WRAP Document

Effective 07/01/2023

SUMMARY OF PLAN SPONSOR RESPONSIBILITIES

The Summary Plan Description, or SPD, is the main vehicle for communicating plan rights and obligations to participants and beneficiaries. As the name suggests, it is a summary of the material provisions of the plan document, and it should be understandable to the average participant of the employer. However, in the context of health & welfare benefit plans, it is not uncommon for the SPD to be a combination of a complete description of the plan's terms and conditions, such as a Certificate of Coverage, and the required ERISA disclosure language. **Note: An insurance company's Master Contract, Certificate of Coverage, or Summary of Benefits is not a plan document or SPD.**

As the Plan Sponsor/Administrator, you will have sole responsibility to comply with all plan administration, implementation, amendments, filing, reporting, disclosure and plan compliance requirements imposed by the plan, ERISA, the Internal Revenue Code or any other applicable law, specifically including, but not limited to:

- Reviewing the sample documents (plan, summary plan description, and information) with legal counsel, executing the SPD Adoption Agreement, and distributing the summary plan description to employees on, or before their enrollment date, or within 90 days of enrollment.
- Ensuring that only common law employees participate in the plan [employees of companies described in IRC Section 414 (b), (c) or (m) and listed in the plan as participating affiliates may also participate] and ensuring that the terms of its plan document are enforced.
- Conducting initial and annual enrollments.
- Form 5500 Annual Returns. You may be required to file a Form *5500* Annual Return for the component benefit plans, *(component benefit plans would be any self-funded or partially self-funded health plans sponsored by you through ERISA, Health Flexible Spending Accounts (FSA) with more than 100 employees are still required to file a Form 5500).*
- Retaining documentation relating to plan operations that may be requested in an IRS or Department of Labor audit of plan operations - including, but not limited to: executed copies of the plan, salary redirection agreements, plan amendments, resolutions adopting the plan, and Form 5500s - for seven years after the close of each plan year.
- Employers with 20 or more employees must provide COBRA continuation benefits to those employees with a positive FSA Account balance on the date of the COBRA qualifying event.

SECTION 1

RESOLUTION TO ADOPT

PLACE THIS PAGE AFTER TAB 1

SECTION 1 SHOULD CONSIST OF

THE FOLLOWING RESOLUTION TO ADOPT

JEFFERSON COUNTY COMMISSION

RESOLUTION TO ADOPT

EMPLOYEE BENEFITS PLAN &

ERISA WRAP SUMMARY PLAN DESCRIPTION

WHEREAS, Jefferson County Commission has determined that it would be in the best interests of its employees to adopt an "Employee Benefit(s) Plan" allowing for medical and other benefit coverage, so-called; be it known that a vote was taken, and all were in favor.

RESOLVED, that Jefferson County Commission adopt an "Employee Benefit(s) Plan," all in accordance with the specifications annexed hereto; and, be it known that the "Jefferson County Commission Employee Benefits Plan" was executed.

RESOLVED FURTHER, that Jefferson County Commission adopt the required ERISA "Wrap Summary Plan Description," with all of the specifications annexed hereto; be it known that the "Jefferson County Commission Employee Benefits Plan SPD Document" was also executed.

RESOLVED FURTHER, that the Company undertake all actions necessary to implement and administer said Employee Benefit(s) Plan, and distribute said ERISA Wrap SPD to all participants and their beneficiaries.

IN WITNESS WHEREOF, I have executed my name for the above named Company on July 1, 2023.

ATTEST:

Witness

By: Cindy Rezmer

Cindy Rezmer

SECTION 2

ERISA WRAP SPD DOCUMENT

PLACE ALL PAGES OF THE SPD DOCUMENT AFTER TAB 2

JEFFERSON COUNTY COMMISSION
EMPLOYEE BENEFITS PLAN &
ERISA WRAP SUMMARY PLAN DESCRIPTION

PLAN PURPOSE

Jefferson County Commission (the "Employer") maintains the **Employee Benefit(s) Plan** ("the Plan") for the exclusive benefit of its eligible employees and their eligible dependents. Benefits under the Plan are currently provided under a group health insurance contract ("the Group Health Insurance Contract") entered into between the Employer and Highmark WV.

Plan benefits, including information about eligibility, are summarized in the Certificate of Coverage, Member Payment Summary, and Provider & Facility Directory issued by Highmark WV, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the Certificate of Coverage.

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As used in this Summary Plan Description (SPD), "Your" means an active Employee as described under "Who is Eligible."

SPECIFIC PLAN INFORMATION

Plan Name:	Jefferson County Commission Employee Benefit(s) Plan
Type of Plan:	A group health plan (a type of welfare benefits plan subject to the provisions of ERISA).
Plan Year:	July 1 to June 30
Effective Date:	July 1, 2023
Plan Number:	501
Insurance Company:	Highmark WV
Ancillary Insurance Companies:	Highmark WV Hartford NVA
Employer/ Plan Sponsor:	Jefferson County Commission Cindy Rezmer 124 E Washington St Charles Town, WV 25414
Plan Funding and Type of Administration:	The Plan is fully insured. Benefits are provided under the Group Health Insurance Carrier Contract between the Employer and Highmark WV. Claims for benefits are sent to Highmark WV, which is responsible for paying claims. Highmark WV and the Employer share responsibility for administering the Plan. Insurance premiums for employees and their eligible dependents are paid in part by the Plan Sponsor out of its general assets, and in part by employees' payroll deductions.
Plan Sponsor's Employer Identification Number:	55-6000333
Plan Administrator:	Jefferson County Commission 124 E Washington St Charles Town, WV 25414 Attention: Cindy Rezmer

Named Fiduciary:	Jefferson County Commission 124 E Washington St Charles Town, WV 25414
Agent for Service of Legal Process:	Jefferson County Commission 124 E Washington St Charles Town, WV 25414 (304) 728-3284 Service of process may also be made on the Plan Administrator.
Important Disclaimer:	Plan benefits are provided under a Group Health Insurance Contract between the Employer and Highmark WV. If the terms of this summary document conflict with the terms of the Group Health Insurance Contract, the terms of the Group Health Insurance Contract will control, unless superseded by applicable law.

SUMMARY OF PLAN BENEFITS

The Plan provides eligible employees and their eligible dependents with health insurance. These benefits are provided under the Group Health Insurance Contract with Highmark WV. A summary of the benefits provided under the Plan is in the Certificate of Coverage issued by Highmark WV.

The Plan, through the Group Health Insurance Contract, provides benefits in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and Mothers' Health Protection Act (NMHPA), Mental Health Parity Act (MHPA), Women's Health and Cancer Rights Act (WHCRA), Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act (ACA).

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them.

The Plan is fully insured. Benefits are provided under the Group Health Insurance Contract entered into between the Employer and Highmark WV. Claims for benefits are sent to Highmark WV, and Highmark WV, not the Employer, is responsible for paying them. Highmark WV is also responsible for determining eligibility for and the amount of any benefits payable under the Plan and prescribing claims procedures and forms to be followed to receive Plan benefits. Highmark WV also has the discretionary authority to require participants to furnish it with such information as it determines is necessary for the proper administration of claims for Plan benefits.

Claims and Appeals

Highmark WV is responsible for evaluating all benefit claims under the Plan. Highmark WV will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If your claim is denied, you may appeal to Highmark WV for a review of the denied claim and Highmark WV will decide your appeal in accordance with its reasonable procedures, as required by

ERISA. See the Certificate of Coverage for complete details regarding Highmark WV's claims and appeals procedures.

Amendment or Termination of the Plan

As Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine the SPD provided to you each year to determine the benefits of the Plan.

Other Materials

The Certificate of Coverage (including the Member Payment Summary, and the Provider & Facility Directory) issued by Highmark WV are part of the Summary Plan Description as attachments. Please refer to these materials for other important provisions regarding your participation in the Plan.

Who is Eligible

In order to be eligible for benefits you must be scheduled to work 30 or more hours per week. During the Employer Waiting Period, you must work the specified minimum required hours except for paid time off and hours you do not work due to a medical condition, the receipt of healthcare, your health status or disability. Highmark WV may require payroll reports from your employer to verify the number of hours you have worked as well as documentation from you to verify hours that you did not work due to paid time off, a medical condition, the receipt of healthcare, your health status or disability.

To determine whether your spouse and dependent children are eligible to participate in the Plan, please read the eligibility information contained in the Certificate of Coverage issued by Highmark WV.

The Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children. Also eligible is any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable law and determined by your Employer under its QMCSO procedures, a copy of which is available from your Human Resources Department, free of charge.

If eligible, you must complete an application form to enroll in the Plan and Highmark WV (available from your Human Resources Department) or otherwise comply with your Employer's enrollment procedures.

Coverage will terminate if you no longer meet the eligibility requirements. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, etc. (See the Certificate of Coverage for more information.) Coverage for your spouse and dependents stops when your coverage stops. Their coverage will also stop for other reasons specified in the Certificate of Coverage.

Waiting Period

You are eligible to participate on the first day of the month following completion of one day of active employment as an Eligible Employee.

Monthly Measurement Method Used For Determining Full-Time Employee Status

On Feb. 12, 2014, the Internal Revenue Service (IRS) published final regulations on the employer shared responsibility rules. The final regulations provide two methods for identifying full-time employees for purposes of offering health plan coverage and avoiding a pay or play penalty—the monthly measurement method and the look-back measurement method.

A full-time employee is an employee who was employed, on average, at least 30 hours of service per week. The final regulations treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours per service per week.

Jefferson County Commission currently uses the monthly measurement method which involves a month-to-month analysis where full-time employees are identified based on their hours of service for each calendar month. This method is not based on averaging hours of service over a prior measurement period.

SPECIAL SITUATIONS, EXTENSION OF COVERAGE

FMLA does not apply to: (1) employers that do not employ 50 or more employees during 20 or more calendar workweeks in current or preceding calendar year; (2) employees at worksites with less than 50 employees, if the employer employs fewer than 50 employees within a 75-mile radius of that worksite. COBRA does not apply to groups with less than 20 employees in preceding year.

FMLA Leave Entitlement Family and Medical Leave Act (FMLA)

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

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

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

FMLA Benefits & Protection

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

FMLA Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting FMLA Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

FMLA Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

FMLA Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

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

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

For more information please see: https://www.dol.gov/general/topic/benefits-leave/fmla

Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services

As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty,
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

1) You fail to make a premium payment within the required time;
2) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
3) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan Administrator reserves the right to administer the plan in accordance with such actual regulations.

COBRA Continuation Coverage *(only applies to groups of 20+ employees in preceding year)*

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." The following are qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your eligible dependents;
- A reduction in your hours. Coverage may continue for you and/or your eligible dependents;
- Your death. Coverage may continue for your eligible dependents;
- Your divorce or legal separation. Coverage may continue for your eligible dependents;
- Your becoming entitled to Medicare. Coverage may continue for your eligible dependents; and
- Your covered dependent child's ceasing to be a dependent child under the Plan. Coverage may continue for that dependent.
- If the Plan includes retiree coverage, Employer Bankruptcy is a qualifying event.

Note: To choose this continuation coverage, an individual must be covered under the Plan on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

Notification Requirements

Under the law, you or the applicable dependent has the responsibility to inform the Plan Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights.

Your Employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will promptly notify you and other qualifying individual(s) of their continuation coverage rights. You and any applicable dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, they you will be provided with an additional 60 day enrollment period, with continuation coverage beginning on the date of such TAA approval.

Notice of Unavailability of Continuation Coverage

If the Plan Administrator receives a notice of a qualifying event from you or your dependent and determines that the individual (you or your dependent) is not entitled to continuation coverage, the Plan Administrator will provide to the individual an explanation as to why the individual is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Cost of Continuation Coverage

The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Premium payments for continuation coverage for you or your eligible dependent's "initial premium month(s)" are due by the 45th day after electing continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elects continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your Employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

1. The date the maximum continuation coverage period expires;
2. The date your Employer no longer offers a group health plan to any of its employees;
3. The first day for which timely payment is not made to the Plan;
4. The date the qualifying individual becomes covered by another group health plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying

individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;

5. The date the qualifying individual becomes entitled to coverage under Medicare; and
6. The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. In order to be eligible to apply for such coverage from a carrier after ceasing participation in the Plan, you or your eligible dependents must elect continuation coverage under the Plan, continue through the maximum continuation coverage period (18, 29, or 36 months, as applicable), and then apply for coverage with the individual insurance carrier before a 63 day lapse in coverage. For more information about your right to such individual insurance coverage, contact an independent insurance agent or your state insurance commissioner.

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

The Plan intends to comply with all applicable law regarding continuation (COBRA) coverage. If for some reason the information presented in this Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the Plan (which is a type of employee welfare plan called a "group health plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series, if applicable) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from a group health plan or a health insurance issuer when you lose coverage under a group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL NOTICES

Benefits after Childbirth (NMHPA)

Group health plans may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prevents discrimination by group health plans and insurance companies based on genetic information. Generally, this Plan and the insurance companies from which it has purchased coverage are not permitted to:

- Use genetic information to discriminate with respect to premiums or contributions;
- Request or require Participants and/or their Dependents to undergo genetic testing (except in specifically permitted situations);
- Collect genetic information for underwriting purposes or prior to enrollment under the Plan;
- Use genetic information to determine eligibility for coverage.

Genetic information includes any information about (i) an individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual.

Women's Health & Cancer Rights Act (WHCRA)

If the Participant or Dependent have had or are going to have a mastectomy, the individual 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. Therefore, the deductibles and coinsurances shown in the Benefit Description will apply.

ADDITIONAL INFORMATION

Compliance with State and Federal Mandates

With respect to the benefits and as applicable, the Plan will comply with the requirements of all applicable laws. If for some reason the information presented in this Wrap SPD differs from the actual requirements of any law, the Plan reserves the right to administer the Plan in accordance with those requirements.

No Contract of Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any employee or Participant, or as a guarantee of any employee or Participant to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its employees with or without cause.

Medical Loss Ratio Rebates under the Public Health Service Act

In certain circumstances under the Medical Loss Ratio Standards in § 2718 of the Public Health Service Act, rebates may be paid to this Plan based on the insurance carrier's medical loss ratio. Insurance carriers are required to provide Participants with a written notice of a rebate at the time the rebate is paid to the Plan. Any rebate received by the Employer may be retained by the Employer. Any portion of the rebate attributable to Participant contributions will be used for the benefit of the Participants. This may be done by, for example, lowering the Plan costs for those Participants who are enrolled during the next Plan Year, applying the rebate towards the cost of administering the Plan, implementing a wellness or other program to help reduce plan costs, providing additional taxable income to the Participants, or using the rebate in any other reasonable manner.

Additional Information Contained in Attached Benefit Descriptions

The following additional information about the Benefits is included in the Benefit Descriptions for the benefit (if applicable):

- Any additional procedures for enrolling in the Plan;
- A summary of benefits, though this may be provided as a separate document;
- A description of any premiums, deductibles, coinsurance or copayment amounts. The schedule of your contributions, if any, to the premium payment will be provided to you by the Employer;
- A description of any annual or lifetime caps or other limits on benefits;
- Whether and under what circumstances preventive services are covered;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers (if any). If there is a network, the Benefit Description will contain a general description of the provider network and you will receive automatically, without charge, a list of providers in the network from the carrier or administrator;
- Whether and under what circumstances coverage is provided for any out-of- network services;
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any services requiring preauthorization or utilization review as a condition to obtaining a benefit service;
- A summary of the claim procedures. However, if the claims procedures are not included in the Benefit Description, a copy will be provided to you automatically, without charge from the insurance carrier or administrator;
- Provisions describing the coordination of benefits with the benefits provided under another similar plan in which you or another plan participant are enrolled;
- Any subrogation or reimbursement rights that prevent duplicate payments for your health care; and
- Any other benefit limitations and exclusions.

JEFFERSON COUNTY COMMISSION

Schedule A

OTHER COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

DENTAL INSURANCE:
Highmark WV

VISION CARE INSURANCE:
NVA

OTHER SUPPLEMENTAL INSURANCE:
Hartford

*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment and in Schedule B. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above.

Jefferson County Commission
Premium Election Form Plan
Year Start: July 01, 2023
Plan Year End: June 30, 2024

- □ **Change of Personal Information**
- □ **Change of Family Status**
- □ **Ineligibility Termination**
- □ **Waive Participation _____ (Initial)**
- □ **No Changes to Benefit Plan Elections from the 2022-2023 Plan Year**

Personal Information

Last Name	First Name	Middle Initial	Social Security Number

	Street	City	State	Zip
Mailing Address				

Date of Birth (MM/DD/YYYY)	Gender: □ Male □ Female	Marital Status: □ Single □ Married	Date of Hire (MM/DD/YYYY)

Benefit Elections - Employee Cost Per Pay (2 times a month) Payroll Deduction*

Enrollment Tier	**Employee Only**		**Employee & Spouse**		**Employee & Child**		**Employee & Children**		**Family**	
	(√)	*	(√)	*	(√)	*	(√)	*	(√)	*
Medical / Prescription		$48.00		$181.00		$181.00		$244.00		$244.00
Dental		$1.26		$12.89		$12.89		$24.55		$24.55
Vision		$0.38		$2.85		$2.85		$6.40		$6.40

Election	(√)	**
Supplemental Employee Life / AD&D		**$**
Supplemental Dependent Spouse Life		**$**
Supplemental Dependent Child(ren) Life		**$**

***Amount After Employer Contribution is Deducted**

****Deductions for Life Insurance are deducted Post Tax**

Total Cost Per Pay (2 pays per month):	**$**

I have read and understand the explanation I have received regarding my options under the Jefferson County Commission Premium Only Plan. I understand I have the right to have the company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the benefit plan coverage I have designated above. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; a change in worksite; or any change in employment status that affects eligibility; a change in residence for me, my spouse or children; or my dependent either satisfies or ceases to satisfy requirements for coverage due to change in age, student status or any similar circumstances; or a change in my or my spouse's employment status. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy. I understand that government subsidized insurance premiums can only be deducted on a post-tax basis.

I hereby apply for the options listed above. If necessary, I authorize Jefferson County Commission to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from July 1 until June 30, unless my family status changes.

_____ _____

Employee Signature Date

_____ _____

Company Representative Date

JEFFERSON COUNTY COMMISSION

Schedule C

PARTICIPATING AFFILIATED EMPLOYERS

(Companies under common ownership)

The following organizations and entities shall be Participating Employers under the Plan:

Name of Participating Employer

None

SECTION 3

HEALTH INSURANCE CERTIFICATE OF COVERAGE

PLACE CERTIFICATE OF COVERAGE AFTER TAB 3

HIGHMARK WEST VIRGINIA
An Independent Licensee of the Blue Cross and Blue Shield Association

Jefferson County Commission - $6,000 Option
Super Blue Plus 2010

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2023	
Benefit Period (1)	Contract Year (July 1 through June 30)	
Deductible (per benefit period) Individual Family	$6,000 $12,000	$6,000 $12,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	$1,000 $2,000	$3,000 $6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	$9,100 $18,200	Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $25 copay	80% after $25 copay
Primary Care Provider Office Visits & Virtual Visits	100% after $25 copay	80% after $25 copay
Specialist Office Visits & Virtual Visits	100% after $35 copay	80% after $35 copay
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $50 copay	80% after $50 copay
	Copayment, if any, does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health and Substance Use Disorder	
Telemedicine Services (3)	100% after $10 copay	not covered
Preventive Care (4) (12)		
Routine Adult Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	80% after deductible
Mammograms, Medically Necessary	100% after deductible	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (11)	$125 copay (waived if admitted) after network deductible, 100% thereafter	
Ambulance Emergency (ground, water, air)	100% (deductible does not apply)	
Ambulance Non-Emergency (ground, water) (10)	100% after program deductible	80% after program deductible
Ambulance Non-Emergency (air)	100% (deductible does not apply)	
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible

Benefit	In Network	Out of Network
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Therapy (Rehabilitative and Habilitative) – **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain (9) Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	100% after $25 copay per visit	80% after $25 copay per visit
	Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after $25 copay per visit	80% after $25 copay per visit
	including rehabilitative services and habilitative services Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	
Occupational Therapy (Rehabilitative and Habilitative) – **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain (9) Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	100% after $25 copay per visit	80% after $25 copay per visit
	Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	
Spinal Manipulations (Rehabilitative and Habilitative) – **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain (9) Limitations are for Physician, Network and Non-Network, Rehabilitative and Habilitative, combined	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Use Disorder (12)		
Inpatient Mental Health Services	$100 inpatient copay/admission after deductible, 100% thereafter	$100 inpatient copay/admission after deductible, 80% thereafter
Inpatient Detoxification / Rehabilitation	$100 inpatient copay/admission after deductible, 100% thereafter	$100 inpatient copay/admission after deductible, 80% thereafter
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	80% after deductible
Outpatient Substance Use Disorder Services	100% after deductible	80% after deductible
Other Services (12)		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services	100% after deductible	80% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	Copayment, if any, does not apply to Diagnostic Services prescribed for the treatment of Mental Health and Substance Use Disorder	
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
	Copayment, if any, does not apply to Diagnostic Services prescribed for the treatment of Mental Health and Substance Use Disorder	
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	limit: 100 visits/benefit period aggregate with visiting nurse	
Hospice	$100 inpatient copay/admission after deductible, 100% thereafter	$100 inpatient copay/admission after deductible, 80% thereafter
Infertility Counseling, Testing and Treatment (6)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	limit: 35 visits/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
Transplant Services	100% after deductible	$100 inpatient copay/admission after deductible, 80% thereafter
Precertification Requirements (7)	Yes	Yes

Prescription Drugs

Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (34-day Supply)** $10 generic copay $20 Formulary brand copay $40 Non-Formulary brand copay **Retail Drugs (35-90 day Supply)** $30 generic copay $60 Formulary brand copay $120 Non- Formulary brand copay Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30 day supply **Mail Order Drugs (34-day Supply)** $10 generic copay $20 Formulary brand copay $40 Non-Formulary brand copay **Mail Order Drugs (35-90 day Supply)** $30 generic copay $60 Formulary brand copay $120 Non- Formulary brand copay Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30 day supply

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Telemedicine services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark approved telemedicine vendor. Additional services provided by a Highmark approved telemedicine vendor are paid according to the benefit category that they fall under (E.G. PCP is eligible under the PCP office visit benefit, behavioral health is eligible under outpatient mental health).
(4) Services are limited to those listed on the Highmark WV Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) After initial evaluation, applied behavioral analysis will be covered as specified above. All other covered services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (E.G. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limit
(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(7) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Please note that certain outpatient procedures also require prior authorization. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that your services are not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Anti-Cancer medications orally administered or self-injected. Deductible, copayment and coinsurance amounts for patient administered anti-cancer medications that are covered benefits are applied on no less favorable basis than for provider injected or intravenously administered anti-cancer medications.
(9) 30 visit maximum per event for combined physical therapy, occupational therapy and spinal manipulations
(10)Unless otherwise provided for benefits for emergency ambulance services rendered by a non-network provider will be subject to the same cost-sharing amount, if any, that is applicable to network services. The member will be responsible for any amounts billed by the non-network provider for non-emergency ground and water ambulance services that are in excess of the amount that Highmark WV pays.
(11)Benefits for emergency care services rendered by an out-of-network provider will be paid at the network services level. Benefits for hospital services or medical care services rendered by an out-of-network provider to a member requiring an inpatient admission or observation immediately following receipt of emergency care services will be paid at the network services level. The member will not be responsible for any amounts billed by the out-of network provider that are in excess of the plan allowance for such services.
(12) Covered virtual services will be paid according to the benefit category (e.g., primary care provider office visit, maternity visit, etc.) For example, virtual visits relating to the treatment of mental illness or substance use disorder are covered under your outpatient mental health and substance use disorder benefit and subject to the cost sharing amount in excess of the plan allowance for such services.

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, www.highmarkbcbswv.com or call 1-888-809-9121. 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 1-888-809-9121 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6,000 individual/$12,000 family network. $6,000 individual/$12,000 family out-of-network.	Generally, you must pay all of 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. Office visits, preventive care services, emergency medical transportation, urgent care, rehabilitation services, and prescription drug benefits are covered before you meet your network deductible. Copayments and coinsurance amounts don't count toward the network 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,000 individual/$2,000 family network out-of-pocket limit, up to a total maximum out-of-pocket of $9,100 individual/$18,200 family. $3,000 individual/$6,000 family out-of-network.	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.

An example of a certificate book can be found at https://shop.highmark.com/sales/#!/sbc-agreements.

What is not included in the out–of–pocket limit?	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expenses, 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.highmarkbcbswv.com/find-a-doctor or call 1-888-809-9121 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.
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 overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply.	20% coinsurance after $25 copay/visit Deductible does not apply.	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. Please refer to your preventive schedule for additional information.
	Specialist visit	$35 copay/visit Deductible does not apply.	20% coinsurance after $35 copay/visit Deductible does not apply.	
	Preventive care/screening/immunization	No charge Deductible does not apply.	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.highmarkbcbswv.com/find-a-doctor/#/drug.	Generic drugs	$10/$30 copay per prescription (retail) $10/$30 copay per prescription (mail order) Deductible does not apply.	Not covered	Up to 34/35-90-day supply retail pharmacy and maintenance prescription drugs through mail order. This plan uses a Comprehensive Formulary. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply.
	Formulary Brand drugs	$20/$60 copay per prescription (retail) $20/$60 copay per prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Brand drugs	$40/$120 copay per prescription (retail) $40/$120 copay per prescription (mail order) Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$125 copay/visit	$125 copay/visit	Out-of-network: Subject to network deductible. Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge Deductible does not apply.	No charge Deductible does not apply.	----------none----------
	Urgent care	$50 copay/visit Deductible does not apply.	20% coinsurance after $50 copay/visit Deductible does not apply.	The Copayment, if any, does not apply to Urgent Care Services prescribed for the treatment of Mental Health or Substance Abuse.
If you have a hospital stay	Facility fees (e.g., hospital room)	No charge	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% coinsurance	Precertification may be required.
	Inpatient services	No charge after $100 copay per admission	20% coinsurance after $100 copay per admission	Precertification may be required.
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Combined network and out-of-network: 100 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	$25 copay/visit Deductible does not apply.	20% coinsurance after $25 copay/visit Deductible does not apply.	Combined network and out-of-network: habilitation and rehabilitation services. Combined network and out-of-network: 30 physical medicine visits, and 30 occupational therapy visits per benefit period for other than chronic pain. Combined network and out-of-network: 30 combined physical medicine, occupational therapy, and spinal manipulation visits per event for chronic pain. Copayment, if any, does not apply to Therapy services prescribed for the treatment of Mental Illness or Substance Abuse. Limit does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse. Precertification may be required.
	Habilitation services	$25 copay/visit Deductible does not apply.	20% coinsurance after $25 copay/visit Deductible does not apply.	
	Skilled nursing care	No charge	20% coinsurance	Precertification may be required.
	Durable medical equipment	No charge	20% coinsurance	Precertification may be required.
	Hospice services	No charge after $100 copay per admission	20% coinsurance after $100 copay per admission	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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----------

Jefferson County Commission

HRA In-Network Medical Plan Deductible Reimbursement Policy
Effective July 1, 2023

Highmark West Virginia will continue as the **PPO** carrier for the 2023-2024 benefit plan year The Medical Plan's In-Network Deductible will continue as $6,000 per Individual and $12,000 per Family.

The Highmark Medical Plan Deductible Resets on July 1, 2023 and ends on June 30, 2024 for the 12-month Deductible Benefit Period.

The Jefferson County HRA Plan will continue to provide the in-network deductible reimbursement allowance based on the following enrollment structure:

- **Deductible Reimbursement for the Employee Only Enrollment:**

The Employee pays the first $750.00 and the HRA Plan will reimburse the employee for the 2nd portion of the In-Network Deductible met on an individual basis up to a maximum of $5,250.00.

- **Deductible Reimbursement for the Employee + 1 or more Dependents Enrollment:**

The Employee & Dependent(s) pay the first $1,500.00 and the HRA Plan will reimburse the employee for the 2nd portion of the In-Network Deductible met on a Family Basis up to a maximum of $10,500.00.

No Individual (employee or dependent) will have a deductible liability of more than $750.00

Medical Plan Copayments & RX Copayments are EXCLUDED from Reimbursement Allowances.
Out-of-Network Expenses are EXCLUDED from Reimbursement Allowances.

In order to receive reimbursement for the In-Network Deductible, copies of the **Highmark West Virginia EOB (**Explanation of Benefits) statements **AND a completed and signed Deductible Reimbursement Claim Form will need to be submitted to Millenium Insurance Group**.

The Reimbursement Claim Form includes a REQUIRED question to confirm if there is Other Insurance Coverage for the Employee and for enrolled dependent spouse and child(ren). Your submission will be placed on hold if neither the Yes or No box is left blank. For any Claim Form received that has the "Yes" box checked, you will need to complete a **Coordination of Benefits Form** and submit for review and determination if your claims are eligible for reimbursement by the Jefferson County Commission HRA plan.

Due to federal confidentiality restrictions, this must be done by the employee.
All reimbursement requests will be adjudicated based on the employers In-Network plan specifications. Upon verification of the In-Network deductible claim eligibility and processing, Jefferson County Commission will reimburse the employee. **It is the employee's responsibility to pay all providers associated with this reimbursement.** All submissions will be processed on a weekly basis.

Note: You do not pay taxes on the reimbursed deductible amounts.

Jefferson County Commission

2023-2024 Plan Year
HRA In-Network Medical Plan Deductible Reimbursement
Policy {COB} Coordination of Benefits Provision

Your HRA submission indicated that You and/or your Enrolled Dependent(s) may have Insurance Coverage (Primary or Secondary) other than the Jefferson County Commission Group Medical/Rx Plan & the Jefferson County Commission HRA Policy.
To comply with IRS Regulations and the guidelines of the Jefferson County Commission Plan Policy, you are required to provide additional information to determine if the claims you submitted are eligible for reimbursement by the Jefferson County Commission HRA plan.

Please complete the following for the Other Insurance:

Confirm Type of Insurance:

- ◻ Medicare – Part A Only
- ◻ Medicare – Part A and Part B
- ◻ State Medicaid or Medical Assistance
- ◻ Employer Group Health Plan or Retiree Plan
  Name of Carrier _____
  - Confirm If the Plan is an HSA/Qualified High Deductible Health Plan

List Who is Covered on the Insurance Plan Indicated Above:

_____

_____

Provide the Effective Date of the Insurance Coverage Indicated Above: _____

Sign and Date as indicated below acknowledging that you may be required to present additional documentation to verify the Insurance Plan's Individual/Family Deductible as well as the EOB statements for the claims you submitted to the Jefferson County Commission HRA so that calculations can determine if the required $750 / $1,500 Deductible Responsibility will be offset by a primary and/or a secondary insurance coverage.

_____ _____/_____/_____

Employee Confirmation Signature **Date of Signature**

Please submit this form to Millenium Insurance Group to review. You will be notified in writing if additional detail or documentation is required for your HRA Submission to be processed for the allowable reimbursement allowance by the Jefferson County Commission HRA policy.

Jefferson County Commission
2023/2024 PLAN YEAR HRA REIMBURSEMENT CLAIM FORM

Millenium Insurance Group, 135 East Main St., New Holland, PA 17557
Toll Free Telephone: (888) 577-7373 / Email Claims to: smartin@millig.com / Fax Claims to: (717) 354-0459

Employer Name: **Jefferson County Commission**	
Employee Name:	SSN: (last 4 digits only)
Address: (complete only if address changed)	

HRA Reimbursement Account - Reimbursement Request

All Reimbursement Requests will be adjudicated based on the employer's plan specifications.

Claimant Name & Relationship Employee / Spouse / Dependent	Date of Service	Type of Service	Dollar Amount
(Not required to list each claim in this section. Your submission should contain the Year-to-Date Patient or Program Deductible Benefit Summary Page along with each detailed EOB processing page)			
			$
			$
			$
			$
		Total:	$

****(REQUIRED) Do you and/or your Enrolled Dependent(s) have any Medical Benefits Insurance Coverage (Primary or Secondary) other than the Jefferson County Commission Group Medical/Rx Plan & the HRA Benefit? ☐ YES** ☐ No**

****If you checked the Yes box, then you will need to Complete & Submit the COB (Coordination of Benefits) Form**

To the best of my knowledge and belief, my statements in the requested expenses are complete and true. I am requesting reimbursements only for eligible expenses incurred during the applicable plan year for myself and my eligible dependents. **I certify that these expenses have not been and will not be reimbursed under another employer sponsored benefit plan** and will not be claimed as an income tax deduction. In addition, **I certify that these expenses have not been previously reimbursed under this plan or under any other HRA Plan**. I authorize that my plan account may be reduced by the amount of the requested reimbursement.

_____ _____/_____/_____

Employee Confirmation Signature Date of Signature

A COPY OF EACH APPLICABLE DETAILED PROCESSING EOB (EXPLANATION OF BENEFITS) MUST BE ATTACHED OR REIMBURSEMENT WILL NOT BE PAID.

Date Received by Administrator _____/_____/_____
Processing Notes:

Jefferson County Commission

Highmark WV Super Blue Plus 2010 $6,000/$12,000 Medical/RX Plan
HRA Applicable

Effective July 1, 2023

Monthly Rates:

Employee Only - $ 899.65
Employee + Spouse - $ 1,799.31
Employee + Child- $ 1,799.31
Employee + Child(ren) - $ 2,249.13
Family – $ 2,249.13

MLR rebates are used to offset current and future costs to the company and employees.

SECTION 4

ANCILLARY BENEFIT PLANS

PLACE ANCILLARY BENEFIT BROCHURES AFTER TAB 4

2023
Commission: 10%
Effective Date: 07/01/2023
Benefit Year: Calendar Year

Summary of Benefits:
Blue Edge Dental Flex

Blue Edge Dental Flex plan options provide you maximum flexibility. Benefits are paid at the same level for care received from any provider. The listed percentages represent the portion of the maximum allowable charge (MAC) for which the plan is responsible. Network providers agree to accept the MAC as payment in full and agree to file your claims. ***If you receive covered services from an out-of-network provider, the plan will apply the percentages shown to the 50th percentile for covered services and you will be responsible for the difference, up to the provider's charge.*** *Standard deductibles, exclusions and limitations apply. Network dentists may elect to discount non-covered services and services above the annual maximum. Discounts vary by service and region and when agreed to by the provider; not permitted in all jurisdictions.*

***Jefferson County Commission - Blue Edge* Dental Flex 3W (NS)**		
Network		Elite Plus
Deductible – Individual/Family (waived for In and Out-of-network Class I services)		$50 / $150
Benefit Period Maximum per member		$1,500
Class I Services		
Exams		100%
X-rays		100%
Cleanings		100%
Fluoride Treatment		100%
Sealants		100%
Space Maintainers		100%
Palliative Treatment (Emergency)		100%
Class II Services		
Basic Restorative (Fillings), Posterior Resins		80%
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		80%
Oral Surgery (including Simple and Surgical Extractions)		80%
General Anesthesia		80%
Endodontics		80%
Periodontics (Surgical and Nonsurgical)		80%
Class III Services		
Inlays, Onlays, Crowns		50%
Prosthetics (Bridges, Dentures)		50%
Orthodontics (dependents to age 19)		
Diagnostic, Active, Retention Treatment		Not Covered
Orthodontic Lifetime Maximum per covered dependent		Not Applicable
Implants		
Implant Surgery, Supported Restoration		50%
Additional Features		
☐ TMD/TMJ*	☒ Smile for Health®--Wellness	☒ Pregnancy
☐ Annual Maximum Rollover*	☒ College Tuition Benefit	☒ Preventive Incentive*
☐ Occlusal Guard*		

Insurance is provided by Highmark Blue Cross Blue Shield West Virginia, an independent licensee of the Blue Cross and Blue Shield Association. United Concordia is a separate company that administers Highmark dental benefits.

Smile for Health–Wellness is a registered service mark of United Concordia Companies, Inc.

*These features are for Large Group only. Additional fees may apply.

Jefferson County Commission

Highmark WV Dental

Effective July 1, 2023

Monthly Rates:

Employee Only - $22.44
Employee + Spouse - $ 48.66
Employee + Child- $ 48.66
Employee + Child(ren) - $ 72.96
Family – $ 72.96

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Jefferson County Commission
Effective 07/01/2015
Revised 01/01/2018
Group Number #8703

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses and contact lens evaluation/fitting once every plan year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com, or download our mobile app by searching NVA Vision, or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 8703000001 or the group number on the identification card and enter in your search parameters. It's that easy!

Schedule of Vision Benefits

Benefit Frequency	*Participating Provider*	*Non-Participating Provider*
Examination Once Every Plan Year	▪ Covered 100% After $10 copay	Reimbursed Amount ▪ Up to $35
Lenses Once Every Plan Year	Standard Glass or Plastic	
▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	▪ Covered 100%	▪ Up to $25 ▪ Up to $45 ▪ Up to $75 ▪ Up to $75
Frame Once Every Plan Year	Retail Allowance ▪ Up to $130 (20% discount off balance)*	▪ Up to $45
Contact Lenses Once Every Plan Year	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses	▪ Up to $130 Retail (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $98
Fit/Follow-Up*** Standard Daily Wear Standard Extended Wear Specialty Wear	 ▪ Covered 100% ▪ Covered 100% ▪ Covered 100% ▪ After $20 copay	 ▪ Up to $20 ▪ Up to $30 ▪ Up to $30
Medically Necessary****	▪ Covered 100%	▪ Up to $200

*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers. ***Only covered if you choose Contact Lenses. ****Pre-approval from NVA required.

Due to their everyday low prices (EDLP) the amounts listed below may not be applicable at Wal-Mart/Sam's Club.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $10 Solid Tint
- $12 Fashion / Gradient Tint
- $10 Standard Scratch-Resistant Coating
- $12 Ultraviolet Coating
- $40 Standard Anti-Reflective
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $75 Polarized
- $50 Progressive Lenses Standard
- $65 Transitions Single Vision Standard
- $70 Transitions Multi-Focal Standard
- $25 Polycarbonate (Single Vision)
- $30 Polycarbonate (Multi-Focal)
- $30 Blended Bifocal (Segment)
- $55 High Index
- $100 Progressive Lenses Premium

Fixed Pricing not available in certain states.
For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses $75 Polarized Lenses $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard $15 Standard Scratch Coating $12 UV Coating $35 Polycarbonate $45 Standard Anti-Reflective
Contact Lens Fitting:	Retail Less 10%	
Lenses:	Glass or Plastic	
Single Vision	$35.00	
Bifocal	$55.00	
Trifocal or Lenticular	$70.00	
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices (EDLP) Wal-Mart / Sam's Club stores do not provide additional discounts.

At NVA, We Work Only for Our Clients.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

Jefferson County Commission

National Vision Administrators

Effective July 1, 2023

Monthly Rates:

Employee Only - $ 6.94
Employee + Spouse - $ 11.88
Employee + Child- $ 11.88
Employee + Child(ren) - $ 18.98
Family – $ 18.98

Basic Life and AD&D Insurance

Benefit Highlights

Jefferson County Commission

What is basic life and AD&D insurance?	Your employer provides, at no cost to you, basic life and AD&D insurance in an amount equal to $50,000. Life insurance pays your beneficiary (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your basic life and AD&D insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.
Am I eligible?	You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.
When can I enroll?	As an eligible employee, you are automatically covered by basic life and AD&D insurance; you do not have to enroll. If you have not already done so, you must designate a beneficiary as described below.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
Benefit Reductions	Benefits reduce 50% at age 70. All coverage cancels at retirement.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.

AD&D Coverage	AD&D provides benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The insurance pays: • 100% of the amount of coverage you purchase in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia. • 75% for paraplegia or triplegia (paralysis of three limbs). • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand or uniplegia. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.
Can I keep my life coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group life coverage to your own individual policy (policies).
What is the Living Benefits Option?	If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your life insurance. The remaining amount of your life insurance would be paid to your beneficiary when you die.

Important Details
As is standard with most term life insurance, this insurance coverage includes certain limitations and exclusions:
- the amount of your coverage may be reduced when you reach certain ages.

AD&D insurance does not cover losses caused by or contributed by:

- sickness; disease; or any treatment for either;
- any infection, except certain ones caused by an accidental cut or wound;
- intentionally self-inflicted injury, suicide or suicide attempt;
- war or act of war, whether declared or not;
- injury sustained while in the armed forces of any country or international authority;
- taking prescription or illegal drugs unless prescribed for or administered by a licensed physician;
- injury sustained while committing or attempting to commit a felony;
- the injured person's intoxication.

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This benefit highlights sheet is an overview of the insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlights sheet and the insurance policy, the terms of the insurance policy apply.

Group Benefits from The Hartford

Supplemental Life Insurance

Benefit Highlights

Jefferson County Commission

What is supplemental life insurance?	Supplemental life insurance is coverage that you pay for. Supplemental life insurance pays your beneficiary (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your supplemental life insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.
Am I eligible?	You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.
When can I enroll?	Enrollment in supplemental life insurance begins 5/20/2015 and ends 5/21/2015.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
How much supplemental life insurance can I purchase?	You can purchase supplemental life insurance in increments of $10,000. The maximum amount you can purchase cannot be more than $100,000. Annual earnings are as defined in The Hartford's contract with your employer.
I already have supplemental life insurance coverage; do I have to do anything?	If you take no action, your coverage and coverage for your eligible dependents will automatically continue with The Hartford subject to the terms of the contract.
Am I guaranteed coverage?	This coverage is offered without requiring you to provide evidence of insurability.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.

Are there other limitations to enrollment?	If you do not enroll within 31 days of your first day of eligibility, you will be considered a late entrant. Typically, late entrants may need to show evidence of insurability and may be responsible for the cost of physical exams or other associated costs if they are required. This coverage, like most group benefit insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the insurance coverage that you have elected may not be in effect.
Spouse supplemental life insurance (includes domestic partner)	If you elect supplemental life insurance for yourself, you may choose to purchase spouse supplemental life insurance in increments of $5,000, to a maximum of $50,000. Coverage cannot exceed 50% of the amount of your employee voluntary/supplemental life insurance coverage. You may not elect coverage for your spouse if they are in active full-time military service or is already covered as an employee under this policy. If your spouse is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. If you elect an amount that exceeds the guaranteed issue amount of $50,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.
Child(ren) supplemental life insurance	If you elect supplemental life insurance for yourself, you may choose to purchase child(ren) supplemental life insurance coverage in the amount(s) of $10,000 for each child – no medical information is required. • If your dependent child(ren) is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. • Your child(ren) must be at least 15 days but not yet age 19 to be covered. • Child(ren) age 26 or older may be covered if they were disabled prior to attaining age 26.
Does my coverage reduce as I get older?	Benefits reduce 50% at age 70. All coverage cancels at retirement.
Can I keep my life coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group life coverage to your own individual policy (policies). • If you leave your employer, portability is an option that allows you to continue your life insurance coverage. To be eligible, you must terminate your employment prior to Social Security Normal Retirement Age. This option allows you to continue all or a portion of your life insurance coverage under a separate portability term policy. Portability is subject to a minimum of $5,000 and a maximum of $100,000 and does include coverage for your spouse. To elect portability, you must apply and pay the premium within 31 days of the termination of your life insurance. Evidence of insurability will not be required. Dependent spouse portability is subject to a maximum of $50,000.

What is the living benefits option?	If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your life insurance. The remaining amount of your life insurance would be paid to your beneficiary when you die.
Do I still pay my life insurance premiums if I become disabled?	If you become totally disabled before age 60 and your disability lasts for at least 9 months, your life insurance premium may be waived. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates.

Important Details
As is standard with most term life insurance, this insurance coverage includes certain limitations and exclusions:

- the amount of your coverage may be reduced when you reach certain ages.
- death by suicide (two years).

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This benefit highlights sheet is an overview of the insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlights sheet and the insurance policy, the terms of the insurance policy apply.

EMPLOYEE SUPPLEMENTAL (VOLUNTARY) LIFE - SEMI Monthly Cost

Guaranteed Issue Amount: $100,000

	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
PREMIUM RATE	**0.07**	**0.07**	**0.08**	**0.10**	**0.17**	**0.33**	**0.51**	**0.85**	**1.19**	**2.07**	**3.21**	**5.87**
$10,000	$0.35	$0.35	$0.40	$0.50	$0.85	$1.65	$2.55	$4.25	$5.95	$10.35	$16.05	$29.35
$20,000	$0.70	$0.70	$0.80	$1.00	$1.70	$3.30	$5.10	$8.50	$11.90	$20.70	$32.10	$58.70
$30,000	$1.05	$1.05	$1.20	$1.50	$2.55	$4.95	$7.65	$12.75	$17.85	$31.05	$48.15	$88.05
$40,000	$1.40	$1.40	$1.60	$2.00	$3.40	$6.60	$10.20	$17.00	$23.80	$41.40	$64.20	$117.40
$50,000	$1.75	$1.75	$2.00	$2.50	$4.25	$8.25	$12.75	$21.25	$29.75	$51.75	$80.25	$146.75
$60,000	$2.10	$2.10	$2.40	$3.00	$5.10	$9.90	$15.30	$25.50	$35.70	$62.10	$96.30	$176.10
$70,000	$2.45	$2.45	$2.80	$3.50	$5.95	$11.55	$17.85	$29.75	$41.65	$72.45	$112.35	$205.45
$80,000	$2.80	$2.80	$3.20	$4.00	$6.80	$13.20	$20.40	$34.00	$47.60	$82.80	$128.40	$234.80
$90,000	$3.15	$3.15	$3.60	$4.50	$7.65	$14.85	$22.95	$38.25	$53.55	$93.15	$144.45	$264.15
$100,000	$3.50	$3.50	$4.00	$5.00	$8.50	$16.50	$25.50	$42.50	$59.50	$103.50	$160.50	$293.50

SPOUSE SUPPLEMENTAL (VOLUNTARY) LIFE - SEMI Monthly Cost

Guaranteed Issue Amount: $50,000

**{Employee's Age}	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
PREMIUM RATE	**0.07**	**0.07**	**0.08**	**0.10**	**0.17**	**0.33**	**0.51**	**0.85**	**1.19**	**2.07**	**3.21**	**5.87**
$5,000	$0.18	$0.18	$0.20	$0.25	$0.43	$0.83	$1.28	$2.13	$2.98	$5.18	$8.03	$14.68
$10,000	$0.35	$0.35	$0.40	$0.50	$0.85	$1.65	$2.55	$4.25	$5.95	$10.35	$16.05	$29.35
$15,000	$0.53	$0.53	$0.60	$0.75	$1.28	$2.48	$3.83	$6.38	$8.93	$15.53	$24.08	$44.03
$20,000	$0.70	$0.70	$0.80	$1.00	$1.70	$3.30	$5.10	$8.50	$11.90	$20.70	$32.10	$58.70
$25,000	$0.88	$0.88	$1.00	$1.25	$2.13	$4.13	$6.38	$10.63	$14.88	$25.88	$40.13	$73.38
$30,000	$1.05	$1.05	$1.20	$1.50	$2.55	$4.95	$7.65	$12.75	$17.85	$31.05	$48.15	$88.05
$35,000	$1.23	$1.23	$1.40	$1.75	$2.98	$5.78	$8.93	$14.88	$20.83	$36.23	$56.18	$102.73
$40,000	$1.40	$1.40	$1.60	$2.00	$3.40	$6.60	$10.20	$17.00	$23.80	$41.40	$64.20	$117.40
$45,000	$1.58	$1.58	$1.80	$2.25	$3.83	$7.43	$11.48	$19.13	$26.78	$46.58	$72.23	$132.08
$50,000	$1.75	$1.75	$2.00	$2.50	$4.25	$8.25	$12.75	$21.25	$29.75	$51.75	$80.25	$146.75

CHILD SUPPLEMENTAL (VOLUNTARY) Life SEMI Monthly Cost

$10,000 Benefit Age 15 days to Age 19
{Dep to Age 26 if Full-Time Student}

$10,000	**For Child / Children**	$0.51

Jefferson County Commission

Group Life / Hartford

Effective July 1, 2023

100% Employer Paid based on individual product elected, underwriting and age

SECTION 5

ADMINISTRATION GUIDE

PLACE ALL PAGES AFTER TAB 5

RETAIN TO REFERENCE REGULATIONS AS NEEDED

What is an ERISA Wrap Summary Plan Description (SPD)?

The Summary Plan Description, or SPD, is the main vehicle for communicating plan rights and obligations to participants and beneficiaries. As the name suggests, it is a summary of the material provisions of the plan document, and it should be understandable to the average participant of the employer. However, in the context of health & welfare benefit plans, it is not uncommon for the SPD to be a combination of a complete description of the plan's terms and conditions, such as a Certificate of Coverage, and the required ERISA disclosure language. **Note: An insurance company's Master Contract, Certificate of Coverage, or Summary of Benefits is not a plan document or SPD.**

Here's the "summary" of what the ERISA SPD law requires, the actual CFR law follows. An SPD must contain all of the following information:

- The plan name
- The plan sponsor/employer's name and address
- The plan sponsor's EIN
- The plan administrator's name, address, and phone number
- Designation of any named fiduciaries, if other than the plan administrator, e.g., claim fiduciary
- The plan number for ERISA Form 5500 purposes, e.g., 501, 502, 503, etc. (Note—each ERISA plan should be assigned a unique number.)
- Type of plan or brief description of benefits, e.g., life, medical, dental, disability
- The date of the end of the plan year for maintaining the plan's fiscal records (which may be different from the insurance policy year)
- Each trustee's name, title, and address of principal place of business, if the plan has a trust
- The name and address of the plan's agent for service of legal process, along with a statement that service may be made on a plan trustee or administrator
- The type of plan administration, e.g., administered by contract, insurer, or sponsor
- Eligibility terms, e.g., classes of eligible employees, employment waiting period, and hours per week, and the effective date of participation, e.g., next day or first of the month following satisfaction of an eligibility waiting period
- How the insurer refunds (e.g., dividends, demutualization, and medical loss ratio (MLR) refunds) are allocated to participants. **Note: This is important for obtaining the small plan (<100 participants) exception for filing Form 5500.**
- The plan sponsor's amendment and termination rights and procedures, and what happens to plan assets, if any, in the event of plan termination
- A summary of any plan provisions governing the benefits, rights, and obligations of participants under the plan on termination or amendment of the plan or elimination of benefits
- A summary of any plan provisions governing the allocation and disposition of assets upon plan termination
- Claims procedures—may be furnished separately in a Certificate of Coverage, provided that the SPD explains that claims procedures are furnished automatically, without charge, in the separate document (e.g., a Certificate of Coverage), and time limits for lawsuits, if the plan imposes them

- A statement clearly identifying circumstances that may result in loss or denial of benefits (e.g., subrogation, coordination of benefits, and offset provisions)
- The standard of review for benefit decisions (We recommend consideration of granting full discretion for the plan administrator or authorized fiduciary to interpret the plan and make factual determinations.)
- ERISA model statement of participants' rights
- The sources of plan contributions, whether from employer and/or employee contributions, and the method by which they are calculated
- Interim SMMs since the SPD was adopted or last restated
- The fact that the employer is a participating employer or a member of a controlled group
- Whether the plan is maintained pursuant to one or more collective bargaining agreements, and that a copy of the agreement may be obtained upon request
- A prominent offer of assistance in a non-English language (depending on the number of participants who are literate in the same non-English language)
- Identity of the insurer(s), if any
- Additional requirements for Group Health Plan SPDs:
    - Detailed description of plan provisions and exclusions (e.g., copays, deductibles, coinsurance, eligible expenses, network provider provisions, prior authorization and utilization review requirements, dollar limits, day limits, visit limits, and the extent to which new drugs, preventive care, and medical tests and devices are covered) A link to network providers should also be provided. Plan limits, exceptions, and restrictions must be conspicuous.
    - Information regarding COBRA, HIPAA, and other federal mandates such as the Women's Health Cancer Rights Act, preexisting condition exclusion, special enrollment rules, mental health parity, coverage for adopted children, Qualified Medical Support Orders, and minimum hospital stays following childbirth.
    - Name and address of health insurer(s), if any
    - Description of the role of health insurers (i.e., whether the plan is insured by an insurance company or the insurance company is merely providing administrative services)

Recommended, but not required provisions in an SPD:

- For insured arrangements, attach the Summary of Benefits provided by the insurance companies to help ensure you have provided an understandable summary of the Certificate of Coverage
- For self-insured arrangements, provide the name, address, and phone number of any Third Party Administrator (TPA) paying claims or benefits.
- Language that in the event there is a conflict between the plan document, the SPD, and a Certificate of Insurance, which document controls

Wrap SPD Document Requirements:

Group insurance Certificates of Insurance are typically not SPDs because they do not contain all of the language required by ERISA. An employer must prepare an ERISA "Wrapper" to supplement the Certificate of Insurance. Together, the Wrapper and Certificate of Insurance comprise a proper SPD.

The Law – (Code of Federal Regulations) for which this US Code section provides rulemaking authority.

29 CFR 2520.102-3 – Contents of summary plan description.

- CFR
- Updates
- Authorities (U.S. Code)
- Rulemaking

§ 2520.102-3Contents of summary plan description.

Section 102 of the Act specifies information that must be included in the summary plan description. The summary plan description must accurately reflect the contents of the plans as of the date not earlier than 120 days prior to the date such summary plan description is disclosed. The following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraphs (j) through (n):

(a) The name of the plan, and, if different, the name by which the plan is commonly known by its participants and beneficiaries;

(b) The name and address of—

(1) In the case of a single employer plan, the employer whose employees are covered by the plan,

(2) In the case of a plan maintained by an employee organization for its members, the employee organization that maintains the plan,

(3) In the case of a collectively-bargained plan established or maintained by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, parent or most significantly employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as

(i) A statement that a complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b-1 and 2520.104b-30; or

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor’s address.

(4) In the case of a plan established or maintained by two or more employers, the association, committee, joint board of trustees, parent or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as

(i) A statement that a complete list of the employers sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b-1 and 2520.104b-30, or,

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address.

(c) The employer identification number (EIN) assigned by the Internal Revenue Service to the plan sponsor and the plan number assigned by the plan sponsor. (For further detailed explanation, see the instructions to the plan description Form EBS-1 and "Identification Numbers Under ERISA" (Publ. 1004), published jointly by DOL, IRS, and PBGC);

(d) The type of pension or welfare plan, e.g. pension plans—defined benefit, defined contribution, 401(k), cash balance, money purchase, profit sharing, ERISA section 404(c) plan, etc., and for welfare plans—group health plans, disability, pre-paid legal services, etc.

(e) The type of administration of the plan, e.g., contract administration, insurer administration, etc.;

(f) The name, business address and business telephone number of the plan administrator as that term is defined by section 3(16) of the Act;

(g) The name of the person designated as agent for service of legal process, and the address at which process may be served on such person, and in addition, a statement that service of legal process may be made upon a plan trustee or the plan administrator;

(h) The name, title and address of the principal place of business of each trustee of the plan;

(i) If a plan is maintained pursuant to one or more collective bargaining agreements, a statement that the plan is so maintained, and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b-1 and 2520.104b-30. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes;

(j) The plan's requirements respecting eligibility for participation and for benefits. The summary plan description shall describe the plan's provisions relating to eligibility to participate in the plan and the information identified in paragraphs (j)(1), (2) and (3) of this section, as appropriate.

(1) For employee pension benefit plans, it shall also include a statement describing the plan's normal retirement age, as that term is defined in section 3(24) of the Act, and a statement describing any other conditions which must be met before a participant will be eligible to receive benefits. Such plan benefits shall be described or summarized. In addition, the summary plan description shall include a description of the procedures governing qualified domestic relations order (QDRO) determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

(2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits. In the case of a welfare plan providing extensive schedules of benefits (a group health plan, for example), only a general description of such benefits is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests. In addition, the summary plan description shall include a description of the procedures governing qualified medical child support order (QMCSO) determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

(3) For employee welfare benefit plans that are group health plans, as defined in section 733(a)(1) of the Act, the summary plan description shall include a description of: any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, existing and new drugs are covered under the plan; whether, and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits on the selection of primary care providers or providers of speciality medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. In the case of plans with provider networks, the listing of providers may be furnished as a separate document that accompanies the plan's SPD, provided that the summary plan description contains a general description of the provider network and provided further that the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document.

(k) In the case of an employee pension benefit plan, a statement describing any joint and survivor benefits provided under the plan, including any requirement that an election be made as a condition to select or reject the joint and survivor annuity;

(l) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. In addition to other required information, plans must include a summary of any plan provisions governing the authority of the plan sponsors or others to terminate the plan or amend or eliminate benefits

under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated; a summary of any plan provisions governing the benefits, rights and obligations of participants and beneficiaries under the plan on termination of the plan or amendment or elimination of benefits under the plan, including, in the case of an employee pension benefit plan, a summary of any provisions relating to the accrual and the vesting of pension benefits under the plan upon termination; and a summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination. Plans also shall include a summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or on an individual account thereof, the payment of which is a condition to the receipt of benefits under the plan. The foregoing summaries shall be disclosed in accordance with the requirements under 29 CFR 2520.102-2(b).

(m) For an employee pension benefit plan the following information:

(1) If the benefits of the plan are not insured under title IV of the Act, a statement of this fact, and reason for the lack of insurance; and

(2) If the benefits of the plan are insured under title IV of the Act, a statement of this fact, a summary of the pension benefit guaranty provisions of title IV, and a statement indicating that further information on the provisions of title IV can be obtained from the plan administrator or the Pension Benefit Guaranty Corporation. The address of the PBGC shall be provided.

(3) A summary plan description for a single-employer plan will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at *http://www.pbgc.gov.*

(4) A summary plan description for a multiemployer plan will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:

Your pension benefits under this multiemployer plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. A multiemployer plan is a collectively bargained pension arrangement involving two or more unrelated employers, usually in a common industry.

Under the multiemployer plan program, the PBGC provides financial assistance through loans to plans that are insolvent. A multiemployer plan is considered insolvent if the plan is unable to pay benefits (at least equal to the PBGC's guaranteed benefit limit) when due.

The maximum benefit that the PBGC guarantees is set by law. Under the multiemployer program, the PBGC guarantee equals a participant's years of service multiplied by (1) 100% of the first $5 of the monthly benefit accrual rate and (2) 75% of the next $15. The PBGC's maximum guarantee limit is $16.25 per month times a participant's years of service. For example, the maximum annual guarantee for a retiree with 30 years of service would be $5,850.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan becomes insolvent; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law; (2) benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the earlier of: (i) The date the plan terminates or (ii) the time the plan becomes insolvent; (3) benefits that are not vested because you have not worked long enough; (4) benefits for which you have not met all of the requirements at the time the plan becomes insolvent; and (5) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street, N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at *http://www.pbgc.gov.*

(n) In the case of an employee pension benefit plan, a description and explanation of the plan provisions for determining years of service for eligibility to participate, vesting, and breaks in service, and years of participation for benefit accrual. The description shall state the service

required to accrue full benefits and the manner in which accrual of benefits is prorated for employees failing to complete full service for a year.

(o) In the case of a group health plan, within the meaning of section 607(1) of the Act, subject to the continuation coverage provisions of Part 6 of Title I of ERISA, a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning qualifying events and qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage.

(p) The sources of contributions to the plan—for example, employer, employee organization, employees—and the method by which the amount of contribution is calculated. Defined benefit pension plans may state without further explanation that the contribution is actuarially determined.

(q) The identity of any funding medium used for the accumulation of assets through which benefits are provided. The summary plan description shall identify any insurance company, trust fund, or any other institution, organization, or entity which maintains a fund on behalf of the plan or through which the plan is funded or benefits are provided. If a health insurance issuer, within the meaning of section 733(b)(2) of the Act, is responsible, in whole or in part, for the financing or administration of a group health plan, the summary plan description shall indicate the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (e.g., payment of claims) provided by the issuer.

(r) The date of the end of the year for purposes of maintaining the plan's fiscal records;

(s) The procedures governing claims for benefits (including procedures for obtaining preauthorizations, approvals, or utilization review decisions in the case of group health plan services or benefits, and procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any plan), applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of Title I of the Act). The plan's claims procedures may be furnished as a separate document that accompanies the plan's SPD, provided that the document satisfies the style and format requirements of 29 CFR 2520.102-2 and, provided further that the SPD contains a statement that the plan's claims procedures are furnished automatically, without charge, as a separate document.

(t)

(1) The statement of ERISA rights described in section 104(c) of the Act, containing the items of information applicable to the plan included in the model statement of paragraph (t)(2) of this section. Items which are not applicable to the plan are not required to be included. The statement may contain explanatory and descriptive provisions in addition to those prescribed in paragraph (t)(2) of this section. However, the style and format of the statement shall not have the effect of misleading, misinforming or failing to inform participants and beneficiaries of a plan. All such information shall be written in a manner calculated to be understood by the average plan participant, taking into account factors such as the level of comprehension and education of

typical participants in the plan and the complexity of the items required under this subparagraph to be included in the statement. Inaccurate, incomprehensible or misleading explanatory material will fail to meet the requirements of this section. The statement of ERISA rights (the model statement or a statement prepared by the plan), must appear as one consolidated statement. If a plan finds it desirable to make additional mention of certain rights elsewhere in the summary plan description, it may do so. The summary plan description may state that the statement of ERISA rights is required by Federal law and regulation.

(2) A summary plan description will be deemed to comply with the requirements of paragraph (t)(1) of this section if it includes the following statement; items of information which are not applicable to a particular plan should be deleted:

As a participant in (name of plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age * * *) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be

provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(u)

(1) For a group health plan, as defined in section 733(a)(1) of the Act, that provides maternity or newborn infant coverage, a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. If federal law applies in some areas in which the plan operates and state law applies in other areas, the statement should describe the different areas and the federal or state law requirements applicable in each.

(2) In the case of a group health plan subject to section 711 of the Act, the summary plan description will be deemed to have complied with paragraph (u)(1) of this section relating to the required description of federal law requirements if it includes the following statement in the summary plan description:

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).

(Approved by the Office of Management and Budget under control number 1210-0039)

[42 FR 37180, July 19, 1977, as amended at 62 FR 16984, Apr. 8, 1997; 62 FR 31695, June 10, 1997; 62 FR 36205, July 7, 1997; 63 FR 48375, Sept. 9, 1998; 65 FR 70241, Nov. 21, 2000; 66 FR 34994, July 2, 2001; 66 FR 36368, July 11, 2001]

Documenting Method for Identifying Full-time Employees

Beginning in 2015, the Affordable Care Act (ACA) imposes a penalty on applicable large employers (ALEs) that do not offer health insurance coverage to substantially all full-time employees and dependents. An ALE may also be subject to a penalty if it offers health insurance coverage to full-time employees and dependents, but the coverage is unaffordable or does not provide minimum value. An ALE is only liable for a penalty if one or more of its full-time employees receives a health insurance subsidy for coverage under an Exchange.

The ACA's employer penalty rules are often referred to as "employer shared responsibility" or "pay or play" rules. The pay or play rules will take effect for many ALEs on Jan. 1, 2015.

This Legislative Brief includes a brief overview of the two methods for identifying full-time employees, and it provides guidelines for documenting the method an employer decides to use. It also includes sample language for describing the look-back measurement method. This sample language, which requires customization, could be incorporated into an employer policy, health plan document or summary plan description (SPD).

METHODS FOR IDENTIFYING FULL-TIME EMPLOYEES

On Feb. 12, 2014, the Internal Revenue Service (IRS) published final regulations on the employer shared responsibility rules. The final regulations provide two methods for identifying full-time employees for purposes of offering health plan coverage and avoiding a pay or play penalty—the monthly measurement method and the look-back measurement method.

A full-time employee is an employee who was employed, on average, at least 30 hours of service per week. The final regulations treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours per service per week.

Monthly Measurement Method
The monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each calendar month. This method is not based on averaging hours of service over a prior measurement period. Month-to-month measuring may cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules, and it could result in employees moving in and out of health plan coverage on a monthly basis.

Look-back Measurement Method
To give employers flexible and workable options and greater predictability for determining full-time employee status, the IRS developed an optional look-back measurement method as an alternative to the monthly measurement method.

Under the look-back measurement method, an employer counts an employee's hours of service during one period (called a measurement period) to determine his or her full-time status for a future period (called the stability period). The details of this method are complex, and vary based

on whether the employees are ongoing or new and whether new employees are expected to work full time or are variable, seasonal or part-time employees.

Selecting a Measurement Method

In general, an employer must use the same measurement method for all employees. Thus, an employer generally cannot use the monthly measurement method for employees with predictable hours of service and the look-back measurement method for employees whose hours of service vary.

However, an employer may apply either the monthly measurement method or the look-back measurement method to the following groups of employees:

- Each group of collectively bargained employees covered by a separate bargaining agreement;
- Salaried and hourly employees;
- Employees whose primary places of employment are in different states; and
- Collectively bargained and non-collectively bargained employees.

DOCUMENTING MEASUREMENT METHODS

Pay or Play Penalty Disputes

The final regulations from the IRS do not require ALEs to document the measurement method they use for identifying full-time employee status and determining when employees are eligible for coverage. Also, the Internal Revenue Code (Code) Section 6056 reporting requirement for ALEs does not require employers to report on the method used for determining full-time employee status.

> Key Point:
> Although the IRS does not require employers to document their measurement method, maintaining a description of the selected measurement method and a record of the method's outcomes for individual employees may help an ALE demonstrate its compliance with the shared responsibility rules and avoid a pay or play penalty.
>
> For instance, if the IRS notifies an ALE of its potential liability for a penalty because an employee received a health insurance subsidy, the employer will want to have documentation showing that either the employee was offered health coverage that meets the ACA's standards, or the ALE was not required to offer coverage because the employee did not have full-time status.

ERISA Compliance

Most employer-sponsored health plans are subject to ERISA, a broad federal law that sets minimum standards for employee benefit plans. Among other requirements, ERISA requires health plans to:

- Be "established and maintained pursuant to a written instrument" that enables employees to determine their rights and obligations under the plan. In other words, ERISA requires health plans to have a plan document. For insured health plans, the plan document typically consists of the insurance policy or contract that describes the plan's benefits and

a "Wrap" document that includes other ERISA-required information, such as the plan's eligibility rules.
- Provide participants with a summary plan description (SPD) that describes important plan information, including the plan's eligibility rules. The SPD must be written in a manner calculated to be understood by the average plan participant.

Also, a summary of material modifications (SMM) is required any time there is a material change in the terms of the plan or any change in the information that is required to be included in the SPD.

Key Point:
To comply with ERISA, the health plan's plan document and SPD must describe the plan's eligibility requirements. This description should include the measurement method the employer uses to determine employees' full-time status. The SPD's description of the measurement method should explain how an individual can determine if he or she is eligible under the plan in a way that is understandable to the average participant and not overly complex.

Also, if a plan changes its eligibility rules (for example, by adopting the look-back measurement method), the plan sponsor should distribute either an SMM or an updated SPD to explain the revised rules to participants.

The summary of benefits and coverage (SBC) is not required to include health plan eligibility information. Thus, the SBC does not need to include information about the plan's measurement method for determining full-time employee status.

ACTION STEPS
Once an ALE decides which measurement method it will use for determining employees' full-time status, it should consider taking the following steps:

- Document the selected method and how it will be implemented. For example, if an employer selects the look-back measurement method, employers should document the length of the measurement, stability and administrative periods for groups of employees. This documentation could be included in a separate policy.

- Establish a method for keeping records on outcomes for individual employees (that is, whether an employee qualifies as a full-time employee who is eligible for coverage under the selected measurement method). For employers that use the look-back measurement method, this may be part of an employee tracking tool used by the employer.

- Update the plan document and SPD to include information about the measurement method. A plan sponsor should either distribute an SMM or an updated SPD to explain the revised eligibility rules to participants.