800 $200 copayment for pre and post orthodontic records. $300 copayment
Consultation		
Evaluation		
Records		
8080 Children - Normal Class II		
8090 Adult - Normal Class II		
8680 Orthodontic Retention		



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

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	Up to $300
Any Overages	Additional 20% Off Any Overage[1]	Additional 20% Off Any Overage[1]
The Exclusive Collection: Fashion/Designer/Premier	Covered in Full/$15/$40	Covered In Full
LENSES	$25	$0
COPAYS FOR OPTIONS & UPGRADES		
LENS OPTIONS		
Clear Plastic Single-Vision, Bifocal, Trifocal or Lenticular Lenses (any RX)	$0	$0
Oversized Lenses	$0	$0
Plastic Lenses	$0	$0
Polycarbonate Lenses (Children/Adults)	$0/$35	$0/$30
High Index Lenses 1.67/ High Index Lenses 1.74	$60/$120	$55/$120
Polarized Lenses	$75	$75
Progressive Lenses (Standard/Premium/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 Scratch-Resistant Coating/Premium Scratch-Resistanct Coating	$0 / $30	$0 / $30
Scratch-Protection Plan (Single-Vision | Multifocal)	$20 | $30	$20 | $40
ADDITIONAL SAVINGS		
Retinal Imaging (Member charge)	$39	$39
Additional Pairs of Eyeglasses	30% Discount[1]	30% Discount[1]
CONTACTS[2] IN LIEU OF GLASSES		
Contact Allowance	$100	$120
Any Overages	Additional 15% Off Any Overage[1]	Additional 15% Off Any Overage[1]
The Exclusive Collection of Contact Lenses: [3]	N/A	Covered In Full

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COVERED VISION SERVICES CONTINUED

	BASE PLAN COPAY	PREMIER PLAN COPAY
OUT-OF-NETWORK BENEFITS		
The out-of-network benefit allows you to select any out-of-network provider and reimburses a fixed dollar amount based on the schedule shown for the out-of-network services. The following chart indicates the benefits the plan pays for the services you receive. For more information, see the Davis plan literature.		
OUT-OF-NETWORK REIMBURSEMENT SCHEDULE (UP TO)		
Eye Examination	$40	$40
Frame	$50	$50
Single-Vision Lenses	$40	$40
Bifocal / Progressive Lenses	$60	$60
Trifocal Lenses	$80	$80
Lenticular Lenses	$116	$116
Elective Contact Lenses	$100	$120
Visually Required Contacts	$210	$210

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



Under 65 - Life Insurance

The monthly life and AD&D insurance rate is 17¢ per thousand dollars of your pre-retirement annual salary.

_____ x .00017 = $_____

ANNUAL SALARY | RATE | MONTHLY PREMIUM

* Your life insurance coverage is reduced when you reach age 65. The coverage options are $15,000 or $20,000.

65 and Over Life Insurance RETIREES' AGE	MONTHLY RATES FOR $15,000 IN COVERAGE	MONTHLY RATES FOR $20,000 IN COVERAGE
65-69	$ 8.55	$ 11.40
70-74	$ 14.10	$ 18.80
75+	$ 19.50	$ 26.00

Optional Life Insurance

Optional life coverage is not available through the Retiree Group. If enrolled at the time of your retirement, you may elect to convert this coverage to an individual policy. The policy is available to you without medical approval, but will be provided by Reliance Standard Life Insurance Company at their prevailing individual insurance rates. You may convert up to the amount of coverage in force at retirement. Contact the insurance carrier to obtain rates and policy options. Reliance Standard Life Insurance Company 1-800-351-7500.

Basic Life Insurance for Retirees Under Age 65

The group basic life insurance coverage provided to active employees at no cost may be continued at retirement, at your expense. The Life Insurance for Retirees Under 65 also includes Basic AD&D. The rate is $.155/$1,000 for Basic Life and $.015/$1,000 for the AD&D for a combined total of $.17. The coverage amount for retirees under age 65 is equivalent to their pre-retirement annual base salary. As long as the coverage was in force prior to retirement, the benefit may be continued.

Basic Life Insurance for Retirees Age 65+

Retirees age 65+ may elect either $15,000 or $20,000 of life insurance coverage.

Remember to keep your beneficiary designation current. A new beneficiary may be named at any time. To update your beneficiary call the FBMC Customer Service Center at 855-56JHS4U (855-565-4748) and request a Life Insurance Beneficiary Update Form. Make sure your beneficiary designation form is legible and contains no erasures or cross-out marks. Specify the percentage of benefits for each named beneficiary to receive. The total percent allocation among the beneficiaries must add up to 100 percent. Please be sure your beneficiary is aware of the benefit and knows how to contact our office in the event of your death.

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

Be Protected When Legal Happens

Legal issues can come up at any time. And facing them alone can be overwhelming when you're not sure what to do. A legal insurance plan from ARAG® provides access to experienced network attorneys and trusted resources for a wide range of legal needs, like the examples below.

- You get caught speeding and you want to fight the ticket.
- Your neighbor's ugly fence is on the property line.
- You want to add your newborn child to your will.
- Your dog bites a neighbor.
- The mechanic botches your car repair.

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 save legal documents online, like a will, trust or power of attorney, using **state-specific, attorney-reviewed templates.**

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.

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

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

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

Any legal matter that occurs or is initiated prior to the effective date of your legal plan will be considered excluded and no benefits will apply. ARAG defines this as an event covered by this policy whose initiation date will be considered the earlier of the date (a) written notice of a legal dispute is sent or filed by you or received by you; or (b) a ticket or citation is issued; or (c) an attorney is hired.

If your matter is considered pre-existing, in-office benefits are not available; however, as long as the matter is not listed under "Exclusions" in the plan, you are able to receive advice from a network attorney under the telephone legal access services benefit. You can also receive a reduced fee benefit of at least 25% off the network attorney's normal rate if you have not previously hired an attorney.

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

Click or scan QR Code visit the ARAG Legal website.



Enroll today to start saving!

Pet Assure Veterinary Discount Plan

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

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

Here's what your membership includes:

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

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

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

PetPlus Prescription Discount Plan

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

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

Additional Benefits:

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

Pet Assure & PetPlus Rates	Monthly Rates
Pet Assure Unlimited Plan	$8.00
PetPlus Single Pet Plan	$4.50
PetPlus Unlimited Plan	$8.50
Pet Assure Unlimited + PetPlus Single Pet	$12.50
Pet Assure Unlimited + PetPlus Unlimited	$16.50

Unlimited plans covers all pets in your household.

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

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

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

Features and Benefits:

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

Full Access to Credit Reports
With ConstantCredit, you have access to your full credit report at any time, regardless of what level of plan you have.

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

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

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

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

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

ConstantCredit Rates	Monthly Rate
Retiree	$11.50
Retiree + Spouse	$23.00

ID Commander

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

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

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

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

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

ID Commander Monthly Rates	Ultimate
Retiree	$10.50
Family	$22.50

JHS NURSE EMERITUS PROGRAM

The JHS Nurse Emeritus Program is our way of supporting our new to practice nurses as they integrate into the workforce, and ensure that their experience is a positive one.

Our nurses will gain real time experiences with our retired nurses, called Nurse Emeriti, to help them navigate the ups and downs of their new profession.

The JHS Nurse Emeritus program will help us to fulfill our mission to retain the brightest and the best for the care of our patients.

So, if you have retired from JHS with in the last 3 years and would like to give back, while being paid, to this fine organization that helped you to retire comfortably.

Please contact us at the JHS Center for Academic Partnerships:

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

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

Jackson volunteer program opportunities

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

Jackson Memorial Medical Center Volunteer Services:

305-585-6541

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

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

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



Extended Illness

For employees covered under the AFSCME, SIEU, GSAF Bargaining Unit, please refer to your Union contract or contact your local representative. Payout after a minimum of ten years of full-time continuous employment in accordance with the following schedule:

Less than 10 years	No payment
10 years but less than 11 years	25% payment
11 years but less than 12 years	30% payment
12 years but less than 13 years	35% payment
13 years but less than 14 years	40% payment
14 years but less than 15 years	45% payment
15 years but less than 16 years	50% payment
16 years but less than 17 years	55% payment
17 years but less than 18 years	60% payment
18 years but less than 19 years	65% payment
19 years but less than 20 years	70% payment
20 years but less than 21 years	75% payment
21 years but less than 22 years	77.5% payment
22 years but less than 23 years	80% payment
23 years but less than 24 years	82.5% payment
24 years but less than 25 years	85% payment
25 years but less than 26 years	87.5% payment
26 years but less than 27 years	90% payment
27 years but less than 28 years	92.5% payment
28 years but less than 29 years	95% payment
29 years but less than 30 years	97.5% payment
30 years or more	100% payment

Non union employees hired prior to October 1, 2017 with less than thirty (30) years full-time PHT/County employment – who retire or resign from the PHT – will be eligible to receive payment for up to a maximum of 1,000 hours of accrued extended illness leave at the employee's rate of pay and tier as of September 30, 2017.

Personal Leave

Payout of 100 percent of accrued bank up to 500 hours at current base hourly rate of pay. The 500-hour accrual maximum includes converted sick leave.

Non union employees shall be eligible for a pro-rated payment of accrued personal leave (based on number of complete pay periods), up to 80 hours (if less than 10 years of service or FTE equivalent) and up to 120 hours (if 10 or more years of service/ FTE Equivalent) at the base rate of pay.



Tax-Sheltered Annuity (TSA) Contact List

COREBRIDGE FINANCIAL: (formerly AIG Retirement)
JHS 403(b) & 457(b) Plans

Roxann Murphy – Financial Advisor
Mobile Number: 954-826-2915
Roxann.Murphy@corebridgefinancial.com

Alex Harriehausen – Financial Advisor
Mobile Number: 305-710-6525
Alex.Harriehausen@corebridgefinancial.com

Richard Maurisma – Financial Advisor
Mobile Number: 786-350-8796
Richard.Maurisma@corebridgefinancial.com

Christian Martinez – Financial Advisor
Mobile Number: 305-401-8918
Christian.d.martinez@corebridgefinancial.com

Armando Vazquez – Senior Financial Advisor
Mobile Number: 305-433-1790
Armando.Vazquez@corebridgefinancial.com

Dida Langsdale – Senior Financial Advisor
Mobile Number: 786-390-8710
Candida.Langsdale@corebridgefinancial.com

Abraham Ser – Financial Advisor
Mobile Number: 561-232-7893
Abraham.ser@corebridgefinancial.com

Grandfathered Plans
JHS 403(b) & 457(b) Plans

LINCOLN FINANCIAL GROUP:
403(b) & 457
403(b) Account Contact:
800-454-6265
457 Account call:
800-341-0441
Alejandro M. Jerez CPWA Direct:
305-570-1816
Alejandro.Jerez@lfg.com

FIDELITY INVESTMENTS:
403(b)
1-800-343-0860
#51502 (Employer Plan Number)

VOYA FINANCIAL
403(b) & 457(b)
Group#09058
Stacey Sherbinsky
954-486-2236
s.sherbinsky@voyafa.com

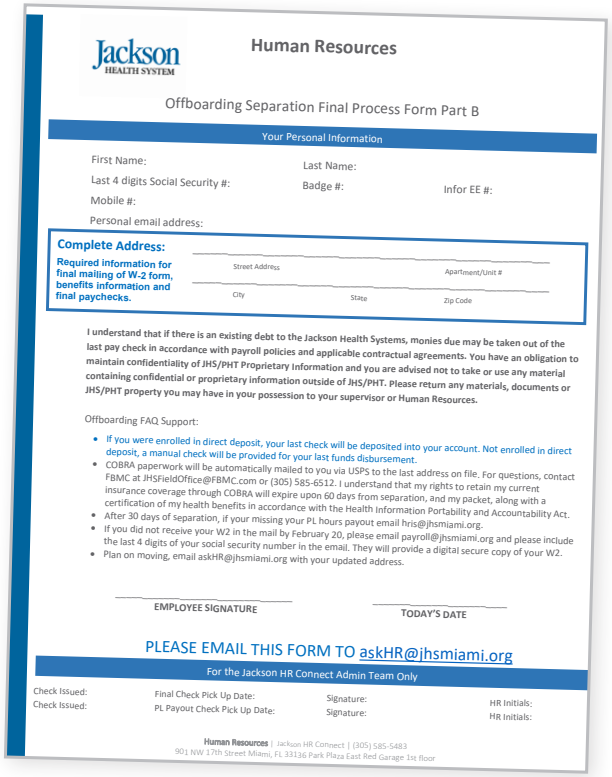
Gwenn Wayne
954-486-2236
gwenn.wayne@voyafa.com

NATIONWIDE RETIREMENT SOLUTIONS:
457(b)
Aaron R. Schwartz
305-439-9550
schwara5@nationwide.com
#609177 (Employer Plan Number)

2027 Payroll Calendar

PP#	BEGIN	END	PAYDAY
1	12-20	01-02	01-08
2	01-03	01-16	01-22
3	01-17	01-30	02-05
4	01-31	02-13	02-19
5	02-14	02-27	03-05
6	02-28	03-13	03-19
7	03-14	03-27	04-02
8	03-28	04-10	04-16
9	04-11	04-24	04-30
10	04-25	05-08	05-14
11	05-09	05-22	05-28
12	05-23	06-05	06-11
13	06-06	06-19	06-25
14	06-20	07-03	07-09
15	07-04	07-17	07-23
16	07-18	07-31	08-06
17	08-01	08-14	08-20
18	08-15	08-28	09-03
19	08-29	09-11	09-17
20	09-12	09-25	10-01
21	09-26	10-09	10-15
22	10-10	10-23	10-29
23	10-24	11-06	11-12
24	11-07	11-20	11-26
25	11-21	12-04	12-10
26	12-05	12-18	12-24
01	12-19	01-01	01-07-2028

Attachment B Form



Jackson HEALTH SYSTEM

Human Resources

Offboarding Separation Final Process Form Part B

Your Personal Information

First Name: Last Name:

Last 4 digits Social Security #: Badge #: Infor EE #:

Mobile #:

Personal email address:

Complete Address:

Required information for final mailing of W-2 form, benefits information and final paychecks.

Street Address Apartment/Unit #

City State Zip Code

I understand that if there is an existing debt to the Jackson Health Systems, monies due may be taken out of the last pay check in accordance with payroll policies and applicable contractual agreements. You have an obligation to maintain confidentiality of JHS/PHT Proprietary Information and you are advised not to take or use any material containing confidential or proprietary information outside of JHS/PHT. Please return any materials, documents or JHS/PHT property you may have in your possession to your supervisor or Human Resources.

Offboarding FAQ Support:

- If you were enrolled in direct deposit, your last check will be deposited into your account. Not enrolled in direct deposit, a manual check will be provided for your last funds disbursement.
- COBRA paperwork will be automatically mailed to you via USPS to the last address on file. For questions, contact FBMC at JHSFieldOffice@FBMC.com or (305) 585-6512. I understand that my rights to retain my current insurance coverage through COBRA will expire upon 60 days from separation, and my packet, along with a certification of my health benefits in accordance with the Health Information Portability and Accountability Act.
- After 30 days of separation, if your missing your PL hours payout email hris@jhsmiami.org.
- If you did not receive your W2 in the mail by February 20, please email payroll@jhsmiami.org and please include the last 4 digits of your social security number in the email. They will provide a digital secure copy of your W2.
- Plan on moving, email askHR@jhsmiami.org with your updated address.

EMPLOYEE SIGNATURE TODAY'S DATE

PLEASE EMAIL THIS FORM TO askHR@jhsmiami.org

For the Jackson HR Connect Admin Team Only

Check Issued: Final Check Pick Up Date: Signature: HR Initials:

Check Issued: PL Payout Check Pick Up Date: Signature: HR Initials:

Human Resources | Jackson HR Connect | (305) 585-5483
901 NW 17th Street Miami, FL 33136 Park Plaza East Red Garage 1st floor



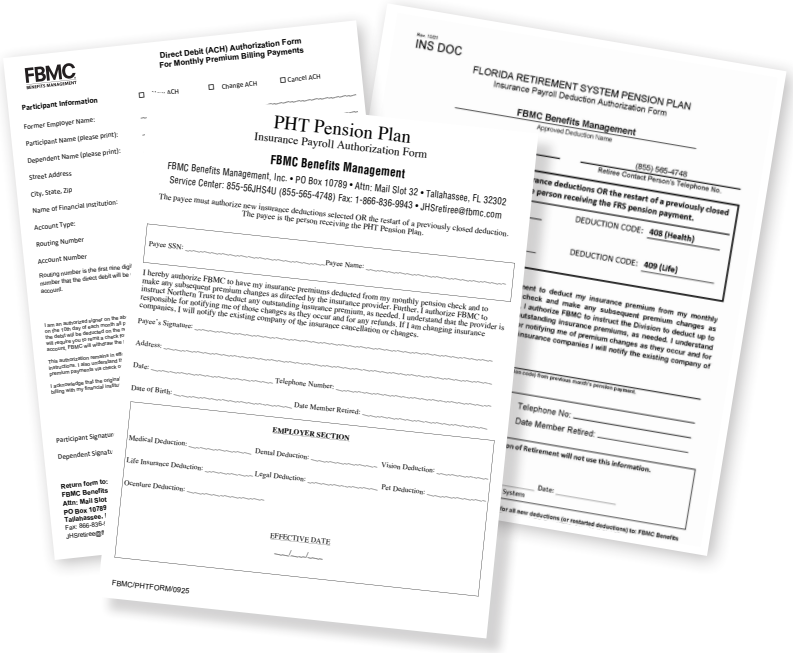
DOWNLOAD AN FRS, PHT, OR ACH FORM AT JACKSONBENEFITS.ORG

FAX IN OR MAIL TO:

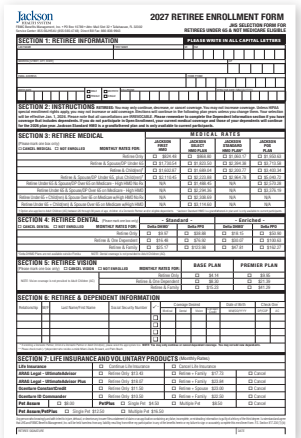
FBMC Benefits Management, Inc.
PO Box 10789
Attn: Mail Slot 32
Tallahassee, FL 32302-2789

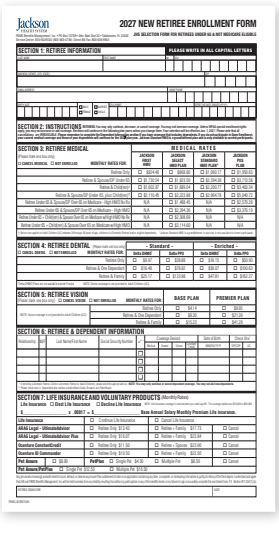
Fax: 1-866-836-9943

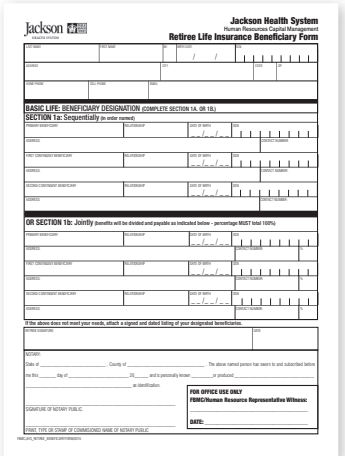
Forms are only required if you are adding any NEW benefits.



REVIEW YOUR ENROLLMENT FORMS AT JACKSONBENEFITS.ORG



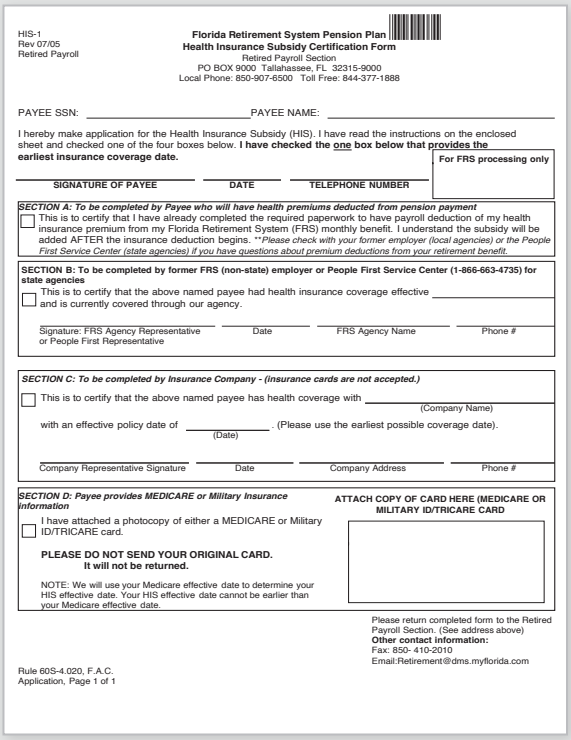




If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

FRS Pension/Additional Forms

1.



HIS-1
Rev 07/05
Retired Payroll

Florida Retirement System Pension Plan
Health Insurance Subsidy Certification Form
Retired Payroll Section
PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888

PAYEE SSN: _____ PAYEE NAME: _____

I hereby make application for the Health Insurance Subsidy (HIS). I have read the instructions on the enclosed sheet and checked one of the four boxes below. **I have checked the one box below that provides the earliest insurance coverage date.**

For FRS processing only

SIGNATURE OF PAYEE | DATE | TELEPHONE NUMBER

SECTION A: To be completed by Payee who will have health premiums deducted from pension payment

☐ This is to certify that I have already completed the required paperwork to have payroll deduction of my health insurance premium from my Florida Retirement System (FRS) monthly benefit. I understand the subsidy will be added AFTER the insurance deduction begins. ***Please check with your former employer (local agencies) or the People First Service Center (state agencies) if you have questions about premium deductions from your retirement benefit.*

SECTION B: To be completed by former FRS (non-state) employer or People First Service Center (1-866-663-4735) for state agencies

☐ This is to certify that the above named payee had health insurance coverage effective _____ and is currently covered through our agency.

Signature: FRS Agency Representative or People First Representative | Date | FRS Agency Name | Phone #

SECTION C: To be completed by Insurance Company - (insurance cards are not accepted.)

☐ This is to certify that the above named payee has health coverage with _____ (Company Name)

with an effective policy date of _____ (Date). (Please use the earliest possible coverage date).

Company Representative Signature | Date | Company Address | Phone #

SECTION D: Payee provides MEDICARE or Military Insurance information

☐ I have attached a photocopy of either a MEDICARE or Military ID/TRICARE card.

PLEASE DO NOT SEND YOUR ORIGINAL CARD. It will not be returned.

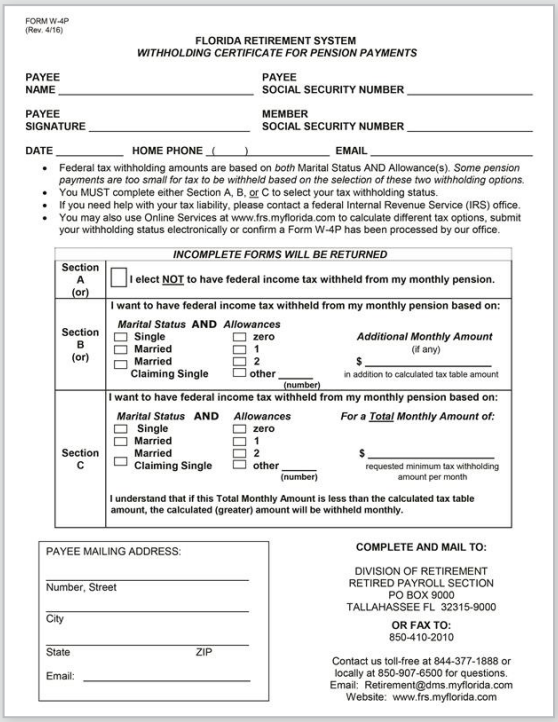
NOTE: We will use your Medicare effective date to determine your HIS effective date. Your HIS effective date cannot be earlier than your Medicare effective date.

ATTACH COPY OF CARD HERE (MEDICARE OR MILITARY ID/TRICARE CARD

Please return completed form to the Retired Payroll Section. (See address above)
Other contact information:
Fax: 850- 410-2010
Email:Retirement@dms.myflorida.com

Rule 60S-4.020, F.A.C.
Application, Page 1 of 1

2.



FORM W-4P
(Rev. 4/16)

FLORIDA RETIREMENT SYSTEM
WITHHOLDING CERTIFICATE FOR PENSION PAYMENTS

PAYEE NAME _____ **PAYEE SOCIAL SECURITY NUMBER** _____

PAYEE SIGNATURE _____ **MEMBER SOCIAL SECURITY NUMBER** _____

DATE _____ **HOME PHONE** (____) _____ **EMAIL** _____

- Federal tax withholding amounts are based on *both* Marital Status AND Allowance(s). *Some pension payments are too small for tax to be withheld based on the selection of these two withholding options.*
- You MUST complete either Section A, B, or C to select your tax withholding status.
- If you need help with your tax liability, please contact a federal Internal Revenue Service (IRS) office.
- You may also use Online Services at www.frs.myflorida.com to calculate different tax options, submit your withholding status electronically or confirm a Form W-4P has been processed by our office.

INCOMPLETE FORMS WILL BE RETURNED

Section A (or) ☐ **I elect NOT to have federal income tax withheld from my monthly pension.**

Section B (or) — **I want to have federal income tax withheld from my monthly pension based on:**

Marital Status **AND** ***Allowances***
☐ Single ☐ zero
☐ Married ☐ 1
☐ Married ☐ 2
☐ Claiming Single ☐ other _____ (number)

Additional Monthly Amount (if any)
$ _____ in addition to calculated tax table amount

Section C — **I want to have federal income tax withheld from my monthly pension based on:**

Marital Status **AND** ***Allowances***
☐ Single ☐ zero
☐ Married ☐ 1
☐ Married ☐ 2
☐ Claiming Single ☐ other _____ (number)

For a Total Monthly Amount of:
$ _____ requested minimum tax withholding amount per month

I understand that if this Total Monthly Amount is less than the calculated tax table amount, the calculated (greater) amount will be withheld monthly.

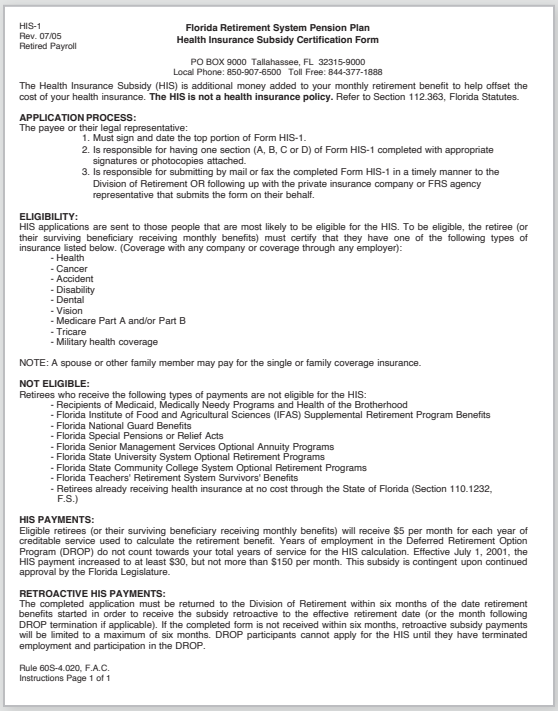
PAYEE MAILING ADDRESS:
_____
Number, Street
_____
City
_____
State ZIP
Email: _____

COMPLETE AND MAIL TO:

DIVISION OF RETIREMENT
RETIRED PAYROLL SECTION
PO BOX 9000
TALLAHASSEE FL 32315-9000

OR FAX TO:
850-410-2010

Contact us toll-free at 844-377-1888 or locally at 850-907-6500 for questions.
Email: Retirement@dms.myflorida.com
Website: www.frs.myflorida.com



HIS-1
Rev. 07/05
Retired Payroll

Florida Retirement System Pension Plan
Health Insurance Subsidy Certification Form

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888

The Health Insurance Subsidy (HIS) is additional money added to your monthly retirement benefit to help offset the cost of your health insurance. **The HIS is not a health insurance policy.** Refer to Section 112.363, Florida Statutes.

APPLICATION PROCESS:
The payee or their legal representative:
1. Must sign and date the top portion of Form HIS-1.
2. Is responsible for having one section (A, B, C or D) of Form HIS-1 completed with appropriate signatures or photocopies attached.
3. Is responsible for submitting by mail or fax the completed Form HIS-1 in a timely manner to the Division of Retirement OR following up with the private insurance company or FRS agency representative that submits the form on their behalf.

ELIGIBILITY:
HIS applications are sent to those people that are most likely to be eligible for the HIS. To be eligible, the retiree (or their surviving beneficiary receiving monthly benefits) must certify that they have one of the following types of insurance listed below. (Coverage with any company or coverage through any employer):
- Health
- Cancer
- Accident
- Disability
- Dental
- Vision
- Medicare Part A and/or Part B
- Tricare
- Military health coverage

NOTE: A spouse or other family member may pay for the single or family coverage insurance.

NOT ELIGIBLE:
Retirees who receive the following types of payments are not eligible for the HIS:
- Recipients of Medicaid, Medically Needy Programs and Health of the Brotherhood
- Florida Institute of Food and Agricultural Sciences (IFAS) Supplemental Retirement Program Benefits
- Florida National Guard Benefits
- Florida Special Pensions or Relief Acts
- Florida Senior Management Services Optional Annuity Programs
- Florida State University System Optional Retirement Programs
- Florida State Community College System Optional Retirement Programs
- Florida Teachers' Retirement System Survivors' Benefits
- Retirees already receiving health insurance at no cost through the State of Florida (Section 110.1232, F.S.)

HIS PAYMENTS:
Eligible retirees (or their surviving beneficiary receiving monthly benefits) will receive $5 per month for each year of creditable service used to calculate the retirement benefit. Years of employment in the Deferred Retirement Option Program (DROP) do not count towards your total years of service for the HIS calculation. Effective July 1, 2001, the HIS payment increased to at least $30, but not more than $150 per month. This subsidy is contingent upon continued approval by the Florida Legislature.

RETROACTIVE HIS PAYMENTS:
The completed application must be returned to the Division of Retirement within six months of the date retirement benefits started in order to receive the subsidy retroactive to the effective retirement date (or the month following DROP termination if applicable). If the completed form is not received within six months, retroactive subsidy payments will be limited to a maximum of six months. DROP participants cannot apply for the HIS until they have terminated employment and participation in the DROP.

Rule 60S-4.020, F.A.C.
Instructions Page 1 of 1

Contact 844-377-1888 or visit myfrs.com for required forms.

1.

HIS-1

Public Health Trust Defined Benefit Pension Plan
Health Insurance Subsidy Certification Form
The Benefits Department
1500 NW 12th Ave Suite 106W Miami, FL 33136
Phone: 786-466-8355 Fax: 305-355-5011

PAYEE SSN: _____ PAYEE NAME: _____

I hereby make application for the Health Insurance Subsidy (HIS). I have read the instructions on the enclosed sheet and checked one of the four boxes below. **I have checked the one box below that provides the earliest insurance coverage date.**

For PHT Processing Only

SIGNATURE OF PAYEE | DATE | TELEPHONE NUMBER

SECTION A: To be completed by Payee who will have health premiums deducted from pension payment

☐ This is to certify that I have already completed the required paperwork to have payroll deduction of my health insurance premium from my monthly pension benefit. I understand the subsidy will be added AFTER the insurance deduction begins. ***Please check with the the Benefits Department if you have questions about premium deductions from your retirement benefit.*

SECTION B: To be completed by the Jackson Benefits Department.

☐ This is to certify that the above named payee had health insurance coverage effective _____ and is currently covered through our agency.

Signature: Jackson BenefitsRepresentative | Date | Phone #

SECTION C: To be completed by Insurance Company - (Insurance cards are not accepted.)

☐ This is to certify that the above named payee has health coverage with _____ (Company Name)

with an effective policy date of _____ (Date). (Please use the earliest possible coverage date).

Company Representative Signature | Date | Company Address | Phone #

SECTION D: Payee provides MEDICARE or Military Insurance information

☐ I have attached a photocopy of either a MEDICARE or Military ID/TRICARE card.

PLEASE DO NOT SEND YOUR ORIGINAL CARD.
It will not be returned.

NOTE: We will use your Medicare effective date to determine your HIS effective date. Your HIS effective date cannot be earlier than your Medicare effective date.

ATTACH COPY OF CARD HERE (MEDICARE OR MILITARY ID/TRICARE CARD

Please Return to the Benefits Department:
1500 NW 12th Ave Suite 106W
Miami, FL 33136
Phone: 786-466-8355 Fax: 305-355-5011

Public Health Trust Defined Benefit Pension Plan
Health Insurance Subsidy Certification Form
The Benefits Department
1500 NW 12th Ave Suite 106W Miami, FL 33136
Phone: 786-466-8355 Fax: 305-355-5011

The Health Insurance Subsidy (HIS) is additional money added to your monthly retirement benefit to help offset the cost of your health insurance. The HIS is not a health insurance policy.

APPLICATION PROCESS:

1. Must sign and date the top portion of Form HIS-1.
2. Is responsible for having one section (A,B,C or D) of Form HIS-1 completed with appropriate signatures or photo copies attached.
3. Is responsible for submitting by mail or fax the completed Form HIS-1 in a timely manner to the Benefits Department.

ELIGIBILITY:

HIS applications are sent to those people that are most likely to be eligible for the HIS. To be eligible, the retiree must certify that they have one of the following types of insurance listed below. (Coverage with any company or coverage through any employer):

- Health
- Cancer
- Accident
- Disability
- Dental
- Vision
- Medicare Part A and/or Part B
- Tricare
- Military health coverage

NOTE: A spouse or other family member may pay for the single or family coverage insurance.

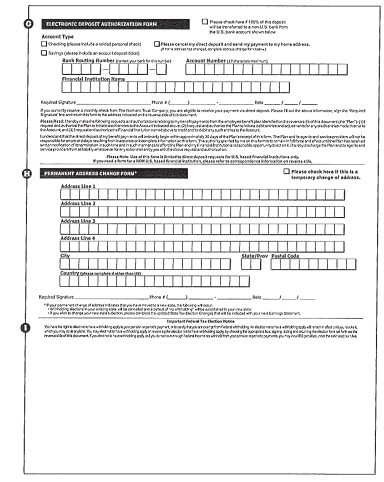
NOT ELIGIBLE:

Retirees who receive the following types of payments are not eligible for the HIS:

- Recipients of Medicaid, Medically Needy Programs and Health of the Brotherhood
- Florida Institute of Food and Agricultural Sciences (IFAS) Supplemental Retirement Program Benefits
- Florida National Guard Benefits
- Florida Special Pensions or Relief Acts
- Florida Senior Management Services Optional Annuity Programs
- Florida State University System Optional Retirement Programs
- Florida State Community College System Optional Retirement Programs
- Florida Teachers' Retirement System Survivors' Benefits
- Retirees already receiving health insurance at no cost through the State of Florida (Section 110.1232, F.S.)

HIS PAYMENTS:
Eligible retirees will receive $5 per month for each year of creditable service used to calculate the retirement benefit. The HIS subsidy is at least $30, but not more than $150 per month. The maximum health insurance subsidy of $150 is the total maximum you may receive from both the FRS and PHT combined.

2.



Data Elements Referenced

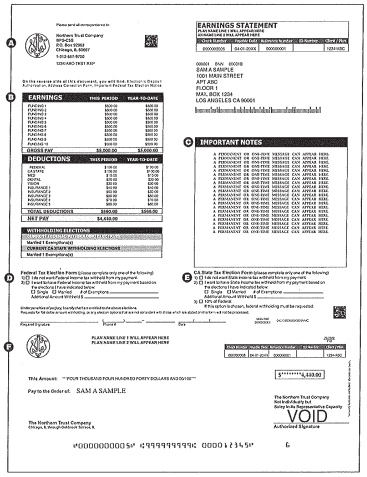
- **C** Use the Electronic Deposit Authorization Form to initiate instructions for direct deposit of your benefit.
- **H** Use the Address Change Form to submit an address change.
- **I** The Federal Tax Election Notice (a.k.a, TEFRA) language satisfies legal requirements for notifying participants of their tax election rights.

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Q10185 (8/11)

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SAMPLE CHECK



Data Elements Referenced

- **A** Client logo can appear on the check stock.
- **B** An itemized listing of the gross and net amount of the benefit in addition to year-to-date earnings and deductions appear in this section.
- **C** Check the "Important Notes" section each month; prints messages up to 1,000 characters.
- **D** The Federal Tax Election Form allows participants to update their federal tax elections.
- **E** The individualized State Tax Election Form allows participants to update their state tax withholding elections. The election options on the statement are compliant with state withholding requirements.
- **F** When participants receive their benefit in the form of a paper check, the actual check will be printed at the bottom of the page. The check can be easily detached at the perforations.

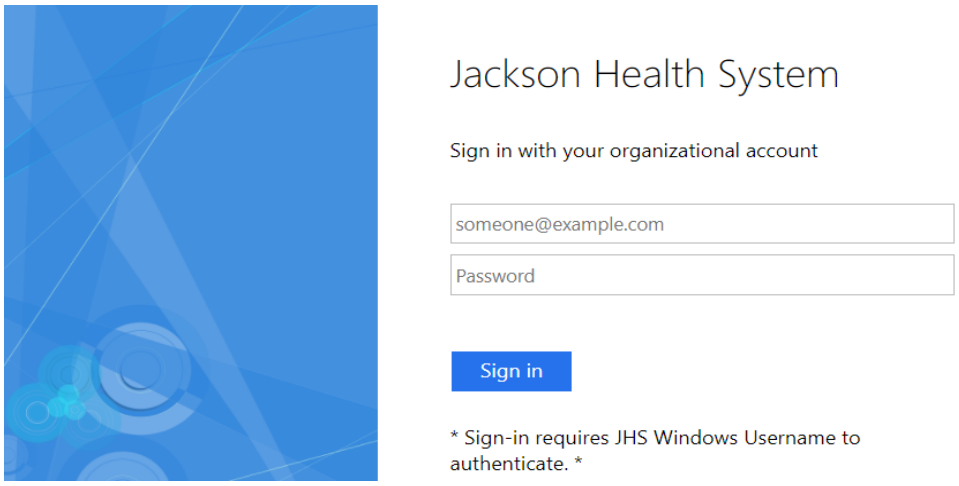
Northern Trust

northernTrust.com | Sample Check | 1 of 2

PHT Pension Modeling Tool

Accessing the Pension Modeling Tool and Logging On for ACTIVE MEMBERS

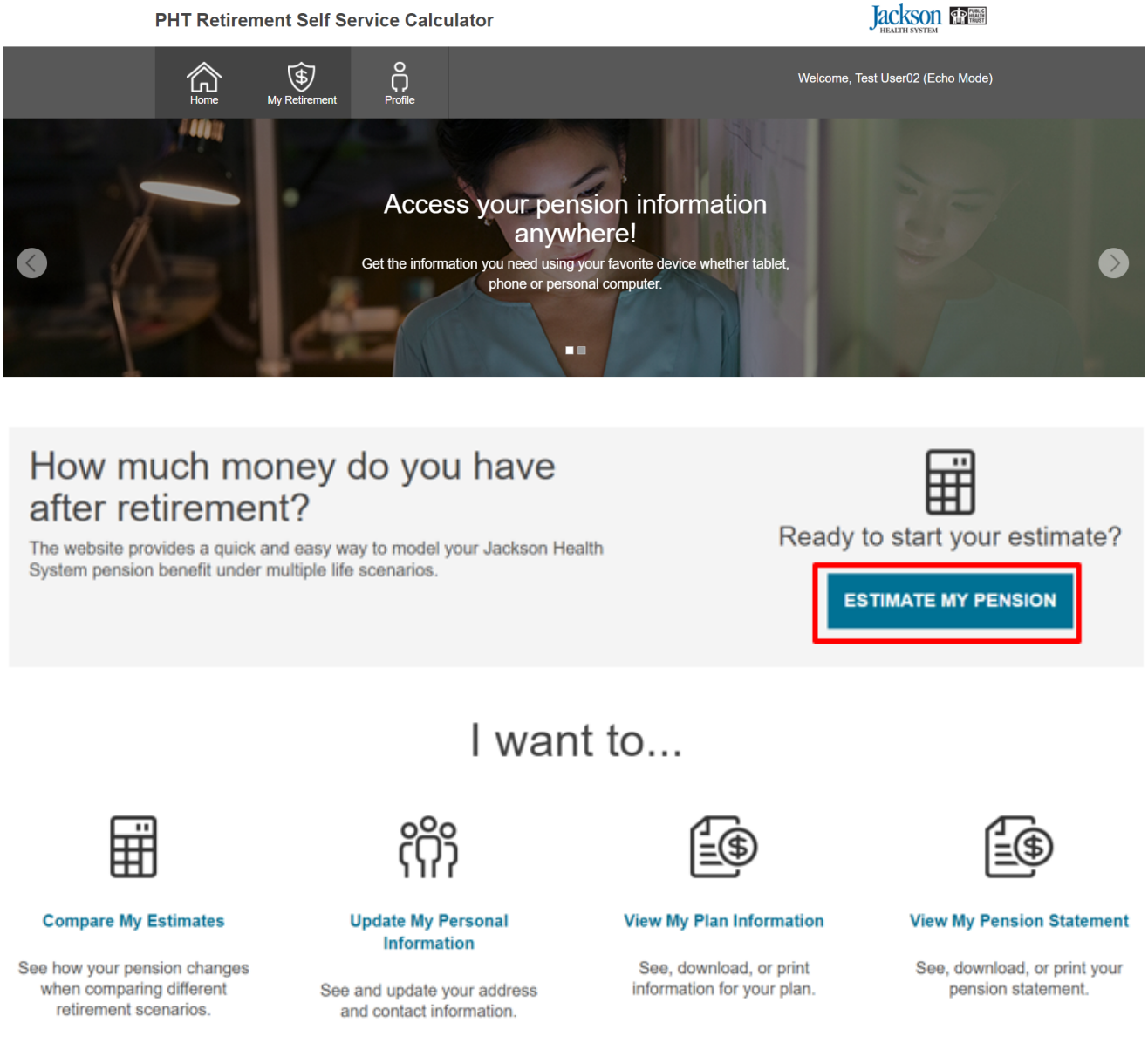
Access the tool by logging on at: https://adfs.jhsmiami.org/adfs/ls/idpinitiatedsignon.aspx



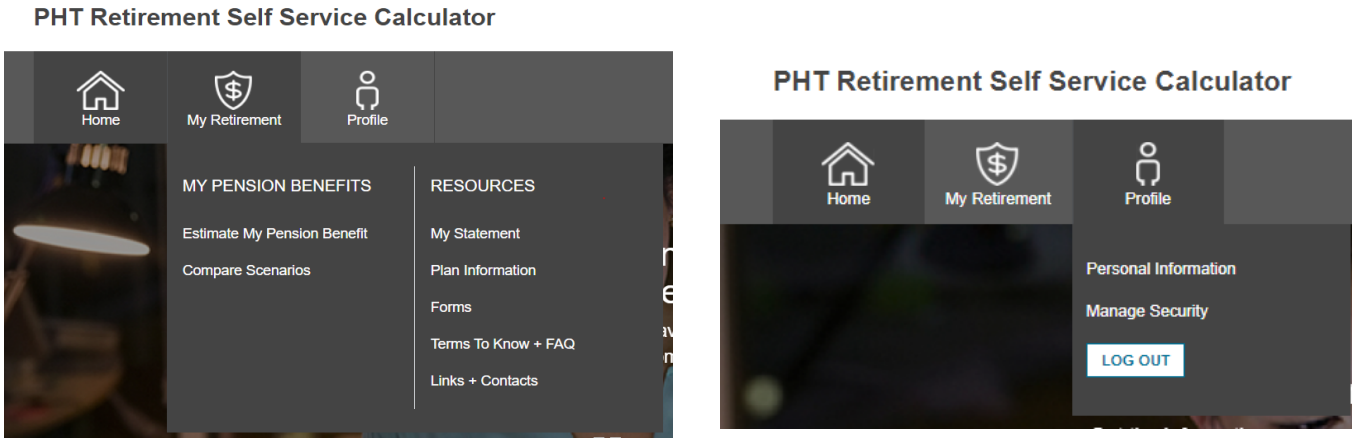
NOTE: Active Members do not need to register for an account to access the tool.

Using Pension Self Service Calculator

As soon as your account is created or you log in, you will be taken to the Welcome page (Home page). To navigate around the website, you can click on the Menu options at the top of the page or scroll down to the quick links on the page.



PHT Pension Modeling Tool



Use the **Estimate My Pension Benefit** menu option to create a single payout scenarios based on age or retirement date.

Use the **Compare Scenarios** menu option to create different payout scenarios based on age or retirement date.

Use the **My Statement** to view, download and print a copy of your most recent pension statement.

Use the **Plan Information** menu option to view, download and print copies of various plan related documents such as the Summary Plan Description.

Use the **Forms** menu option to view, download and print a copy of the of the retirement application.

Use the **Terms To Know + FAQ** menu option to view, download and print copies of the frequently asked questions for Retiree Medical, Dental, Vision and Life Insurance Plans or the PHT DROP or the Monthly information session schedule.

Use the **Links + Contacts** menu option to access contact information and other external websites.

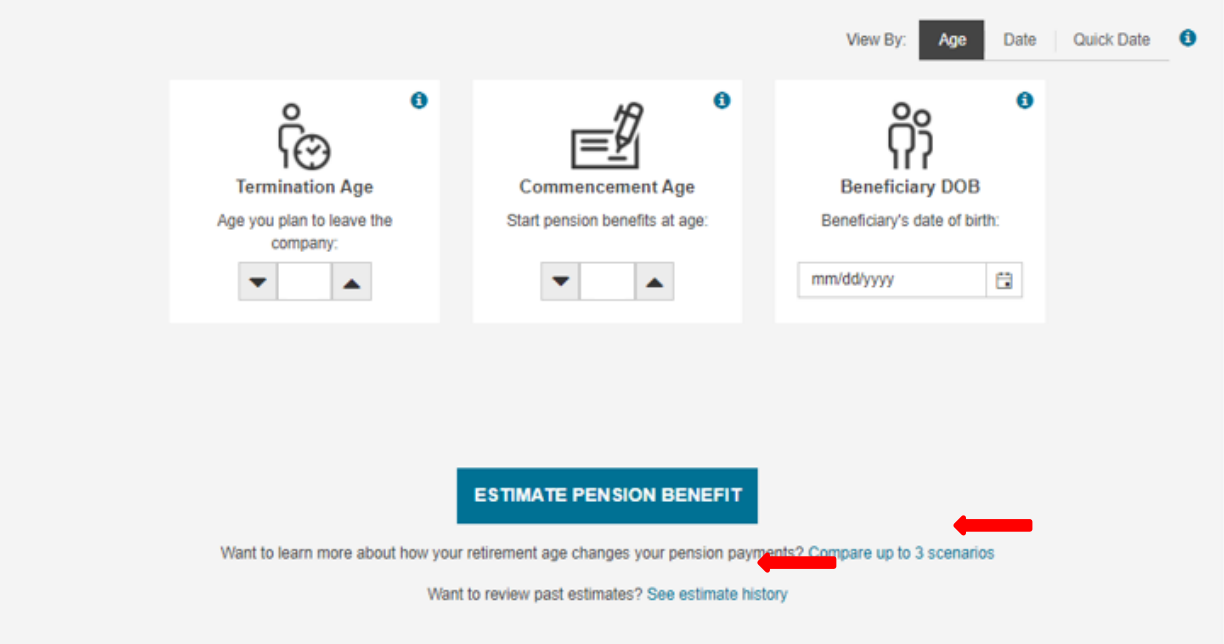
Use the **Personal Information** menu option to view your personal information and update your contact information, if applicable.

Use the **Manage Security** menu option to change your password and security questions.

Running Your Estimates

To estimate a single scenario pension benefit:

- Click on the **Estimate My Pension** from the Home page or **Estimate My Pension Benefit** from the Retirement menu option
- Select whether you want to enter the assumptions for your estimate by Age or Date .
- If applicable, enter the age or date you plan to leave the company
- Enter date or age you want payments to commence.
- If applicable, enter your beneficiary's date of birth
- Click on Estimate Pension Benefit to generate your estimate results



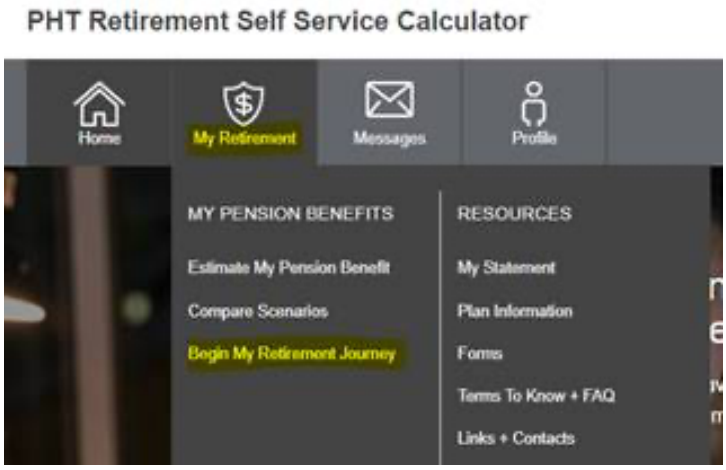
Use the **Compare up to 3 scenarios** link go to the page where you can enter up to three different combinations at one time.

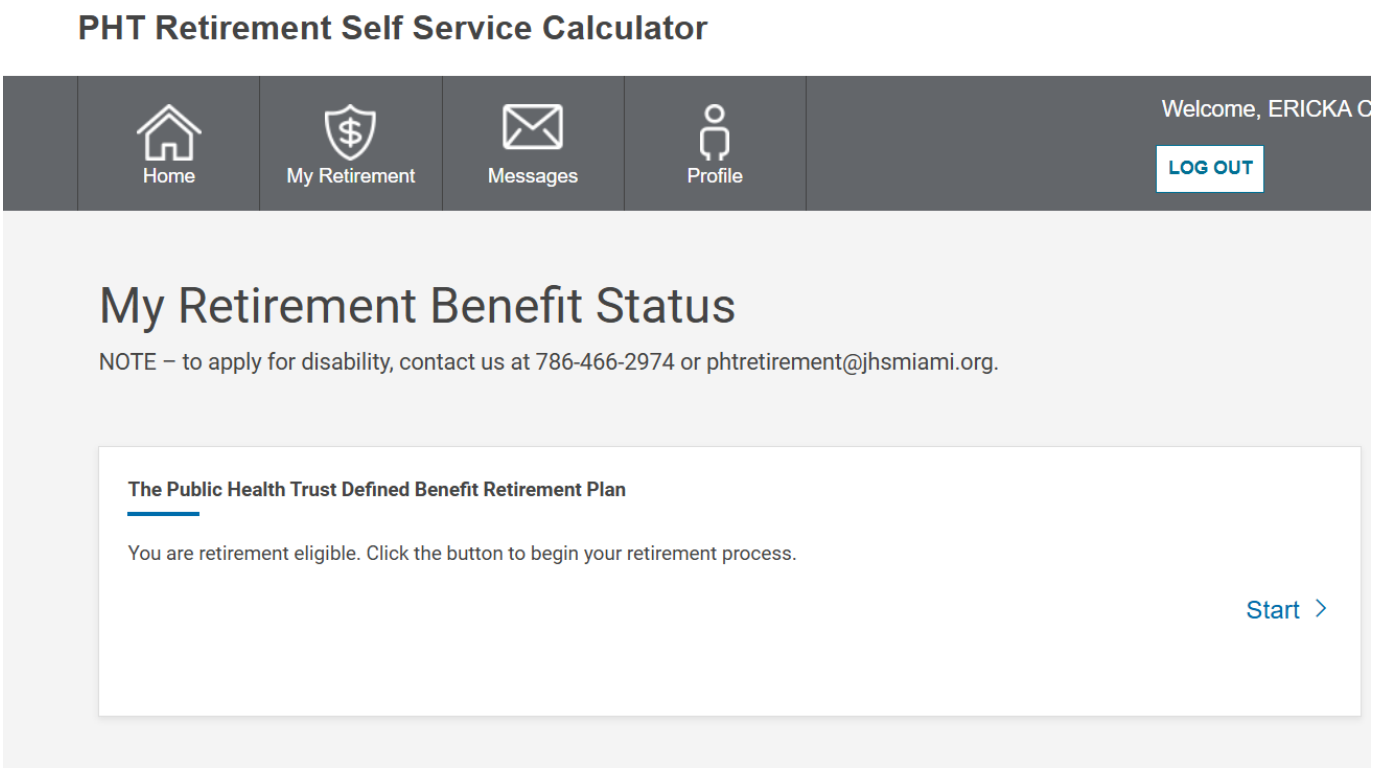
Use the **See estimate history** link to view prior scenarios that you have generated.

IMPORTANT: All results are estimates only and do not represent a guarantee of retirement income.

PHT RETIREMENT ONLINE APPLICATION

If you wish to begin your retirement process, click on "Begin My Retirement Journey" located in the "My Retirement" section, as the banner has recently been relocated.





HIPAA PRIVACY

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

HIPAA SPECIAL ENROLLMENT NOTICE

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Call your Plan Administrator for more information.

COBRA OVERVIEW

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event, also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

Your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. This is not a complete account of all COBRA terms and conditions. Please contact your Plan Administrator for more information.

Note: This is optional and not required. It doesn't really satisfy any rule. This is just alerting the retiree that his or her dependents may have a COBRA right.

The retiree no longer has COBRA rights if he or she has elected the retiree plan.

Designation of Primary Care Physician

JHS generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, JHS designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Aetna at 1-855-755-0507 or visit www.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 Aetna at 1-855-755-0507 or visit jhs.aetna.com.

NEWBORN AND MOTHER'S HEALTH PROTECTION ACT

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than: 48 hours following a vaginal delivery OR 96 hours following a cesarean section.

Determination of when the hospital stay begins is based on the following:

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

- Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

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

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

NOTICE OF FBMC'S CAPACITY

FBMC Benefits Management, Inc. (FBMC) has been authorized by your employer to provide certain administrative services for some the insurance plans offered within your employer's benefit program.

Importantly, FBMC is not the policyholder or an insurance company. The policyholder is the entity to whom the insurance policy has been issued; the employer is the policyholder for group insurance products and the employee is the policyholder for individual products.

The policyholder is identified on either the face page or schedule page of the policy or certificate. The insurance companies noted in this guide have been selected by your employer and are liable for the funds to pay your insurance claims.

CREDITABLE COVERAGE NOTICE

Important Notice from Jackson Health System About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Jackson Health System and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 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.
- 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.
- 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, 2026 to Dec. 7, 2027.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of you current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Jackson Health System coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Jackson Health System and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...Refer to your certificate of coverage issued by your medical insurance plan or visit 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
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Last Updated: Oct. 22, 2026
Name of Entity: Jackson Health System
Contact-Position/Office: Human Resources
Health and Wellness Department
Address: 901 NW 17th Street, Miami, FL 33136
Phone Number: 786-466-8378

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

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

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.

If you think you've been wrongly billed, you may contact the Department of Health and Humans Services Center for Medicare and Medicaid Services by calling the No Surprises Helpdesk at 1-800-985-3059, or visiting http://www.cms.gov/nosurprises.

Visit http://www.cms.gov/nosurprises for more information about your rights under federal law.

Notes

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



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

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