The choice is yours.

2022

Benefits guide

BENEFITS FOR A HEALTHY LIFE

Your 2022 benefit choices

JONES COUNTY · IOWA

WELCOME TO YOUR BENEFITS ENROLLMENT

We recognize how important benefits are to you. That’s why we’re committed to helping you and your family enjoy the best possible physical, financial, and emotional well-being. It’s also why we provide you with a comprehensive, highly competitive benefits package, with the flexibility to make the choices that best meet your needs.

Use this guide to better understand your 2022 benefits options. Then, be sure to make your choices by the enrollment deadlines to receive coverage for the coming year.

Inside this guide

Who can enroll?

- Each Active, Full-time Employee as defined in the bargaining unit agreement or Each Active, Full-time Non-Union Employee as defined in the Jones County Employee Handbook OR an Elected Official OR as required by federal law.

- **Eligible dependents –** Includes employee's spouse/and children to age 26, plus disabled dependent children of any age who meet plan criteria.

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 32 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 on in the back of this guidebook.

HEALTH

Quality health coverage is one of the most valuable benefits you enjoy as a JONES COUNTY employee. Our benefits program offers plans to help keep you and your family healthy and also provide important protection in the event of illness or injury.

Medical

- **JONES COUNTY offers a Basic PPO**, a preferred provider organization plan that reduces your out-of-pocket responsibility when you need care by offering a lower deductible and higher paycheck contributions.

Key features

JONES COUNTY's medical plans offer:

- Comprehensive, affordable// coverage for a wide range of health care services.
- Flexibility to see any provider you want, although you'll save money when you stay in-network.
- Prescription drug coverage included.
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year.
- Choice of two coverage levels: Employee Only or Family.

Wellness

Take advantage of preventive care benefits

Good preventive care can help you stay healthy and detect any "silent" problems early, when they are most likely to be treatable. Most in-network preventive services are covered in full, so there is no excuse to skip it.

- **Have a routine physical exam each year.** You'll build a relationship with your doctor and can reduce your risk for many serious conditions.
    - One preventive exam per calendar year
    - One gynecological exam per calendar year
    - One mammogram per calendar year
    - Preventive medical examinations performed for administrative purposes are covered in addition to the one regular preventive physical

Don't have a personal doctor? You should. Here's why.

- **Better health.** Getting the right health screenings each year can reduce your risk for many serious conditions. And remember, preventive care doesn't cost you anything.
- **A healthier wallet.** A PCP can help you avoid costly trips to the emergency room. Your doctor will also help you decide when you really need to see a specialist and can help coordinate care.
- **Peace of mind.** Advice from someone you trust — it means a lot when you're healthy, but it's even more important when you're sick.

Compare medical plans

The chart below provides key coverage features and costs.

	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	
Medical coverage		
Doctor's office visits	Deductible waived, 20% coinsurance	Deductible then 40% coinsurance
Preventive care – One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Preventive medical examinations performed for administrative purposes are covered in addition to the one regular preventive physical	$0 Copay	Deductible then 40% coinsurance
Specialist visits	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Telemedicine	Deductible waived, 20% coinsurance	Deductible then 40% coinsurance
Outpatient surgery	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Inpatient hospital (per stay)	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Emergency room	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Labs and X-rays	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Retail prescription drugs (30-day supply)		
Rx Deductible Per Person / Per Family	$50 / $100	Not Covered
Rx Out of Pocket Per Person / Per Family	$1,000 / $2,000	Not Covered
Tier 1	$10 Copay	Not Covered
Tier 2	$20 Copay	Not Covered
Tier 3 / Tier 4	$45 Copay	Not Covered
Specialty	Preferred: $100 copay Non preferred: 50% Coinsurance	Not Covered

*This contains only a partial description of the benefits, limitations, and other provisions of your Medical plan. It is not a contract or policy. It is a general overview only. In the event there are discrepancies between this document and the Certificate of Coverage and/or Policy, the terms and conditions of the Certificate of Coverage and/or the Policy will govern.

**Mail Order Rx Covered at 3 times the copay.

Money-saving tips

To stretch your health care dollars, remember to:

- **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.

Wellmark®

FEELING BETTER
SHOULD BE EASY.

Visit a doctor on your smartphone, tablet or computer virtually anywhere, any time.

dr. on demand

Getting started is easy.

- Download the Doctor On Demand® app or visit DoctorOnDemand.com.
- Have your Wellmark Blue Cross and Blue Shield member ID card ready.
- Create an account or sign in.

See a doctor in minutes

Getting sick is bad enough without having to get out of bed to see a doctor. With Doctor On Demand, you and your family members can connect face-to-face with a board-certified doctor on your schedule.

Get treatment for:

- Cold and flu
- Bronchitis and sinus infections
- Urinary tract infections
- Sore throats
- Allergies
- Fever
- Headache
- Pink eye
- Skin condition
- Other conditions such as mental health (if covered by your group health plan)[1]

[1] Mental health treatment cost share is subject to group plan coverage. Mental health coverage includes psychiatry services and medication management along with treatment for psychological conditions, emotional issues and chemical dependency. For more information, call Wellmark with the number on the back of your ID card.

QUESTIONS? CALL 800-997-6196.

Callers could experience longer wait times between 10 p.m. and 6 a.m. CST or may be directed to schedule an appointment in some instances.

KNOWING CHANGES EVERYTHING

myWellmark®

Shop, rate and compare doctors and facilities with myWellmark.

Visit myWellmark.com to learn how much care will cost you based on your Wellmark Blue Cross and Blue Shield insurance plan. Find patient reviews and quality scores to help you select the right doctor. You can also locate doctors and hospitals in your health plan's network, too. When you know more, you can be more confident in the care you and your family are getting.

KNOW COST OF CARE

Search common health care services to know your cost based on your plan's benefits and your current out-of-pocket costs.

KNOW QUALITY OF CARE

Compare doctors using performance-based quality scores or find a facility known for expertise on certain procedures and conditions.

KNOW PATIENT REVIEWS

Select a doctor using patient ratings and comments, or leave your own feedback.

KNOW WHERE TO GET CARE

Find a doctor or facility in your ZIP code and in your health plan's network.

my

SEE FOR YOURSELF BY LOGGING IN TO myWELLMARK!

NOT REGISTERED? NO PROBLEM. Get your Wellmark ID card and get started at myWellmark.com.

Your health care — at your fingertips. myWellmark is your one-stop source for personalized health care information. Log in or register at myWellmark.com.

Want to make your health insurance even easier? Confirm you have the security, speed and convenience of digital documents in three easy steps by logging in and:

Selecting the **Profile** tab from the menu at the top.

Clicking **Notifications.**

Choosing your preferences and click **Agree & Save.**

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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) 。

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Wellmark®

ENROLL WITH CVS SPECIALTY™

Convenient and cost-effective access to your specialty drugs

ORDERING SPECIALTY DRUGS WITH YOUR WELLMARK HEALTH PLAN: Wellmark understands that when you have a chronic or complex disease, having a convenient way to access your specialty drugs is important. Though enrollment isn't required,* CVS Specialty provides competitive rates and professional expertise once you sign up.

There are three ways to get started with CVS Specialty:

CALL THE PHARMACY

- Call 800-237-2767.
- Identify yourself as a Wellmark Blue Cross and Blue Shield member.
- A representative will collect your information and contact your physician to obtain a new prescription.

ENROLL ONLINE

- Go to Wellmark.com/Prescription.
- Click Specialty Drugs.
- Click "enroll online" link under CVS/caremark to begin the process.
- If your prescription has a copay assistance program, you may need to call the drug manufacturer to enroll.

ASK YOUR DOCTOR

- Ask your physician to fax a completed enrollment form, found at CVSSpecialty.com, to 800-323-2445.
- A representative will contact you for any information needed to complete the order.

*If you choose not to enroll, you may have a higher cost share depending upon your benefit design, which sets your specialty drug cost share amount.

PLEASE NOTE: You may experience longer claims processing for specialty drugs, which could cause your out-of-pocket accumulations to appear inflated while your claim is being processed.

Where do I get my specialty drugs?

Once you enroll with CVS Specialty, your prescription can be delivered directly to you at home or work, or you may pick it up at a CVS pharmacy near you. With CVS Specialty, you can:

- Refill prescriptions and check order status from your computer or phone.
- Pick up prescriptions locally or have them shipped to you.
- Talk to your CareTeam, led by pharmacists and nurses, who can assist with managing side effects, checking dosage and medication schedules and helping to answer all your questions.
- Access injection training, home infusion and other services.
- Receive help with third-party copay assistance programs if available, which may lower your out-of-pocket costs.

LEARN MORE

How do I know if I take a specialty drug?

Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

If you are unsure whether your prescription falls into the "specialty drug" category, simply:

1. Go to Wellmark.com/Prescription.
2. Select "Wellmark Drug List."
3. Select your plan name.
   Note: If you don't know your plan name, you can find it by calling the Customer Service number on the back of your card, or in your Coverage Manual or Summary of Benefits and Coverage (SBC).
4. Search the drug by name.

myWellmark®

Get more from your health plan

Check claims details, view health care spending, find an in-network doctor, use tools to understand your benefits and more. It's all available with myWellmark®, your one-stop source for personalized health care information.

Plus, get the most out of your prescription drug benefits:

- Use the Check Drug Cost tool to see what you will pay.
- Check drug interactions and generic alternatives.
- View prescription history.
- Use the year-to-date spend report to view your spending history for provider and pharmacy claims.

HAVEN'T REGISTERED YET? IT TAKES LESS THAN FIVE MINUTES!
Go to myWellmark.com to get started.

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Wellmark®

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Wellmark®

WHEN DOES AMY USE HER HEALTH INSURANCE? EVERY TIME SHE GOES FOR A WALK.

Most people are grateful for insurance when something bad happens. But Wellmark members are grateful for their insurance 365 days of the year. That's because they have Blue365®. Members get exclusive discounts on wellness products and services they use all the time, like fitness trackers, eyeglasses and athletic shoes.

SIGN UP TODAY AT WELLMARK.COM/BLUE365

Just by being a Wellmark member, you have access to Blue365. When you sign up, you get exclusive discounts for wellness products and services you use every day.

Savings are just a click away

Register for Blue365 at Wellmark.com/Blue365. It's free and you can start saving right away. Browse the discounts and be the first to know about the latest deals to hit Blue365 through a weekly email sent right to your inbox.

Wondering what types of deals are available? Here are just a few ways you can save money while meeting your health and personal goals:

APPAREL AND FOOTWEAR. Save up to 20 percent on Reebok® shoes or 30 percent on Skechers®.

FITNESS. Get access to a network of gyms near you for just $29 per month or track your health with discounted wearables from FitBit®, Garmin® and Polar®.

HEARING AND VISION. Save an average of $1,100 on LASIK eye surgery. Or, get eyeglass frames and hearing aids at a discounted rate.

HOME AND FAMILY. Switch to Sprint and get up to a $200 pre-paid gift card. Or, make sure your pet's health is covered with 10 percent off pet insurance.

NUTRITION. Eat well for less with a free 3-month Jenny Craig® membership.

TRAVEL. Travel for less with an extra 10 percent off hotels through Hotels.com™ and 20 percent off Fairmont Hotels and Resorts.

Visit Wellmark.com/Blue365 for a full list of deals and discounts available to you.

Wellmark members get more

Blue365 isn't the only way you get more for being a Wellmark member. As part of your health plan, you also have access to products and services like:

- **myWellmark®** — your one-stop-shop for tools and resources to help you get the most out of your health care.
- **BeWell 24/7℠** — get connected with a real person who can help you with a variety of health-related concerns. Just call 844-84-BEWELL (239355).
- **Doctor On Demand®** — see a board-certified doctor from virtually anywhere using a smartphone, tablet or computer.

Register for Blue365 today!

Go to Wellmark.com/Blue365. All you need to register is a valid email address and the first three characters of your Wellmark ID number.

Blue365 is a discount program available to members who have medical coverage with Wellmark. This is not insurance.

Wellmark

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Wellmark

IDX
The Privacy Platform

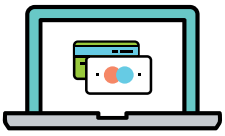
SAFE, SECURE AND PROTECTED

Your Wellmark health insurance coverage keeps you safe, secure and protected from more than the cost of health care. Just by being a member, you and your dependents have exclusive, free access to identity protection services called IDX™ Identity. It's just another way you get more as a Wellmark member.

Priceless peace of mind

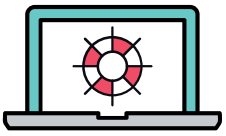
Join thousands of people around the country who have already chosen IDX Identity for identity protection services.

With IDX Identity, you can:



Monitor your credit record.

Keep track of your online activity 24 hours a day, seven days a week.



Have access to complete identity recovery if fraudulent activity is found.

Enroll in identity protection services today!

Register or sign in to myWellmark® at myWellmark.com to get started.

1. Select Identity Protection under Do More and click the Enroll/Log in link.

2. Select Enroll Now from the home page.

3. Fill out the Group ID and Subscriber ID (also known as your Wellmark ID number). Both are found on your Wellmark ID card.

4. Enter your personal information and create a username and password.

5. To activate credit monitoring, enter your birth date and Social Security number.

Rather enroll over the phone?

JUST CALL 866-486-4812 and make sure you have your Wellmark ID card handy.

Identity protection services aren't the only ways you get more for being a Wellmark member.

As part of your health plan, you also have access to products and services like:

myWellmark — your one-stop-shop for tools, resources and insights to help you manage health care spending and live a healthier life.

BeWell 24/7℠ — get connected with a real person who can help you with a variety of health-related concerns. Just call **844-84-BEWELL (239355).**

Blue365® — find exclusive ways to save on top wellness services and products you use every day.

Blue℠ — simply visit Wellmark.com/Blue to stay informed on health plan updates and the latest in health and wellness.

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Wellmark

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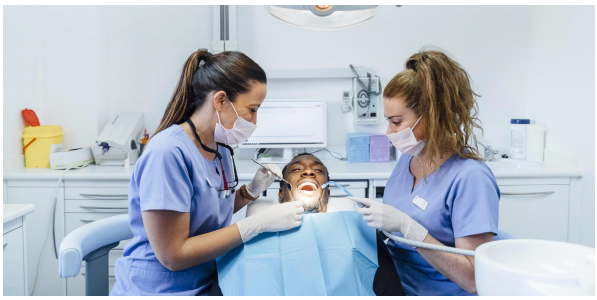
Dental Your health care benefits include more than just medical coverage. You can also choose from valuable dental benefits to protect yourself and your family.



Dental

Healthy teeth and gums are important to your overall wellness. That's why it's important to have regular dental checkups and maintain good oral hygiene. Learn about the dental plans available to help you maintain your oral health.

Wellmark Dental Plans Coinsurance is Member's Responsibility	**Blue Dental Premium**	**Blue Dental Basic**
Annual deductible (per person/per family)	$50 / $150	$100 / $300
Calendar-year maximum	$1,500	$1,000
Diagnostics and Preventative - 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 filings, 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 Monthly Premiums

Plan	**Single**	**Family**
Blue Dental Premium	$40.16	$96.18
Blue Dental Basic	$29.62	$69.32

VISION

Your health care benefits include more than just medical coverage. You can also choose from valuable vision benefits to protect yourself and your family.

Vision plan

Having vision coverage allows you to save money on eligible eye care expenses such as periodic eye exams, eyeglasses, contact lenses, and more for yourself and your covered dependents.

Even if you have perfect eyesight, you should have your vision checked on a regular basis. Eye doctors are often the first health care professionals to detect chronic systemic diseases, such as high blood pressure and diabetes.

Delta Vision – Insight Network	**In-Network**	**Out-of-Network**
Exam (once per calendar year)	$10 Copay	Up to $35
Materials copay		
Lenses (once per calendar year) Single Vision Bi-Focal Tri-Focal Standard Progressive Lens Premium Progressive Lens Lenticular	 $25 Copay $25 Copay $25 Copay $90 Copay Tiered $110 - $135 $25 Copay	 Up to $25 Up to $40 Up to $55 Up to $40 Up to $40 Up to $55
Lens Options: Standard Polycarbonate Standard Plastic Scratch Coating Tint (Solid and Gradient UV Treatment Standard Anti-reflective Coating	 $40 Copay $15 Copay $15 Copay $15 Copay $45 Copay	 N/A
Frames (once every two calendar year)	80% of Balance Over $150	Up to $75
Contact lenses (instead of glasses) Conventional Lens Contact Lens – Disposable Standard Fit and Follow up Exam	 85% of Balance over $150 Balance over $150 $40	 Up to $120 Up to $120 N/A
Premiums	**$7.00 SINGLE ---- $17.90 FAMILY**	

FINANCIAL

Your benefits include programs to help ensure financial security for you and your family. JONES COUNTY fully pays the cost of Basic Life, AD&D, and Long-Term Disability benefits on your behalf.

Life and accident insurance

As a JONES COUNTY employee, you receive company-paid life and accident insurance.

Employee Basic Life insurance

JONES COUNTY provides you with basic life insurance so that you can protect those you love from the unexpected. There is no cost to you for this coverage. Your benefit amount will be $20,000.

Employee AD&D insurance - with medical coverage election

JONES COUNTY provides you with AD&D insurance so that you can protect those you love from the unexpected. There is no cost to you for this coverage. Your benefit amount will be $35,000.

Spouse/domestic partner AD&D insurance - with medical coverage election

JONES COUNTY provides AD&D insurance for your spouse and dependents covered under your medical insurance.

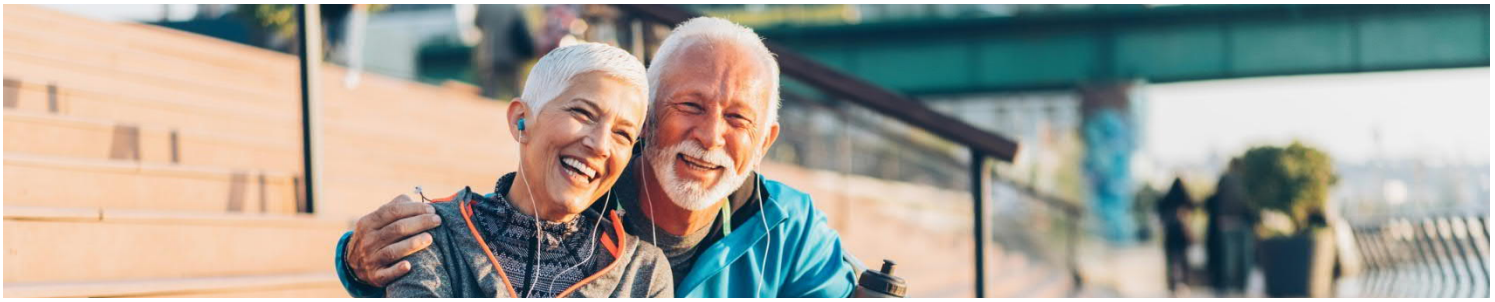
- Spouse with no children: 50% of the Insured Person's Principal Sum
- Spouse with Children: 40% of the Insured Person's Principal Sum
- Children with spouse: 10% of the Insured Person's Principal Sum
- Children with no spouse: 15% of the Insured Person's Principal Sum

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.

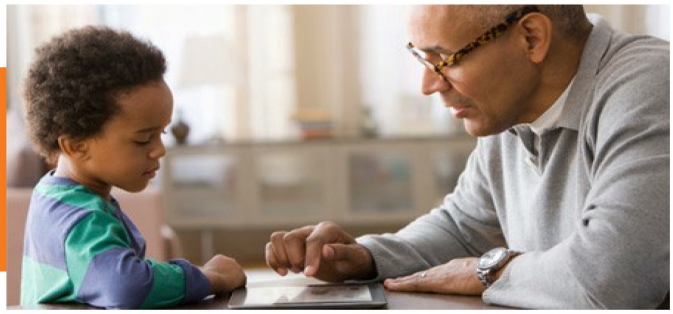
Have you named a beneficiary?

Be sure you've selected a beneficiary for all your life and accident insurance policies. The beneficiary will receive the benefit paid by a policy in the event of the policyholder's death. It's important to designate a beneficiary and keep that information up-to-date.



Plan Highlights

Group Basic Life Insurance



Jones County

ELIGIBILITY

Each Active, Full-time Employee as defined in the bargaining unit agreement working 30 or more hours per week OR Each Active, Full-time Non-Union Employee working 35 or more hours per week OR an Elected Official.

BENEFIT AMOUNT

Basic Life:
$20,000

GUARANTEED ISSUE (INITIAL ELIGIBILITY PERIOD ONLY)

Employee: $20,000

BENEFIT REDUCTION DUE TO AGE

Age	Original Benefit Reduced To
70	65%
75	50%

FEATURES

- Living Benefit Rider(expressed as Accelerated Death Benefit in some states and Imminent Death Benefit in PA)
- Conversion Privilege
- FMLA/MSLA Continuation
- Portability
- Waiver of Premium

CONTRIBUTION REQUIREMENTS

Coverage is employer paid.

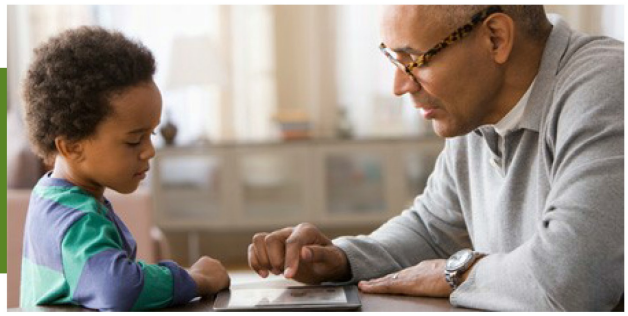
EXCLUSIONS

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-6422, et al.

Plan Highlights

Voluntary Group Accidental Death & Dismemberment Insurance



Jones County

ELIGIBILITY

Each Active, Full-time Employee as defined in the bargaining unit agreement working 30 or more hours per week OR Each Active, Full-time Non-Union Employee working 35 or more hours per week OR an Elected Official OR a Retiree. All eligible must also be enrolled in the County's Medical Plan.

BENEFIT AMOUNT

Employee: $35,000

Family:

Spouse with no children: 50% of the Insured Person's Principal Sum
Spouse with children: 40% of the Insured Person's Principal Sum
Children with spouse: 10% of the Insured Person's Principal Sum
Children with no spouse: 15% of the Insured Person's Principal Sum

Dependents:

You must be insured in order for Dependents to be covered. Dependents are:

- your legal spouse not legally separated or divorced from you.
- your unmarried dependent children* from birth to 26 years

A person may not have coverage as both an Employee and Dependent. Only one insured spouse may cover Dependent children.

AD&D SCHEDULE

For Accidental Loss of:	Amount Payable:
Life	100%
Two or more Members	100%
Speech and hearing	100%
One Member	50%*
Speech or Hearing	50%*
Thumb & Index Finger of Same Hand	25%

"Member" means hand, foot or eye.

CONTRIBUTION REQUIREMENTS

Coverage is 100% employer paid.

FEATURES

- Conversion Privilege
- Day Care Benefit
- Education Benefit
- Exposure & Disappearance
- Seat Belt & Air Bag Benefit

EXCLUSIONS

Benefits will not be payable for any loss: to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; caused by suicide, or intentionally self-inflicted injuries; caused by or resulting from war; caused by an accident that occurs while in the armed forces of any country; caused by or resulting from: piloting any aircraft; or riding in or getting into or out of any non civilian aircraft or any aircraft owned, leased or operated by you or any of your employers; sustained during the insured's commission or attempted commission of an assault or felony; to which the insured's acute or chronic alcoholic intoxication is a contributing factor; or, to which the insured's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic is a contributing factor.

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-8604, et al.

Group Long Term Disability Income Benefit

SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: NONE

ELIGIBLE CLASSES: Each active, Full-time employee, except any person employed on a temporary or seasonal basis, according to the following classifications:

CLASS 1: Employee and Elected Official earning $60,000 or more per year

CLASS 2: Employee and Elected Official earning less than $60,000 per year

WAITING PERIOD: 15 days of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month coinciding with or next following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: 6 months

MINIMUM PARTICIPATION REQUIREMENTS: Percentage: 100% Number of Insureds: 10

LONG TERM DISABILITY BENEFIT

ELIMINATION PERIOD: 90 consecutive days of Total Disability.

MONTHLY BENEFIT: The Monthly Benefit is an amount equal to 60% of Covered Monthly Earnings, payable in accordance with the section entitled Benefit Amount.

MINIMUM MONTHLY BENEFIT: In no event will the Monthly Benefit payable to an Insured be less than the greater of:
(1) 10% of the Covered Monthly Earnings multiplied by the Monthly Benefit percentage(s) as shown above; or
(2) $100

MAXIMUM MONTHLY BENEFIT: $3,000 (this is equal to a maximum Covered Monthly Earnings of $5,000).

MAXIMUM DURATION OF BENEFITS: Benefits will not accrue beyond the duration specified below:

Age at Disablement	Duration of Benefits
Less than 62	The lesser of: (1) 60 months; or (2) to age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or more	12 months

CHANGES IN MONTHLY BENEFIT: Increases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date of the change, provided the Insured is Actively at Work on the effective date of the change. If the Insured is not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date the Insured returns to Active Work. Decreases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date the change occurs.

CONTRIBUTIONS: Insured: 0%

Premium contributions will not be included in the Insured's gross income.

For purposes of filing the Insured's Federal Income Tax Return, this means that under the law as of the date this Policy was issued, the Insured's Monthly Benefit might be treated as taxable. It is recommended that the Insured contact his/her personal tax advisor.

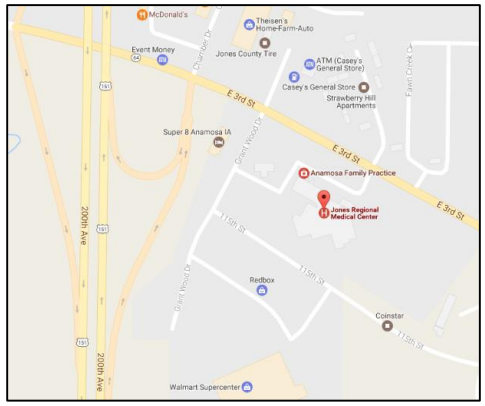
Jones County

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: IA741)**
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**
5. Discharge Instructions
   a. Work restrictions apply for 24 hours a day until recheck, <u>for work and non-work activities.</u>
   b. Call Employer with an update on your status and call JRMC 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.
6. 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 or 319-462-6131
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
319-481-6124
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

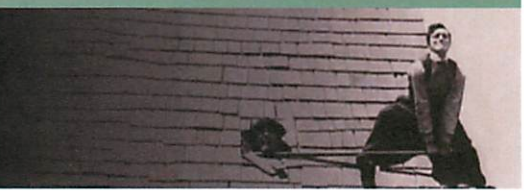
St. Luke's Hospital • Emergency Department
319-369-7105
24 hours a day • 7 days a week
1026 A Ave NE, Cedar Rapids, IA 52402

Updated 7.24.19

IN CASE OF WORKPLACE INJURY

ACCION a seguir en caso de un accidente en el trabajo

COMPANY NURSE™
Because Accidents Happen™



AVAILABLE 24 HOURS A DAY

1-888-770-0928

Employer Name (Nombre De Compania)	Search Code (Código Del Búqueda)
Jones County	IA741

1. **Injured worker notifies supervisor.**
   Empleado lesionado notifica a su supervisor.

2. **Supervisor/Injured worker immediately calls injury hotline.**
   Supervisor / Empleado lesionado llama inmediatamente a la línea de enfermeros/as.

3. **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**
   Profesional Médico obtiene información por teléfono y asiste al empleado lesionado en localizar el tratamiento médico adecuado.

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.

ENROLL

After you've carefully considered your benefit options and anticipated needs, it's time to make your benefit selections. Follow the instructions to enroll yourself and any eligible dependents in health and insurance benefits for 2021-2022.

Changes during the year

After your enrollment opportunity ends, you won't be able to change your benefits coverage during the year unless you experience a qualifying life event, such as marriage, divorce, birth, adoption, or a change in your or your spouse/domestic partner's employment status that affects your benefits eligibility.

Effective date of coverage

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

For existing employees enrolling during Open Enrollment, the effective date of most plans is January 1st.

Contacts

Please contact the appropriate provider listed below to learn more about a specific benefit plan.

Benefit Plan	Provider	Phone number	Website
Medical	Wellmark	866-486-4812	http://myWellmark.com
Prescription	Wellmark	800-237-2767	http://Wellmark.com
Telemedicine services	Doctor on Demand	800-997-6196	http://DoctoronDemand.com
Dental	Wellmark Blue Dental	877-333-0164	www.wellmark.com
Vision	DeltaVision	877-488-5130	www.DeltaDentalia.com
Basic Life, AD&D, LTD	Reliance Standard	See Human Resources	

Summary of Benefits and Coverage

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Wellmark

Coverage Period: 07/01/2021 – 06/30/2022
Coverage for: Single & Family | Plan Type: PPO

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 referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible 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% coinsurance	40% coinsurance	------None------
	Specialist visit	20% coinsurance	40% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	40% coinsurance	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 plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	In-network independent labs for mental health/substance abuse services are not subject to coinsurance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	------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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellmark.com/prescriptions.	Tier 1	$10 copay 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 copay or coinsurance for 30-day supply. 3 copays 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 copay per prescription	Not covered	
	Tier 3	$45 copay per prescription	Not covered	
	Tier 4	$45 copay per prescription	Not covered	
	Specialty drugs	Generic: $50 copay per prescription Preferred: $100 copay per prescription Non-preferred: 50% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	------None------
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	For emergency medical conditions treated out-of-network, you may be balance billed.
	Emergency medical transportation	20% coinsurance	20% coinsurance	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.
	Urgent care	20% coinsurance	40% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	------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------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	------None------
	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.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	------None------
	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 excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- 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 plan document.)

- Applied Behavior Analysis therapy-covered through age 18 subject to annual limits
- 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.cciio.cms.gov.

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.

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.

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

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

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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).

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

주의: 한국어 를 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 Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. 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).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)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 नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 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 yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

M-2318376 09/16 A

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 2021. 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 2021 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 the Jones County prescription drug plan, 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 2021. This is called creditable coverage. Coverage under this 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.

Alliance Select 750

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 Jones County 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 Jones County plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Jones County plan mid-year, 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) or visit the program online at https://www.shiptacenter.org/.
- 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:

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

November 17, 2021

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.

CHIP/MEDICAID NOTICE

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 January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218 For questions about Medicaid, or the NH EASY website, contact the Division of Client Services at 1-844-ASK-DHHS (275-3447)
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – 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: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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 January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

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
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, 2021. 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 9.83% 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 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 will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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. Under these extensions, plan participants and dependents were given extra time to make HIPAA Special Enrollment election changes, file ERISA claims and appeals, receive notifications about COBRA elections, and make COBRA premium payments.

This temporary extension became effective on March 1, 2020 and created individual extension deadlines.

What this means for you and your family

During the period that began March 1, 2020 to present, individual timing extensions can only be extended for a maximum of 12 months. If the original deadline would have been on or after March 1, 2020, your new deadline will now be one-year from your original deadline. For example, if you would have been required to notify the plan of a HIPAA Special Enrollment event (i.e., the birth of a child) by July 1, 2020, your deadline to request an election change under the HIPAA rules will now be June 30, 2021.

Your deadline could end sooner than one year once the National Emergency declaration ends. At the time of this notice, the National Emergency declaration remains ongoing. However, the extensions described here will only last for the *shorter* of the following two periods: one year from your original deadline, or the period between your deadline (if after 3/1/20) and 60 days following the end of the National Emergency declaration.

If you delayed any of the following due to your timing extension, **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;
- 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.

Questions?

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

This guide is intended to describe the eligibility requirements, enrollment procedures, plan highlights, and coverage effective dates for the benefits offered by Jones County. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While the guide is a tool to answer many of your benefit questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plans' operation. The noted plan changes in this guide may serve as a Summary of Material Modifications (SMM) to the SPD. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail.