

2024 BENEFITS

designed with YOU in mind



JONES
COUNTY · IOWA



OPEN ENROLLMENT GUIDE - FULL TIME EMPLOYEES

Open Enrollment begins November 3rd

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WELCOME TO Jones County's *Annual Open Enrollment!*

It's time to enroll in your benefits

Jones County is excited to offer you a comprehensive benefits program with the flexibility you need to choose solid coverage and protection at an affordable price!

If you were hired recently, you must make your benefit elections before the 30-day enrollment window closes. Eligible employees employed on or before the 15th of a month shall be eligible for insurance coverage on the first of the month following the date of hire. Otherwise, coverage will begin on the first of the following month.

When is annual Open Enrollment?

November 3rd, 2023 – December 8, 2023

Who's Eligible?

Employees

You're eligible to enroll in Jones County's benefits program if you're:

- Active, Full-time as defined in the bargaining unit agreement
- Active, Full-time Non-Union Employee as defined in the Jones County Employee Handbook
- Elected Official
- As required by Federal Law

Dependents

When you enroll for benefits, you can also enroll your eligible dependents, including your:

- Legal spouse
- Children up to age 26**
- A disabled child of any age who becomes disabled prior to age 26 and who is dependent on you for financial support

** Includes natural, adopted, legal guardianships, and stepchildren regardless of student, marital, military, or employment status.

Use this guide to:



Review your benefit choices available through the Jones County benefits program



Understand how the plans work



Learn about the tools and resources available with each plan



Select the benefits that are best for you and your family



How To Enroll

Please confirm, enroll in, or decline your benefits through 4MyBenefits, the Jones County online benefit portal. The online portal will allow you to have 24/7 access to your benefit enrollment information, Access your 4MyBenefits enrollment portal at the website:

<https://4mybenefits.employeenavigator.com>

Enter your personal username and password. You would have set these up when you initially enrolled in 4MyBenefits. If you cannot find your personal login information, click on the "forgot username" or "forgot password" link.

If you need assistance navigating the portal, call Kim or Whitney at 319-462-2282

YOUR 3 ENROLLMENT OPPORTUNITIES

You can enroll for benefits:

- When you first become an eligible employee
- During Open Enrollment
- During the plan year, within 30 days of a qualifying life event (see the next page)

1 Upon Hire

Eligible employees employed on or before the 15th of a month shall be eligible for insurance coverage on the first of the month following the date of hire. Otherwise, coverage will begin on the first of the following month.

2 During Open Enrollment

This is your annual opportunity to enroll for benefits or make changes to your existing benefits.

Generally, benefits you elect during Open Enrollment will be effective **January 1, 2024 through December 31, 2024** unless you experience a qualifying life event that lets you change your coverage or makes you ineligible for coverage.

3 Following a Life Event

If you experience a status change or a qualifying life event during the year that affects your eligibility for benefits, you may enroll for coverage in new plans and make changes to existing coverage. You must notify the Auditor's office within 30 - 60 days of the event to make changes.



Only Enrolling in an FSA for 2024?

If you only want to elect FSA coverage for 2024 and wish to decline all other Benefits coverage, log on to:
<https://4mybenefits.employeenavigator.com>

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 33 for more details.

Summary of Benefits and Coverage

The Health section of this guide provides an overview of your medical plan options. You can find detailed information about each plan, including a breakdown of costs, in each plan's Summary of Benefits and Coverage (SBC). The SBCs summarize important information about your health coverage options in a standard format to help you compare costs and features across plans. The SBCs are available from HR and throughout this guide booklet.

QUALIFYING LIFE EVENTS

Qualifying life events include, but aren't limited to, marriage, divorce, legal separation, birth or adoption of a child, or a change to your or your spouse's employment status that affects benefits eligibility.



Life Event Key Points

1 Benefit changes must be CONSISTENT with the life event ...
Example: Your spouse just gave birth. You can't remove your spouse from your medical coverage when this happens because that isn't consistent with the event. But you could add dependent coverage for the newborn child.

2 You have 30-60 DAYS to request changes ...
 To request a change in benefits, contact your Human Resources Department and submit changes within 30 days (60 days for the birth of a child, or eligibility or lose of Medicaid or CHIP coverage) of when the event occurred.

NOT Qualifying Life Events



What Benefits Can Be Changed When						
Benefit that can be changed	Change in marital status (marriage, divorce, death of spouse)	Change in number of dependents (birth, adoption, death of dependent)	Start or end of employment (by spouse or dependent)	Change in your work hours	Significant change in health care plan coverage (through your spouse's plan)	Changes allowed during the year (qualifying life event not necessary)
Medical, Dental, Vision	X	X	X	X	X	
Health Care FSA	X	X	X	X	X	
Dependent Care FSA	X	X	X	X		
Required Documentation	Marriage certificate, divorce decree, death certificate	Birth certificate, adoption agreement, or death certificate	Letter from employer confirming prior coverage termination date and reason for termination		Letter from spouse's employer confirming coverage change and effective date	None



HEALTH *benefits*

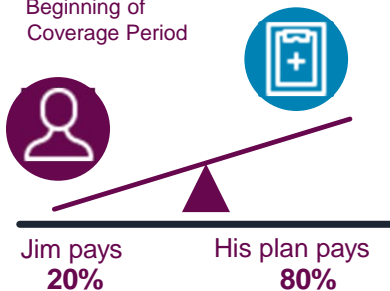
Important Health Insurance Terms

- 1 COPAY:** The fixed dollar amount you pay for certain health services or prescription drugs.
- 2 DEDUCTIBLE:** The amount you pay each year for covered non-preventive care before your health insurance starts to pay.
- 3 COINSURANCE:** Your share (percentage) of costs after you've met your deductible.
- 4 OUT-OF-POCKET (OOP) MAXIMUM:**
The most you have to pay in copays, deductible, and coinsurance during a single year. Once you reach it, your health insurer typically covers 100% of costs for the rest of the year

You and Your Insurer Share Costs – Example

Jim's Plan Deductible: \$750 **Coinsurance:** 20% **Out-of-Pocket Limit:** \$1,500

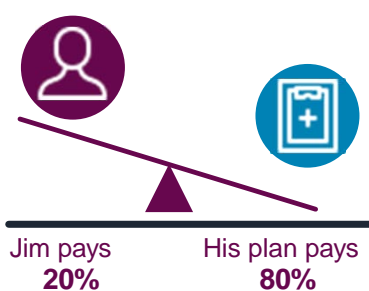
January 1st
Beginning of
Coverage Period



Jim hasn't reached his \$750 **deductible** yet

Deductible waived for office visits
His plan pay part of the cost ..

Office visit costs: \$125
Jim pays: \$25.00
his plan pays: \$100.00



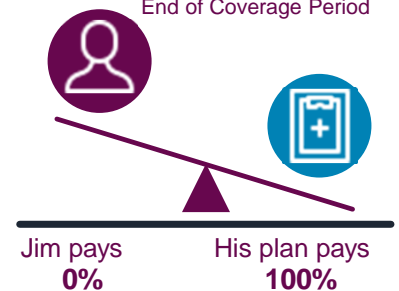
Jim reaches his \$750 deductible, **coinsurance** begins

Jim has had several procedures and paid \$750 in total. His plan pays some of the costs for is next visit.

MRI Cost : \$1,000
Jim pays: 20% of \$1,000 = \$200
His plan pays: 80% of \$1,000 = \$800



December 31st
End of Coverage Period



Jim reaches his \$1,500 **out-of-pocket limit**

Jim has seen the doctor often and paid \$1,500 in total. His plan pays the full cost of his covered health care services for the rest of the year.

Office visit costs: \$200
Jim pays: \$0
His plan pays: \$200

Quick Look: Jones County Medical Plan



Find a
network
provider



[www.wellmark.com/member
/find-provider](http://www.wellmark.com/member/find-provider)
800-524-9242
Wellmark Mobile App

	Basic PPO	
	In-network	Out-of-network
Annual deductible		
Per person/per family	\$750 / \$1,500	
Out-of-pocket maximum		
Per person/per family	\$1,500 / \$3,000	
Lifetime Maximum	Unlimited	
Medical coverage		
Doctor's office visits	Deductible waived, then 20% coinsurance	Deductible, then 40% coinsurance
Preventive care – One preventive exam and one gynecological exam per calendar year. Preventive medical examinations performed for administrative purposes are covered in addition to one regular preventive physical.	\$0 Copay	Deductible, then 40% coinsurance
Specialist Visits	Deductible waived, then 20% coinsurance	Deductible, then 40% coinsurance
Telemedicine	Deductible waived, then 20% coinsurance	Deductible, then 40% coinsurance
Inpatient Hospital & Physician	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Outpatient Hospital & Physician	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Emergency Room	Deductible, then 20% coinsurance	
Urgent Care	Deductible waived, then 20% coinsurance	Deductible, then 40% coinsurance
Pharmacy		
Pharmacy Deductible (Tier 1 excluded)	\$50 Single / \$100 Family	Not Covered
Pharmacy Out-of-Pocket Max	\$1,000 Single / \$2,000 Family	
Tier 1	\$10 Copay	
Tier 2	\$20 Copay	
Tier 3 / Tier 4	\$45 Copay	
Specialty Drugs	Generic: \$50 Copay Preferred: \$100 Copay Non-Preferred: 50% coinsurance	

Money-saving tips to be an educated consumer of your healthcare \$

- **See in-network providers** who have agreed to accept lower negotiated rates. Visit your plan website to search for in-network providers near you.
- **Use the mail-order pharmacy** to save time and money when refilling long-term prescriptions.
- **Talk to your medical provider** about generic alternatives to your medications.
- **\$30 virtual visits** – any plan, any time, any where (with a participating provider)



FLEXIBLE SPENDING ACCOUNTS (FSAs)

Jones County offers three types of flexible spending accounts (FSAs) to help you save on medical, dental, vision, and many daycare expenses: a health care FSA, a limited purpose FSA, and a dependent care FSA.

Remember, you can't have a full-service health care FSA and an HSA at the same time. You can, however, choose a limited purpose FSA to use for dental and vision expenses only along with an HSA.

FSA Fast Facts



Contribution limit. Set aside up to \$3,050 for eligible health care expenses. Any unused funds except for what's eligible to be rolled over is forfeited at year's end.



Lower your taxable income. Money you set aside is pre-tax dollars, so you pay taxes on a lesser amount.



Take advantage of payroll deduction. Contribute equal amounts each pay period.



Changes not allowed. Unless you experience a qualifying life event, you cannot change your annual contribution amount.



Separate accounts. You cannot use health care FSA funds to pay dependent care expenses, or vice versa.

Use-It-Or-Lose-It Rule

Plan your health care FSA contribution amount carefully. Any unused funds greater than the \$610 allowed rollover amount will be forfeited. Visit **healthequity.com** for help estimating expenses. Be sure to keep all receipts for your tax records as you may need to provide proof of eligible expenses.

Quick Look: YOUR FSA OPTIONS

	HEALTH CARE FSA	DEPENDENT CARE FSA
Who may enroll?	Jones County PPO participants	All Employees
What types of expenses are reimbursable? ¹	Eligible medical, dental, vision, and prescription drug expenses (includes deductibles, copays, and coinsurance)	Eligible dependent care expenses (includes child care, day camps, after school care, and adult daycare)
What is the maximum annual contributions?	\$3,050	\$5,000
Does the company contribute?	No	No
Do leftover funds roll over each year?	Yes, up to \$610 can be rolled over from your 2023 FSA account.	Grace Period: 2 ½ Months after plan end date

For eligible expenses – visit **www.healthequity.com**

For Dependent Care FSA (DCFSA) – If you're married, reimbursement is limited to the lesser of your earned income, your spouse's earned income, or a maximum of \$5,000. For a married person who files a separate income tax return, the maximum is \$2,500. Consult your tax advisor if you're uncertain of your specific tax situation.

QUICKSTART GUIDE

Your Flexible Spending Account



At-a-Glance

Your FSA:
The Essentials

Managing Your Account

Using Your FSA Dollars

Register online now!

If you haven't registered online yet, please do so today. To register, just visit www.healthequity.com/wageworks and click "LOG IN/REGISTER" and select "Employee Registration." You'll need to answer a few simple questions and create a username and password.

Questions?

HealthEquity makes it easy for you to get the help you need now. Please call us at 877-924-3967 or visit the Support Center at www.healthequity.com/wageworks where you will find answers to frequently asked questions, important forms, videos and other useful resources.

Download the EZ Receipts® mobile app!

Use your mobile device to file claims and take care of your account paperwork from anywhere. Go to www.healthequity.com/wageworks to learn more.

Welcome to HealthEquity. Start Saving. Here's How.

Welcome to your healthcare and/or dependent care flexible spending account (FSA) sponsored by your employer and brought to you by HealthEquity.

Your FSA is a great way to save on hundreds of eligible expenses like prescriptions, copayments, over-the-counter (OTC) items, and child and elder care.

Your FSA: The Essentials

Your FSA is governed by IRS regulations that detail who is eligible to use the account and where and how the money in it is to be used. Your FSA was designed to be simple. To keep it that way, it's important to comply with the IRS regulations that govern the program. The following guidelines will help you avoid any inconvenience.

- **Make sure account funds are only spent on expenses for those who are eligible.** Typically, those eligible are you, your spouse and your eligible dependents.
- **Know what expenses are eligible.** Log in to your account at www.healthequity.com/wageworks for a complete list of eligible healthcare expenses. Generally, eligible healthcare expenses include services and products that are medically necessary to treat a specific condition. Dependent care expenses typically include care provided for your qualifying child (under age 13) or other qualifying dependent so you can work.
- **Keep your receipts.** Save receipts that describe exactly what you paid for. Make sure the amount and service date—not the payment date—are included.
- **Over-the-counter (OTC) medications, drugs and menstrual care products.** You can use your HealthEquity® Visa® Healthcare Card (Card) for OTC medications and drugs, including menstrual care products. Alternatively, you can pay for the item out of pocket and use Pay Me Back to submit your claim to HealthEquity for reimbursement. Pay Me Back claims can be submitted online, or with your smartphone or mobile device. (FSA plans vary by employer, and these changes do not necessarily change the benefits under your employer's plan.)
- **Watch where you shop.** If using a HealthEquity Healthcare Card, shop only at general merchandise stores or pharmacies that have an IRS-approved inventory system in place. Visit www.sigis.com for the most updated list of approved merchants. The healthcare Card will not work at a non-certified merchant.
- **Verify all healthcare Card transactions.** If a transaction is not automatically verified at checkout or by a third-party system, you will be notified by email or upon login to your account. Failure to verify an outstanding transaction may result in healthcare Card suspension.
- **Register for an online account at www.healthequity.com/wageworks.** When you register online and provide a current email, you ensure that you will have 24/7 access to your account and will be automatically signed up to receive important updates and alerts. You also must have an account to use the mobile app and take advantage of features like Submit Receipt or Claim and healthcare Card usage requests.
- **Keep track of your FSA balance.** Plan ahead to make sure you spend the full amount of your balance.

QUICKSTART GUIDE

Managing Your Account

You can manage and check up on your account through HealthEquity online or over the phone. The “Claims and Activity” page online details all your account activity and will even alert you if any healthcare Card transactions are in need of verification.

For the latest information, visit **www.healthequity.com/wageworks** and log in to your account 24/7. In addition to reviewing your most recent FSA activity, you can:

- Update your account preferences and personal information.
- View your transactions and account history.
- Schedule payments to healthcare and dependent care providers.
- Check the complete list of eligible expenses for your FSA program.
- Order additional HealthEquity Healthcare Cards for your family.
- Download the EZ Receipts app to file claims and healthcare Card use paperwork.

Using Your FSA Dollars

When you pay for an eligible healthcare or dependent care expense, you want to put your FSA to work right away. HealthEquity gives you several options to use your money the way you choose.

Automatic Health Plan Claim (AHPC) – When you visit a healthcare provider such as a doctor or dentist, your insurance carrier later provides the amount of the transaction not covered by the health plan to HealthEquity. This amount represents the “out-of-pocket” cost for which your FSA can be used. HealthEquity uses this data to initiate payment directly to you from your Healthcare FSA.

To change the settings for your account reimbursement, check with your employer.

Using your HealthEquity Healthcare Card – Use your HealthEquity Healthcare Card (Card) instead of cash or credit at healthcare providers and pharmacies for eligible services, goods and prescriptions. You can also use the healthcare Card at general merchants and drug stores that have an industry standard (IIAS) checkout system that can automatically verify if the item is eligible for purchase with your account.

- Go to **www.sigis.com** to review a list of eligible merchants, like drug stores, supermarkets and warehouse stores, that accept the healthcare Card.
- When you swipe your healthcare Card at the checkout, choose “credit” (even though it isn’t a credit card).
- Pay for items or services on the day you receive them. If your health plan covers a portion of the cost, make sure you know what amount you need to pay before using the healthcare Card, by presenting your health plan member ID card first, so the merchant can identify your copay or coinsurance amount and ensure the service is claimed to your healthcare, dental, or vision insurance plan.
- Save your receipts or digital copies. You will need them for tax purposes. Plus, even when your healthcare Card is approved, a detailed receipt may still be requested.
- If you’ve lost or can’t produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the plan for the amount of the transaction.
- If you use your healthcare Card at an eye doctor’s or dentist’s office, we will most likely ask you to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to do so may result in your healthcare Card being suspended.
- If you lose your healthcare Card, please call HealthEquity immediately and order a new one. You will be responsible for any charges until you report the lost healthcare Card.

Using your Mobile Device

With the EZ Receipts mobile app, you can file and manage your reimbursement claims and healthcare Card usage paperwork on the spot, with a click of your mobile device camera, from anywhere.

To use EZ Receipts:

- Download at **www.healthequity.com/wageworks/employees/go-mobile**.
- Log in to your account.
- Choose the type of receipt from the simple menu.
- Enter some basic information about the claim or healthcare Card transaction.
- Use your mobile device camera to capture the documentation.
- Submit the image and details to HealthEquity.

Paying online

You can pay many of your eligible healthcare and dependent care expenses directly from your FSA with no need to fill out paper forms.* It’s quick, easy, secure and available online at any time.

To pay a provider:

- Log in to your FSA at **www.healthequity.com/wageworks**.
- Select “Submit Receipt or Claim.”
- Request “Pay My Provider” from the menu and follow the instructions.
- Make sure to provide an invoice or appropriate documentation. When you’re done, HealthEquity will schedule the checks to be sent in accordance with the payment guidelines. If you pay for eligible, recurring expenses, follow the online instructions to set up automatic payments.

* You must, however, provide documentation. For more information about the documentation requirements and payment guidelines, visit **www.healthequity.com/wageworks**.

Filing a claim

You also can file a claim online to request reimbursement for your eligible healthcare and dependent care expenses.

- Go to **www.healthequity.com/wageworks**, log in to your account and select “Submit Receipt or Claim.”
- Select “Pay Me Back.”
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
 - Date of service or purchase
 - Detailed description
 - Provider or merchant name
 - Patient name
 - Patient portion or amount owed

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

If you prefer to submit a paper claim by fax or mail, download a Pay Me Back claim form at **www.healthequity.com/wageworks** and follow the instructions for submission.

DENTAL INSURANCE



Find a
network
provider

www.wellmark.com

877-333-0164

Think about all the ways you use your mouth throughout your day. From eating, drinking, and talking to cheering your favorite sports team.

Jones County provides dental insurance for you and your family to help ensure you can continue to enjoy these activities and keep your mouth and teeth healthy.

	Blue Dental Premium	Blue Dental Basic
CALENDAR YEAR DEDUCTIBLE		
Individual / Family	\$50 / \$150	\$100 / \$300
ANNUAL MAXIMUM		
Per Individual	\$1,500	\$1,000
COINSURANCE / COPAYS — YOU PAY		
Diagnostics and Preventive		
Cleaning (prophylaxis and periodontal maintenance), fluoride (under age 19), X-rays, topical sealant (under age 15) and space maintainers (under age 15)	No Deductible, then 0%	Deductible, then 0%
Basic Services		
Cavity repair, general anesthesia/sedation, emergency pain/infection relief	Deductible, then 20%	Deductible, then 50%
Oral Surgery		
Basic and complex extractions, complex surgical procedures	Deductible, then 50%	Deductible, then 50%
Endodontics		
Root canals, retrograde fillings, apicoectomy/periradicular, direct pulp caps	Deductible, then 50%	Deductible, then 85%
Periodontics		
Gum and bone disease, non-surgical and complex surgical procedures	Deductible, then 50%	Deductible, then 50%
Major Restorative		
Crowns, posterior composites, onlays, inlays, posts and cores	Deductible, then 50%	Deductible, then 80%
Prosthodontics		
Dentures, partials, bridges, implants, repairs and adjustments	Deductible, then 50%	Deductible, then 90%

Dental 2024 Monthly Premium Deductions (before tax)

Plan	Employee Only	Family
Blue Dental Premium	\$40.16	\$96.18
Blue Dental Basic	\$29.62	\$69.32

DeltaVision Plan



Find a
network
provider



www.deltadentalia.com

877-333-0164

Delta Dental Mobile App

Think about all the ways you use your eyes throughout your day. From using your phone, working on computers, to binge watching your favorite shows. You rely on your eyes for almost everything you do.

Jones County provides vision insurance for you and your family to help ensure you can maintain healthy eyesight.

	In-Network	Out-of-Network
Exam (once per calendar year)	\$10 Copay	Up to \$35
Materials Copay	\$25 Copay	
Contact Lenses (in lieu of eyeglasses – every calendar year)		
Conventional Lenses	<ul style="list-style-type: none"> 85% of Balance over \$150 	<ul style="list-style-type: none"> Up to \$120
Contact Lens – Disposable	<ul style="list-style-type: none"> Balance over \$150 	<ul style="list-style-type: none"> Up to \$120
Standard Fit and Follow Up Exam	<ul style="list-style-type: none"> \$40 	<ul style="list-style-type: none"> Not Covered
Prescription Glasses		
Frame (Every other calendar year)	80% of balance over \$150	Up to \$75
Lenses (Once per calendar year)		
Single Vision	<ul style="list-style-type: none"> \$25 Copay 	<ul style="list-style-type: none"> Up to \$25
Bi-Focal	<ul style="list-style-type: none"> \$25 Copay 	<ul style="list-style-type: none"> Up to \$40
Tri-Focal	<ul style="list-style-type: none"> \$25 Copay 	<ul style="list-style-type: none"> Up to \$55
Standard Progressive Lens	<ul style="list-style-type: none"> \$90 Copay 	<ul style="list-style-type: none"> Up to \$40
Premium Progressive Lens	<ul style="list-style-type: none"> Tiered \$110 - \$135 	<ul style="list-style-type: none"> Not Covered
Tier 4 Premium Progressive Lens	<ul style="list-style-type: none"> \$90 Copay, plus 80% of amount over \$120 	<ul style="list-style-type: none"> Not Covered
Lenticular	<ul style="list-style-type: none"> \$25 Copay 	<ul style="list-style-type: none"> Up to \$55
Lens Options:		
Standard Polycarbonate	<ul style="list-style-type: none"> \$40 Copay 	Not Covered
Standard Plastic Scratch Coating	<ul style="list-style-type: none"> \$15 Copay 	
Tint (Solid and gradient)	<ul style="list-style-type: none"> \$15 Copay 	
UV Treatment	<ul style="list-style-type: none"> \$15 Copay 	
Standard Anti-Reflective Coating	<ul style="list-style-type: none"> \$45 Copay 	

Vision 2024 Per-Paycheck Deductions (before tax)

	Employee Only	Family
Vision Plan	\$7.00	\$17.90

DeltaVision®



FOCUS ON WELLNESS

The wellness programs and services below are available to either all employees, or to medical plan members based upon your specific plan choice. Use these resources to help you and your family live a healthier lifestyle, remain active, and enjoy the best life possible.

Take advantage of preventive care benefits

Good preventive care can help you stay healthy and detect any “silent” problems early, when they’re most likely to be treatable.

- **Have a routine physical exam each year.** You’ll build a relationship with your doctor and can reduce your risk for many serious conditions.
- **Get regular dental cleanings.** Numerous studies show a link between regular dental cleanings and disease prevention — including lower risks of heart disease, diabetes, and stroke.
- **See your eye doctor at least once every year.** If you have certain health risks, such as diabetes or high blood pressure, your doctor may recommend more frequent eye exams.

Go to MyWellmark.com

Once you receive your Wellmark ID Card, register on www.MyWellmark.com and see the following benefits that are available to you:

- **Blue365.** Various discounts for fitness are available. Go to www.Wellmark.com/Blue365
- **BeWell 24/7.** A Real person available to talk on health related concerns. Call 844-84-BEWELL (239355)
- **Identity Theft Protection through IDX.** You can register for this free benefit on www.MyWellmark.com or call 866-486-4812

Don’t have a primary care physician (PCP)? You should. Here’s why.

- **Better health.** Getting the right health screenings each year can reduce your risk for many serious conditions.
- **A healthier wallet.** A PCP can help you avoid costly trips to the emergency room. Your doctor will also help coordinate specialist care, if needed.
- **Peace of mind.** Advice from someone you trust means a lot when you’re healthy, but it’s even more important when you’re sick.

Virtual care: \$69/visit any plan

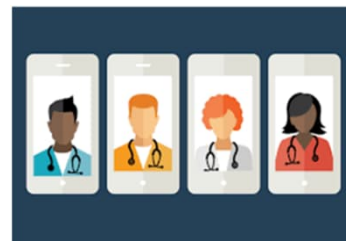
Avoid waiting rooms and wait times with Doctor on Demand virtual care services. See a board-certified doctor 24 hours a day, 7 days a week in just minutes.

1. Download the Doctor on Demand™ app
2. Have your Wellmark member ID card ready
3. Create an account or sign in.

Treatment for:

- Cold and flu
- Bronchitis sinus infections
- Urinary tract infections
- Sore throats
- Fever
- Allergies
- Headache
- Pink eye
- Skin conditions
- Mental Health

Call 800-977-6196



Listen Up

Your ears could be telling you something



Do you often find yourself asking others to repeat themselves? Is there a constant ringing in your ears? If so, your ears could be trying to tell you something.

What causes hearing loss?

Hearing loss is caused by temporary obstructions in the outer or middle ear or permanent damage to the tiny hairs in the inner ear. Common causes of damage include exposure to noise, aging, other health conditions, and certain medications.

When should I get my hearing checked?

Hearing loss can come gradually. You may not even notice it's happening. If your hearing test reports your hearing is okay, stick to once every three to five years. You should test your hearing more often if you are 55 or older or are experiencing any of the following:

- **Consistent exposure** to loud noises
- **ringing** in your ears
- **Difficulty understanding** in noisy environments or in groups
- **Hearing mumbling** or feeling as though people are not speaking clearly



1 in 9

Americans have hearing loss. By 2030, that number is expected to double.¹

Delta Dental of Iowa now offers hearing discount benefits.

[See back for benefit information >>](#)

FOR MORE INFORMATION

Call **866-925-1698**

or visit deltadentalia.com/hearing

¹ <https://www.asha.org/articles/untreated-hearing-loss-in-adults/>

Worried about your hearing?

We have you covered.

If you think you may have hearing loss, don't worry. Delta Dental of Iowa has teamed up with Amplifon to offer you quality hearing care.

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Hearing Aid Features	Standard features	Additional, easy-to-use functions	Designed for work and play	Enhanced to keep you on the go	Leading technology keeps you connected
One Simple Price	\$995/ear	\$1,495/ear	\$1,795/ear	\$2,195/ear	\$2,645/ear

Complimentary Aftercare*

Risk-free trial – find your right fit by trying your hearing aids for 60 days
Follow-up care – ensures a smooth transition to your new hearing aids
Battery support – battery supply or charging station to keep you powered
Warranty – 3 year coverage for loss, repairs, or damage

*The cost of a hearing exam may be as low as \$45. The cost per hearing aid through the Essential Plan may be as low as \$695.

**Batteries - Maximum of 80 cells/ear per year. Risk-free trial - 100% money-back guarantee if not completely satisfied.

No restocking or return fees. Warranty - Some exclusions apply. Limited to one-time claim for loss and damage. Manufacturer deductible may apply.

Take advantage of these benefits and start hearing better today!

FOR MORE INFORMATION

Call 866-925-1698

or visit deltadentalia.com/hearing



WEALTH *benefits*

Jones County's life and disability insurance programs are designed to help secure your income and provide your family with peace of mind knowing their financial needs will be looked after if something happens to you.

Company-Provided-Paid Life/AD&D Programs

You automatically receive basic life insurance and basic accidental death and dismemberment (AD&D) insurance — at no cost to you with no enrollment required.

What is AD&D Insurance?

Should you lose your life, sight, hearing, speech, or use of your limb(s) in an accident, AD&D provides additional benefits to help keep your family financially secure. AD&D benefits are paid as a percentage of your coverage amount - from 50% to 100% - depending on the type of loss

Quick Look: LIFE/AD&D INSURANCE

	COMPANY-PROVIDED LIFE/AD&D	
	Basic Life	Basic AD&D
Employee	\$20,000	\$35,000
Spouse – No Children	N/A	50% of Insured Person's Principal Sum
Spouse with Children	N/A	40% of Insured Person's Principal Sum
Children with Spouse	N/A	10% of Insured Person's Principal Sum
Children with no Spouse	N/A	15% of Insured Person's Principal Sum

Select Your Beneficiary

Beneficiaries are individuals or entities that you select to receive benefits from your policy. These can include:

• Person(s) • Trust • Charity

You can change your beneficiary designation at any time.

You may designate a sole beneficiary or multiple beneficiaries to receive payment in the amount you specify.

To select or change your beneficiary, contact the Auditor's Office or log in to 4mybenefits.employeeenavigator.com

Long-Term Disability (LTD)

	LTD Coverage
Who Pays?	Employer pays for up to \$6,000 in coverage, based on current annual salary. You will have your salary increased to meet the premium requirement and then it will be deducted from your payroll. This coverage is provided on an after-tax basis so that benefit payouts will not be taxed should you need to use it.
Benefit Percentage	Up to 60% of base month salary
Benefit Maximum Available	Up to \$6,000 per month
When Benefits Begin	After 90 days of disability
Maximum benefit duration	Up to Social Security Normal Retirement Age or when you return to work, whichever comes first

IN CASE OF WORKPLACE INJURY

PASOS a seguir en caso de un accidente en el trabajo

COMPANY NURSE™
Because Accidents Happen™

Powered by
Lintelio

Available
24/7/365



Phone (Teléfono)

1-(888) 770-0928

Digital, powered by Lintelio
(Digital, implementado por Lintelio)



Employer Name (Nombre De la Compañía)

**Jones Co, IA - All
Departments**

Search Code (Código De Búsqueda)

IA670

1

Injured worker notifies supervisor.

El empleado lesionado notifica a su supervisor.

2

Supervisor/Injured worker:

- **Calls above number OR**
- **Scans above code with their smartphone (they will see Lintelio), clicks "Let's Get Started," registers, and selects "Incident."**

Supervisor / Empleado lesionado:

- Llama al número en la parte superior O
- Escanea el código de arriba con su teléfono (ellos verán Lintelio), Da clic en "Let's Get Started/comencemos," se registra, y selecciona "Incident/incidente."

3

Company Nurse gathers information and helps injured worker access appropriate care. Injured worker notifies Supervisor of the outcome of the call.

Company Nurse obtiene información y ayuda al empleado lesionado a adquirir el tratamiento médico adecuado. El trabajador lesionado le notifica al supervisor la conclusión de la llamada.

NOTICE TO EMPLOYER/SUPERVISOR: Please post copies of this poster in multiple locations within your worksite. If the injury is non-life-threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site, when possible.

Jones County

Work-Related Injury Process

1. *If injury is critical, seek medical treatment immediately.*) Injured worker notifies supervisor.
2. Supervisor/injured worker immediately calls **Company Nurse** injury hotline: **1-888-770-0928 (Code: IA670)**
3. *Company Nurse* gathers information over the phone & helps injured worker access appropriate medical treatment. Report all injuries through *Company Nurse* even if you don't think that medical services will be necessary.
4. Seek Medical attention as directed. *Company Nurse* will call the provider to notify them the employee is on the way.
 - a. Go to UnityPoint Jones Regional Medical Center
 - i. **Urgent Care 1st choice for minor injuries**
 - ii. **Emergency Department 2nd choice if Urgent Care unavailable or if injury is severe** (e.g. loss of consciousness at any time, obvious broken bone, breathing difficulty)
 - b. Upon arrival at UnityPoint Jones Regional Medical Center
 - i. Tell Registration the injury occurred at work
 - ii. Tell Registration you work for Jones County, 319-462-2282
 - iii. Tell Registration the work comp insurance carrier is IMWCA
 - iv. **Provide registration with current picture ID**
 - c. Discharge Instructions
 - a. **Work restrictions apply for 24 hours a day until recheck, for work and non-work activities.**
 - b. Call Employer with an update on your status and call JRMHC for follow up appointment.
 - c. **All follow up care will take place at Jones Regional Work Well Clinic** regardless of which department was initially visited, unless directed otherwise by *Company Nurse*/IMWCA. Call Jones Regional Work Well Clinic at (319) 481-6124 to schedule a follow up appointment.
 - d. Fill prescriptions and take as prescribed, if ordered. Notify pharmacy to bill Jones County if possible, otherwise bring receipt to Auditor's Office.
 - e. Follow up with specialist, if ordered.
 - f. Complete and submit all work comp forms to the Auditor's Office.
5. Follow Up Care
 - a. **If a worker fails to keep an appointment, the worker will be assumed to be fully recovered, at full duty and at Maximum Medical Improvement with no impairment.**
 - b. If Jones County has no work available within the restrictions ordered, then it is up to Jones County to remove the injured worker from work.

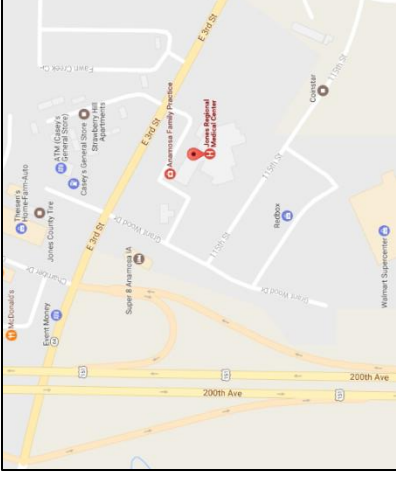


UnityPoint Clinic

Jones Regional Medical Center • Anamosa Urgent Care

319-481-6291

Monday - Friday • 8:00 am–8:00 pm
Saturday & Sunday • 8:00 am– 3:00 pm
Holidays • 8am – 12 noon
1795 Highway 64 East, Anamosa, IA
52205



UnityPoint Health

Jones Regional Medical Center • Emergency Department

319-481-6349 (Direct) or 319-462-6131 (Front Desk)

24 hours a day • 7 days a week

1795 Highway 64 East, Anamosa, IA 52205

Follow-up care:

Jones Regional Medical Center • Work Well Clinic

319-481-6147

Center for Specialty Medicine (building left of the main entrance)

Monday/Tuesday/Wednesday/Friday mornings • 8:00 am – 12:00 noon

1795 Highway 64 East, Anamosa, IA 52205

Additional approved treatment facilities:

Mercy Medical Center • Emergency Department

319-398-6041

24 hours a day • 7 days a week

701 10th St SE, Cedar Rapids, IA 52403

St. Luke's Hospital • Emergency Department

319-369-7105

24 hours a day • 7 days a week

1026 A Ave NE, Cedar Rapids, IA 52402

IMPORTANT CONTACTS



BENEFIT	CARRIER	PHONE	WEBSITE
HEALTH CARE BENEFITS			
Medical Plan Benefits	Wellmark	866-486-4812	www.mywellmark.com
Prescription Benefits	Wellmark	800-237-2767	www.wellmark.com/prescriptions
Telemedicine Services	Doctor on Demand	800-997-6196	www.DoctorOnDemand.com
Wellness Program	Wellmark	866-486-4812	www.mywellmark.com
Dental Plan Benefits	Wellmark Blue Dental	877-333-0164	www.wellmark.com
Vision Plan Benefits	Delta Vision	877-488-5103	www.deltadentalia.com

SAVINGS AND SPENDING ACCOUNTS

Health Savings Account (HSA) and Flexible Spending Accounts (FSAs)	Health Equity	877-924-3967	www.HealthEquity.com
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INCOME PROTECTION AND FINANCIAL SECURITY

Basic Life and AD&D and Long Term Disability	Reliance Standard	See Human Resources
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NOTES

[illegible]

SUMMARY OF BENEFITS & COVERAGE




Jones County PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$750 person/\$1,500 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, in-network preventive care, in-network office services, in-network independent labs, in-network urgent care and in-network prosthetic limbs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50 person/\$100 family per calendar year for drug card, which does not apply to Tier 1 Rx. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Health: \$1,500 person/\$3,000 family per calendar year. Drug Card: \$1,000 person/\$2,000 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions		Answers	Why this Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .
 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.			

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. Preventive medical examinations performed for administrative purposes are covered in addition to a preventive exam. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	In-network independent labs for mental health/substance abuse services are not subject to <u>coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.wellmark.com/prescriptions .	Tier 1	\$10 <u>copay</u> per prescription	Not covered	Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered. 1 <u>copay</u> or <u>coinsurance</u> for 30-day supply. 3 <u>copays</u> for 90-day supply (Retail and Mail order maintenance). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	\$20 <u>copay</u> per prescription	Not covered	
	Tier 3	\$45 <u>copay</u> per prescription	Not covered	
	Tier 4	\$45 <u>copay</u> per prescription	Not covered	
	Specialty drugs	Generic: \$50 <u>copay</u> per prescription Preferred: \$100 <u>copay</u> per prescription Non-preferred: 50% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	-----None-----
	Inpatient services	20% coinsurance	40% coinsurance	-----None-----
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	-----None-----
	Home health care	20% coinsurance	40% coinsurance	-----None-----
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	40% coinsurance	-----None-----
	Habilitation services	20% coinsurance	40% coinsurance	-----None-----
	Skilled nursing care	20% coinsurance	40% coinsurance	-----None-----
	Durable medical equipment	20% coinsurance	40% coinsurance	-----None-----
	Hospice services	20% coinsurance	40% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
	Children's eye exam	Not covered	Not covered	-----None-----
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your [plan](#) document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at [sbccmfinder.wellmark.com](#).

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u>.)	
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Custodial care - in home or facility• Dental care - Adult• Dental check-up• Extended home skilled nursing	<ul style="list-style-type: none">• Eye exam• Glasses• Hearing aids• Long-term care• Routine eye care - Adult• Routine foot care• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan document</u>.)	
<ul style="list-style-type: none">• Applied Behavior Analysis therapy• Chiropractic care• Infertility treatment (\$15,000 LTM)• Most coverage provided outside the U.S.• Private-duty nursing - short term intermittent home skilled nursing	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242 or the Iowa Insurance Division at 515-654-6600.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page. _____

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$750
- PCP coinsurance 20%
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,620

Managing Joe's type 2 Diabetes

(a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$750
- Specialist coinsurance 20%
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$700
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$750
- Specialist coinsurance 20%
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,160

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສົ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ກັບ. (TTY: 888-781-4262.)

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें: अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griegie. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်ဒုးသုၣ်ညါ-နမ့ၢ်ကတိၢ်ကေညါကိၣ်, ကိၣ်တၢ်မၤစၢၤတၢ်ဖဲတၢ်မၤတဖၣ်, လၢတဘျီလၢတဘျီလၢ, ဆိၣ်လၢနီၣ်လၢ, ဆဲးကိၣ်ဆူ ၈၀၀-၅၂၄-၉၂၄ နမ့ၢ် (TTY: ၈၈၈-၇၈၁-၄၂၆) တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: ከግርግር ሃሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውለው ያነጋግሩ።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yánílti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

EMPLOYER NOTICES

Important Notice to Employees from Jones County About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Jones County medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2024. This is known as “creditable coverage.”

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2024 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Jones County and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by Jones County prescription drug plan: Alliance Select 750

You’ll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2024. This is called creditable coverage. Coverage under this these plan will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Jones County plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Jones County coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Jones County plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Jones County and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly

Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Jones County coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Ms. Whitney Hein
Jones County Auditor
Jones County
500 West Main St,
Anamosa, IA 52206
319-462-2282

November 3, 2023

Notice of Special Enrollment Rights for Medical Plan Coverage

As you know, if you have declined enrollment in Jones County's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Jones County will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 30– from the date of the Medicaid/CHIP eligibility change to request enrollment in the Jones County group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 319-462-2282.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 319-462-2282.

Michelle's Law Notice – Extended dependent medical coverage during student medical leaves

The Wellmark plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university). Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school – or change in school enrollment status (for example, switching from full-time to part-time status) – starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact the Jones County Auditor at 319-462-2282 as soon as the need for the leave is recognized to Jones County. In addition, contact Jones County to see if any state laws requiring extended coverage may apply to his or her benefits.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp

	Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

<p>Hawki Phone: 1-800-257-8563</p> <p>HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</p> <p>HIPP Phone: 1-888-346-9562</p>	
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</p> <p>Phone: 1-855-459-6328</p> <p>Email: KIHIPP.PROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx</p> <p>Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp</p> <p>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US</p> <p>Phone: 1-800-442-6003</p> <p>TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms</p> <p>Phone: 1-800-977-6740</p> <p>TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa</p> <p>Phone: 1-800-862-4840</p> <p>TTY: 711</p> <p>Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 (in NH only)
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org	Website: http://healthcare.oregon.gov/Pages/index.aspx

Phone: 1-888-365-3742	Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 Email: HIPPcustomerservice@dmas.virginia.gov
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700

	CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

U.S. Department of Health and Human Services

Employee Benefits Security Administration

Centers for Medicare & Medicaid Services

www.dol.gov/agencies/ebsa

www.cms.hhs.gov

1-866-444-EBSA (3272)

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Jones County HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Jones County health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: *Alliance Select 750*. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Jones County as an employer — that's the way the HIPAA rules work. Different policies may apply to other Jones County programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Jones County

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Jones County for plan administration purposes. Jones County may need your health information to administer benefits under the Plan. Jones County agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. *[Identify classes of employees, such as benefits, payroll, and/or finance staff]* are the only Jones County employees who will have access to your health information for plan administration functions.

Here’s how additional information may be shared between the Plan and Jones County, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose “summary health information” to Jones County, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants’ claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Jones County information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Jones County cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Jones County from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers’ compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You’ll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you’re not present or if you’re incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers’ compensation	Disclosures to workers’ compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
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Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project

Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has

removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “designated record set.” This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn’t maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan’s cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an “accounting of disclosures.” You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a “limited data set” (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which

the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on **July 1, 2023**. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice *e-mailed*.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact Whitney Hein at 319-462-2282

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Whitney Hein at 319-462-2282.

Provider-Choice Rights Notice

1. The Wellmark plan generally requires 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Wellmark's website at www.wellmark.com or customer service - phone number is on the back of your Wellmark ID card. Wellmark's website at www.wellmark.com or customer service - phone number is on the back of your Wellmark ID card.
2. For children, you may designate a pediatrician as the primary care provider.
3. You do not need prior authorization from Wellmark or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Wellmark's website at www.wellmark.com or customer service - phone number is on the back of your Wellmark ID card.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (For 2024) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Whitney Hein at 319-462-2282.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name: Jones County	4. Employer Identification Number (EIN): 42-6004230	
5. Employer address: 500 West Main St	6. Employer phone number: 319-462-2282	
7. City Anamosa	8. State: IA	9. Zip code: 52205
10. Who can we contact about employee health coverage at this job? Whitney Hein		
11. Phone number (if different from above)	12. Email address: Whitney.hein@jonescountyiowa.gov	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are: An Eligible employee is those employees who meet the definition of an eligible employee in their carriers Coverage Manual

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are: An Eligible dependent is those dependents who meet the definition of an eligible dependent in the carriers Coverage Manual

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is **OPTIONAL** for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)

If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.² (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Yearly

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Model COBRA Continuation Coverage General Notice

Model General Notice of COBRA Continuation Coverage Rights

****Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Whitney Hein.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

the necessary documentation that would substantiate the qualifying event that would allow the additional time on COBRA.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period³ to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

³ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Whitney Hein
Jones County Auditor
JONES COUNTY
500 West Main St,
Anamosa, IA 52205
319-462-2282

Whitney.hein@jonescountyiowa.gov

Information about your dependent care benefits

Working families have some options to help with the cost of their dependent care expenses. Below is a brief overview of the DCAP benefits and the dependent care tax credit. As each individual's situation is different, you may wish to consult with your tax advisor to determine whether the DCAP or the tax credit is a better option.

Dependent care tax credit

The dependent care credit offsets the costs associated with dependent daycare care expenses. For the 2021 tax year, the dependent care tax credit will be significantly expanded.

Specifically, the credit is fully refundable and the maximum credit percentage increases to 50% (from 35%). The credit percentage gradually phases down to 20% for individuals with adjusted gross income (AGI) between \$125,000 (currently \$15,000) and \$183,000, and completely phases out for individuals with AGI in excess of \$438,000. The amount of dependent care expenses eligible for the credit increase to \$8,000 (from \$3,000) for one qualifying individual and \$16,000 (from \$6,000) for two or more qualifying individuals (such that the maximum credits are worth \$4,000 and \$8,000 based on the 50% maximum credit percentage).

If your family qualifies, the amount of the tax credit you receive directly reduces your taxes, dollar for dollar. For example, a \$1,000 tax credit decreases your tax bill by \$1,000.

Dependent Care Assistance Program (DCAP)

Under a DCAP (sometimes referred to as a Dependent Care FSA), you set aside funds from your paycheck on a "pre-tax" basis in your own account. This means the funds you elect are taken out of your paycheck before taxes are taken. More details on the DCAP are in the SPD for Wellmark.

At the end of the tax year, you will receive a Form W-2 that will reflect a reduction in your taxable income equal to the DCAP and any other pre-tax deductions.

You need to choose one or the other

You cannot claim a tax credit for the same expenses on your income tax return for which you are reimbursed under the DCAP. Work with your tax advisor to determine which is the better option for your particular situation.

Timing extensions expiring for HIPAA special enrollment events, COBRA coverage and ERISA claim and appeals

The U.S. Department of Labor and IRS announced temporary extensions of certain plan deadlines during the COVID-19 pandemic National Emergency. Under these extensions, plan participants and dependents were given extra time to make HIPAA Special Enrollment election changes, file ERISA claims and appeals, submit COBRA elections, and make COBRA premium payments. During the National Emergency, individuals were given until the earlier of:

- 1 year from the date the deadline would have begun running for that individual; or
- 60 days from the end of the National Emergency, or other date, as announced by the regulators. July 10 is the applicable date (60 days from the May 11th date selected by the regulators).

What this means for you and your family

The National Emergency ended on April 10, 2023 and timing extensions will end on July 10, 2023, if not sooner as noted above. You should act quickly or you may lose your ability to exercise your rights under the plan for:

- Requesting enrollment under the plan due to a HIPAA Special Enrollment event, which includes when you are otherwise eligible for the plan and are—
 - An employee or an employee's spouse or dependent who loses other coverage,
 - An employee that gains a dependent by birth, adoption, or placement for adoption, or marriage, or
 - An employee or a dependent that loses eligibility for state Medicaid or Children's Health Insurance Program (CHIP) coverage or becomes eligible for state premium assistance under Medicaid or CHIP; or
- Filing an ERISA claim or appeal; or
- Enrolling in or making premium payment(s) for your COBRA continuation coverage

If you did not experience a HIPAA Special Enrollment or COBRA qualifying event or did not have the need to file an ERISA claim or appeal, you do not need to take any action. If any of these events occur after July 10, 2023, the Outbreak timing extensions will no longer apply and the plan will apply its normal plan rules.

Questions?

Timing extensions expiring for HIPAA special enrollment events, COBRA coverage and ERISA claim and appeals

What this means for you and your family

The National Emergency ended on April 10, 2023 and timing extensions will end on July 10, 2023, if not sooner as noted above. You should act quickly or you may lose your ability to exercise your rights under the plan for:

- Requesting enrollment under the plan due to a HIPAA Special Enrollment event, which includes when you are otherwise eligible for the plan and are—
 - An employee or an employee's spouse or dependent who loses other coverage,
 - An employee that gains a dependent by birth, adoption, or placement for adoption, or marriage, or
 - An employee or a dependent that loses eligibility for state Medicaid or Children's Health Insurance Program (CHIP) coverage or becomes eligible for state premium assistance under Medicaid or CHIP; or

- Filing an ERISA claim or appeal; or
- Enrolling in or making premium payment(s) for your COBRA continuation coverage

If you did not experience a HIPAA Special Enrollment or COBRA qualifying event or did not have the need to file an ERISA claim or appeal, you do not need to take any action. If any of these events occur after July 10, 2023, the Outbreak timing extensions will no longer apply and the plan will apply its normal plan rules.

Questions?

For more information, contact **Whitney Hein at 319-462-2282.**

No Surprises Act notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are 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 the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

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

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

If you get other 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 care out-of-network. You can choose a provider or facility in your plan’s network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact U.S. Department of Health and Human Services beginning January 1, 2022 at 1-800-985-3059. Visit [No Surprises Act | CMS](#) for more information about your rights under federal law.

Visit www.legis.iowa.gov for more information about your rights under Iowa state law.



YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at <https://www.dol.gov/agencies/vets/>. An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra>
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <https://www.dol.gov/agencies/vets/programs/userra/poster> Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



U.S. Department of Labor
1-866-487-2365



U.S. Department of Justice



Office of Special Counsel



1-800-336-4590

Publication Date — May 2022

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must:**

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must:**

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

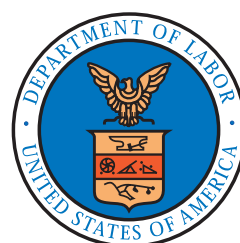
After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing:**

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

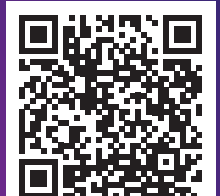
Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**



WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME



Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a medical child support order issued under state law that creates or recognizes the existence of an “alternate recipient’s” right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An “alternate recipient” is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer; know the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.



While every effort has been made to ensure the accuracy of the information in this Benefits Guide, the plan documents and contracts will prevail in any discrepancies. In addition, Jones County reserves the right to modify or terminate any benefit plans at any time. For a copy of the Jones County summary plan description or other detailed plan documents, contact your Human Resources Department.