



BENEFITS GUIDE

A Benefits Guide
For Jefferson County
Employees

Effective January 1, 2016

Jefferson County
Risk Management Department

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This booklet highlights the main features of many of the benefit plans sponsored by Jefferson County. Full details of these benefits are contained in the legal documents governing the plans. If there is any discrepancy or conflict between the plan documents and the information presented here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Jefferson County reserves the right to change or discontinue the plans at any time. Participation in the plans does not constitute an employment contract. Jefferson County reserves the right to modify, amend, or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time.

OUR BENEFITS PROGRAM

Jefferson County offers a comprehensive, cost-effective, and competitive benefits package to help protect you and your family, but it works only if you take control and make thoughtful decisions about your benefits.

In other words, **you** need to take an active role in choosing your benefit coverage. This way, you can be sure your benefits support your needs and goals.

To help you make your benefit choices, Jefferson County gives you several tools, including this *Benefits Guide* booklet, other informational materials, and enrollment forms. Use these tools to make your benefit decisions. Then, **enroll before your deadline** so you can get the maximum value from these plans and programs for yourself and your family.

BENEFIT OPTIONS AT A GLANCE

Medical (Self Insured and Administered by Cigna)

- PPO Plan (In-Network Benefits Only)

Vision (Self Insured and Administered by Cigna)

- PPO Plan

Dental (Self Insured and Administered by Cigna)

- Basic Dental Plan
- High Dental Plan

Life Insurance (through The Standard)

- Basic Employee Life Insurance
- Employee Supplemental Life Insurance and Dependent Life Insurance

Accidental Death & Dismemberment Insurance (through The Standard)

- Basic Employee Accidental Death and Dismemberment (AD&D) Insurance
- Voluntary Accidental Death and Dismemberment (AD&D) Insurance

Flexible Spending Accounts (administered by Cigna)

- Health Care Account (up to \$2,500 per year)
- Dependent Care Account (up to \$5,000 per year)

Long Term Disability Insurance (LTD) (through Reliance)

Additional Benefits

- Employee Health Office
- 457 Deferred Compensation Plan
- Employee Assistance Program

It's time to think about your benefit needs and enroll for the benefits that will meet those needs.

Jefferson County offers a wide range of benefit options and the chance to make new decisions each year.

POINTS YOU NEED TO KNOW

- If you are a newly eligible employee, you can enroll in Jefferson County's benefit plans on your first day of employment. You have a deadline of 30 days to enroll for benefits.
- If you have a special enrollment event during the year, you may make changes in some benefit areas. You must make the benefit change within 30 days of the special enrollment event. See page 6 for more information.
- In each benefit area, you choose from a number of options. This lets you decide if you want coverage and how much coverage you and your family need.
- Some benefit plans require a contribution from you. This guide shows your costs in each benefit area on page 5.
- Each year during annual enrollment, you have the opportunity to make changes for the upcoming year. If you do not make changes to your coverage during annual enrollment, your coverage will typically remain the same from year-to-year. **The primary exception is if you want to continue participating in one or both of the Flexible Spending Accounts. You MUST re-enroll each year if you want to participate in these accounts. Your elections do not automatically carry over.**
- It's a good idea to keep this booklet throughout the year in the event you need to refer back to it for coverage information.

ENROLLMENT INSTRUCTIONS

1. Review Your Benefits

Read this booklet and the other benefit materials thoroughly – they describe Jefferson County’s benefits program.

2. Consider Your Choices Carefully

You have 30 days from your date of hire to enroll. After your enrollment period ends, you cannot change your benefits except at Annual Enrollment or if you have a special enrollment event.

3. Getting Ready to Enroll

It may help to have these items handy:

- Social security numbers and birth dates for yourself and your eligible family members (birth certificates and marriage license for dependents on the Health Plan).
- Information about other benefit coverage or insurance you or a family member may have.
- Beneficiary designation information, so you can properly identify your beneficiaries for your life insurance coverage.
- Out-of-pocket expense records for your medical, dental, vision, and dependent care so you can plan your Flexible Spending Account contribution amounts.

4. Enroll

- Go to the online Benefits Enrollment Center to enroll: <https://www.benefitsinsight.com>
- See Page 25 for more information on completing the online enrollment process.

5. Be Alert!

- Check your first paycheck after your benefits effective date to confirm that your payroll deductions are correct.
- Report any discrepancies or paycheck problems immediately to the Risk Management Department.

**Enrollment
Questions?**

Benefit Questions?

**Access the Risk
Management
website at
[http://co.jefferson
.tx.us/riskman/RM
Index.htm](http://co.jefferson.tx.us/riskman/RMIndex.htm)**

**or
Contact the Risk
Management Dept.
at 835-8672.**

BENEFIT COSTS

PAYING FOR YOUR BENEFITS

Jefferson County pays a portion of the overall cost for your benefits. The amount you pay will depend on the choices you make.

Cost of Coverage

Coverage	Cost per Pay Period
Medical/Vision Plan	
Employee Only	\$0.00
Employee + Spouse	\$127.54
Employee + Child	\$100.56
Family	\$160.57
Dental Plan Basic	
Employee Only	\$0.00
Employee + Spouse	\$8.56
Employee + Child	\$8.56
Family	\$17.48
Dental Plan High	
Employee Only	\$3.85
Employee + Spouse	\$17.36
Employee + Child	\$17.36
Family	\$35.00
Basic Employee Life & AD&D at one time your annual salary	Paid by Jefferson County
Supplemental Employee Life	Age Banded Rates
Supplemental Spouse Life	Age Banded Rates
Supplemental Child Life	\$1.00 per month
Supplemental Employee AD&D	\$0.03 per \$1,000
Supplemental Spouse/Child AD&D	\$0.04 per \$1,000
Long Term Disability	See Premium Table

About Deductions

Your deductions for medical, dental, and flexible spending are made on a pre-tax basis. This reduces your taxable income and saves on federal and social security taxes.

Your deductions for supplemental life insurance and LTD (if any) are made on an after-tax basis. This way, any benefits paid will not be subject to income taxes when received.

WHO IS ELIGIBLE

Employee Eligibility

If you are a regular, full time employee, you are eligible to enroll in Jefferson County's benefit program during your first 30 days of continuous employment or during Annual Enrollment time.

Dependent Eligibility

In most cases, you may also cover your eligible dependents, including:

- **Your legal spouse.**
- **Children** under age 26

"Children" is defined as your natural children, stepchildren, legally adopted children, and children under your legal guardianship. If your child is no longer eligible, you must remove the child from your benefit coverage through the online Benefits Enrollment Center in order for your payroll deduction to cease.

- **Physically or mentally disabled children** of any age who are incapable of self-support. Proof of disability may be requested and disability has to have occurred prior to age 26.
- **Unmarried Grandchildren** younger than 26 years of age, who reside with, and are federal income tax dependents of, the covered employee.

Adding Dependents to Your Coverage

To add a new spouse or child to your benefit coverage, you must add the dependent through the online Benefits Enrollment Center within 30 days of the marriage/birth/adoption/change along with providing the required supporting documentation (marriage license, birth certificate, etc.).

Important note: Newborns are NOT automatically added to your coverage under Jefferson County's benefit plans. You must enroll the newborn within 30 days of the birth.

If your child becomes ineligible for coverage, you must remove the child from your benefit coverage through the online Benefits Enrollment Center in order to change your payroll deductions.

CHANGING YOUR CHOICES

Jefferson County gives you an opportunity to change your benefit choices during Annual Enrollment each year. (Annual enrollment usually occurs each fall.)

Once you have made your enrollment choices, you generally cannot change them during the year. However, you may make certain changes if you have a special enrollment event that affects your benefits. Typical special enrollment events include:

- **Marriage**
- **Divorce**
- **Birth or adoption of a child**
- **Death of a spouse or other eligible dependent**
- **Enrollment in (or loss of) state or federal medical coverage**
- **A change in your spouse's employment**
- **A child no longer qualifies due to age**

You must make any special enrollment benefit changes in the online Benefits Enrollment Center and submit the required supporting documentation (birth certificate, marriage license, divorce papers, etc.) within 30 days of the special enrollment event. If you wait longer than 30 days, you will not be allowed to make any coverage changes until the next annual enrollment – per IRS regulations.

If you have a special enrollment event, you must make the benefit change and provide the supporting documentation (birth certificate, marriage license, divorce decree, etc.) within 30 days of the event.

MEDICAL COVERAGE

Your medical coverage will become effective on your 91st day of employment. Jefferson County offers a PPO plan administered by Cigna. The plan is self-insured which means, there is no insurance company’s money paying for our claims – we pay our own claims with our funds. The plan covers a wide variety of medical services, including office visits, prescription drugs, and inpatient and outpatient care.

Preferred Provider Organization (PPO) Plan

Our medical plan is a PPO medical plan, with only in-network benefits (there are no out-of-network benefits).

If you choose to receive care from a non-network provider, medical benefits are not payable (there is an exception for Emergency Care).

Our PPO Network is **Cigna’s Open Access Plus In-Network**. To find out if a provider is in-network call 1-800-CIGNA24 or go on-line to www.Cigna.com. For medical pre-certification call CIGNA at 1-800-CIGNA24.

After you are enrolled in the medical plan, you may register for www.myCigna.com - your online home for assessment tools, plan management, medical updates and much more.

Visit myCigna – you can:

- Find personal plan and claim information.
- Print a temporary ID card or request a new one.
- Get health care information.
- Track total charges and what you pay out-of-pocket.
- Search for plan-specific providers.
- Access quality and cost information for certain procedures, test, and surgeries.

The next several pages summarize Jefferson County’s medical plan. Please review these summaries carefully.

The medical plan network of participating providers changes frequently. To see the most current list of PPO network providers, go online to search for Doctor or Facility at www.Cigna.com or at www.myCigna.com .

What You Pay & What the Plan Pays

	In-Network Only
Annual Deductible Individual Family – <i>family deductible is cumulative</i>	\$750 \$2,250
Annual Out-Of-Pocket Co-Insurance Maximum Individual Family	\$2,500 \$4,500
Medical Lifetime Maximum	
Physician Office Visit <i>Including injections</i>	80% after Deductible
Diagnostic X-rays & Laboratory	80% after Deductible
Preferred Laboratory test provided by preferred laboratory*	100% Deductible waived
Preventive Care & Well Child Care <i>includes routine x-ray & labs</i>	100% Deductible waived
Inpatient Services at Other Health Care Facilities) <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities; 180 days combined max per year</i>	80% after Deductible
Organ Transplant <i>must be pre-certified; includes all medically appropriate, non-experimental transplants</i>	100% at Lifesource center, otherwise 80% after plan deductible
<i>Travel Services Max – only available for Lifesource facilities</i>	\$10,000

* Both LabCorp and Quest Diagnostics are preferred laboratories.

PLAN SUMMARY

Inpatient Hospital Confinement <i>Must be pre-certified</i> Semi-Private Room General nursing, operating room, anesthesia, medications Intensive care or cardiac care unit Physician & surgeon fees	80% after Deductible
Emergency Room	*\$250 co-pay, then 80%, *waived if admitted
Physical, Occupational, and Speech Therapy <i>Outpatient - 60 days combined max per calendar year</i>	80% after Deductible
Durable Medical Equipment	80% after Deductible
Chiropractic Services <i>- 25 days combined max per calendar year</i>	80% after deductible
Prosthetic Appliances and Orthoptic Devices	80% after deductible
Outpatient Surgery <i>Must be pre-certified</i>	80% after deductible
Home Health Care <i>(includes outpatient private duty nursing when approved as medically necessary)40 days max per calendar year</i>	80% after deductible
Ambulance Services	80% after deductible
Chemotherapy, Radiation, & Inhalation Therapy	80% after deductible
All Other Eligible Charges	80% after deductible
Mental Health and Substance Abuse (Combined) Inpatient - 120 days combined max per calendar year Outpatient – 30 visits combined max per calendar year Outpatient Group Therapy – 30 visits combined max per calendar year	80% after Deductible
Mental Health and Substance Abuse Intensive Outpatient	80% after Deductible

Prescription Drug Coverage

Prescription drug benefits are provided by Cigna. You have the choice of purchasing your prescriptions through retail pharmacies for a 34-day supply or through a mail order program for a 90-day supply.

Retail Prescription Program

The retail prescription program utilizes a network of participating pharmacies. To receive the benefit level, you must use a Cigna Provider Network Pharmacy. Prescriptions you fill at non-participating pharmacies are not covered.

Copays	Retail 30 Day Supply
\$0 Copay Generic Drugs*	\$0
Over-the-Counter Drugs**	\$2
Generic	<i>The greater of: \$10 or 20%</i>
Preferred Brand	<i>The greater of: \$25 or 30%</i>
Non-Preferred Brand	<i>The greater of: \$50 or 40%</i>

*Generic statins for high cholesterol and generic oral anti-diabetic medication.

**Prilosec 20 mg, Prevacid 24hr, Zegerid, Nexium 20 mg, Claritin, Allegra, Zyrtec, Flonase, and Nasacort are covered by the Plan for a \$2 co-pay for a 28-30 day supply with a written prescription from your doctor indicating OTC on the prescription. You must present the OTC prescription to the pharmacist for filling through the Cigna System.

HOME DELIVERY PHARMACY

The Cigna Home Delivery Pharmacy program can be used for medication that you take on a regular basis (maintenance medication). The Home Delivery Pharmacy program provides up to a 90-day supply (specialty drugs are a 30-day supply). If you are interested in using the Cigna Home Delivery Pharmacy, go to Cigna’s website at www.myCigna.com to enroll.

Copays	Mail Order
Generic	\$20
Preferred Brand	\$85
Non-Preferred Brand	\$160
Specialty	\$60 Copay with a 30-day supply limit Must be filled through Cigna Specialty Pharmacy

VISION COVERAGE

In order to participate in the Vision Coverage, you must be enrolled in the Medical Coverage. Your vision coverage will become effective on your 91st day of employment.

The vision plan is a Standard PPO Exam Only Plan and covers an annual vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses.

Cigna Vision			
Standard PPO Exam Only Plan			
Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period**
Exam Copay	\$0	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100%	Up to \$45	12 months
**Your Frequency Period begins on January 1 (Calendar year basis)			

Vision Network Savings Program:

When you see a Cigna Vision Network Eye Care Professional, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

DENTAL COVERAGE

Your dental coverage will become effective your 91st day of employment. Jefferson County's dental plan is administered by Cigna. The plan is self-insured; which means, there is no insurance company's money paying for our claims – we pay our own claims with our funds.

When you or a covered family member needs dental care, you can visit the dentist of your choice (there is no network requirement). However, if you utilize a dentist in the Cigna Dental PPO network, you will pay less for covered services.

You also have the choice of two dental plans, a Basic Plan and a High Plan. If you enroll your dependents in the dental plan, they must participate in the same plan that you are enrolled in.

Note: If you enroll in the Basic Plan and at a later time, wish to enroll in the High Plan, major services and orthodontia will not be covered for the first 12 months you are on the high plan.

BASIC DENTAL SUMMARY

Feature	Benefit Level
Preventative Services Oral Examinations Cleaning Fluoride Application X-rays	100% Deductible waived
Basic Services Fillings Oral Surgery – Simple Extractions Space Maintainers (limited to non orthodontic treatment) Emergency Care to Relieve Pain Repairs - Dentures Endodontics Periodontics Relines, Rebases, and Adjustments	80% After deductible
Major Services	0%
Orthodontia	0%
Calendar-year Deductible individual/family	\$50 / \$150
Annual Maximum Excludes orthodontic services	\$1,500

HIGH DENTAL SUMMARY

Feature	Benefit Level
Preventative Services Oral Examinations Cleaning Fluoride Application X-rays	100% Deductible waived
Basic Services Fillings Oral Surgery – Simple Extractions Space Maintainers (limited to non orthodontic treatment) Emergency Care to Relieve Pain Repairs - Dentures Endodontics Periodontics Relines, Rebases, and Adjustments	80% After deductible
*Major Services Crowns Inlays and onlays Repairs – Bridges, Crowns and Inlays Dentures Bridges	50% After deductible
*Orthodontia Adult and child lifetime maximum	50% \$1,500
Calendar-year Deductible individual/family	\$50 / \$150
Annual Maximum Excludes orthodontic services	\$1,500

Note: If you enroll in the Basic Plan and at a later time, wish to enroll in the High Plan, major services and orthodontia will not be covered for the first 12 months you are on the high plan.

*Limitations: Late Entrant – if you elect the coverage more than 30 days after you become eligible or you again elect it, after you cancel your coverage.

EMPLOYEE HEALTH CLINIC

Jefferson County has an Employee Health Clinic, which is free of charge to all employees and dependents enrolled in the County's group medical plan.

The Employee Health program is managed by a family nurse practitioner and two nurses. They provide a variety of service including health screenings and physicals. If problems are identified, you will be given information regarding management of the problem(s) and asked to follow-up with your family physician. They manage a host of minor acute problems such as upper respiratory infections, sinusitis, bronchitis, as well as acute muscular pain and injuries. They do not manage chronic health problems such as diabetes, hypertension, or mental illness.

The Employee Health program is designed to educate employees and implement programs to keep our employees healthy. Keep in mind that there are limits to the services they provide and they are not there to replace your physician. The Employee Health Clinic feels it is important for children under the age of two to be followed by a pediatrician; therefore, they do not schedule appointments for children under the age of two.

Their office is located at 1225 Pearl, Suite 146A, on the first floor of Annex I, in Beaumont. The office hours are Monday – Friday, 8:30 a.m. – 4:30 p.m. Please call to make an appointment; their phone number is (409) 784-5881. If you have to leave a message, include what the problem is as well as your full name and the phone number where you may be reached.

BASIC LIFE INSURANCE

Jefferson County provides basic life insurance for all eligible employees at no cost. Standard Life Insurance administers the life insurance plan, which is designed to provide financial protection to your beneficiaries in the event of your death.

Company-Provided Benefits

For...	Coverage	Paid By
All Employees	1 times your annual benefit base salary	Jefferson County

Beneficiary Designation

You MUST designate a beneficiary for your life insurance and AD&D benefits when you become eligible for coverage. Your “beneficiary” is the person (or people, estate, trust, etc.) who will receive your life insurance benefits if you die.

- You may change your beneficiary at any time by contacting the Risk Management Department in writing.
- If you do not name a beneficiary, or if your beneficiary dies before you, benefits will be paid to your estate.

Reductions Due to Age

Your basic life insurance coverage can be reduced depending on your age:

- **At age 65** – your life insurance will be 65% of the coverage amount you had prior to age 65.
- **At age 70** – your life insurance will be 50% of the coverage amount you had prior to age 65.

AD&D INSURANCE

Jefferson County provides Accidental Death and Dismemberment Insurance for all eligible employees at no cost. Standard Life Insurance also administers this plan.

For...	Coverage	Paid By
All Employees	1 times your annual benefit base salary	Jefferson County

As part of the company-provided life insurance benefit, Jefferson County also provides Emergency Travel Assistance Services through MEDEX Travel Assist.

Some key benefits include: emergency medical and personal assistance while traveling more than 100 miles away from home and immediate access to doctors, hospitals, pharmacies and certain other services in a medical-related emergency –24 hours a day, 365 days a year.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) let you save taxes on the money you spend for out-of-pocket health care or dependent care expenses. The FSAs are administered by Cigna.

If you enroll, you choose an annual amount you want to contribute. Your contributions are taken from the first two paychecks of each month throughout the year and deposited in your account. Since this money is taken out of your check *before* you pay taxes, you pay less taxes. After you pay an eligible expense, you submit a claim and are reimbursed with the pre-tax dollars from your account or through the automatic reimbursement feature offered by CIGNA.

There are two types of FSAs: the Health Care Account and the Dependent Care Account. You can choose to participate in only one of the accounts, both of the accounts or neither one.

To be eligible, you must incur the expenses during the plan year (January 1 through December 31). However, you have a spend-down period until March 15 of the following year to incur Health Care expenses for the prior plan year. You will have until March 31 of the following year to submit claims for reimbursement.

The elections you make to the health care and dependent care FSAs will remain in effect until December 31 of the plan year. You cannot change or stop your deductions during the year unless you have a special enrollment event (see page 7).

Health Care FSA

The Health Care Account is used to pay for eligible out-of-pocket expenses, such as:

- Deductibles and copays for medical, dental, or vision coverage
- Retail and mail-order prescription copays
- Certain over-the-counter medicines, with doctor's prescription
- Any IRS deductible expense not covered by a health plan

Annual Contribution Amount

The maximum amount you can contribute to this account is \$2,500 per year.

The Internal Revenue Service has a "use-it-or-lose-it" rule for these accounts. This means you must use up your contributions during the year you make them. You can't "roll over" unused amounts to cover next year's expenses.

Health Care FSA Worksheet

Use the worksheet below to estimate your annual out-of-pocket medical/dental/vision/hearing expenses.

ELIGIBLE HEALTH CARE EXPENSES	Estimated Expenses
Medical plan deductibles	\$
Dental plan deductibles	\$
Out-of-pocket medical expenses	\$
Out-of-pocket dental expenses	\$
Eye care expenses - exams, contacts, glasses	\$
Prescription co-pays/coinsurance expenses	\$
Approved over-the-counter medication expenses, with doctor's prescription	\$
Other eligible health care expenses	\$
Annual Total*	\$

FSA deposits are taken from your paycheck. Remember that your pay is reduced each of the first two paychecks of each month to fund your contribution amount.

*Divide your total estimated annual expenses by 24 pay periods, if you are estimating during annual enrollment. If you become eligible to begin contributions during the year, divide by the number of pay periods remaining in the year. Note: Deductions for flexible spending only occur on the first and second pay periods of the month and deduction amounts must be an even dollar amount.

DEPENDENT CARE ACCOUNTS/DAYCARE

The Dependent Care Account can reimburse your eligible day care expenses for a dependent who lives with you, and who is under age 13 (or disabled and any age). You must claim this person as a dependent on your income tax return.

What Is Covered?

You may be reimbursed only for care that enables you to work or look for work on a full-time basis. You can't be reimbursed for care provided by your spouse, your child under age 19, or someone you claim as a dependent.

Annual Contribution Amount

The maximum amount you can contribute to the Dependent Care FSA is \$5,000 (\$2,500 if you are married and file separate tax returns).

Filing Claims for Reimbursement

When you file a Dependent Care FSA claim, you are only reimbursed up to the amount in your account at the time you file your claim. For instance, if you have incurred \$300 in expenses, but you have only \$200 in your account, you will be reimbursed only \$200.

FSA or Tax Credit?

A child-care tax credit is available on your federal income tax return. Expenses you pay through the Dependent Care FSA reduce the tax credit you may claim. If you earn less than \$25,000, you may benefit more by using the tax credit. Ask a tax advisor which is better for you.

Dependent Care Account Worksheet

Weekly cost of care	\$
Times the number of weeks your dependents receive day care	x
Annual total*	

*Divide your total estimated annual expenses by 24 pay periods, if you are estimating during annual enrollment. If you become eligible to begin contributions during the year, divide by the number of pay periods remaining in the year. Note: Deductions for flexible spending only occur on the first and second pay periods of the month and deduction amounts must be an even dollar amount

For a more complete list of eligible FSA expenses, go to www.irs.gov.

Jefferson County offers a number of additional benefits for employees, many of which are described in the following pages. If you need more details on any of these programs, contact the Risk Management Department.

SUPPLEMENTAL LIFE INSURANCE

Jefferson County provides Basic Life coverage at 1 times your Base Annual Earnings. You may also apply for Additional Life coverage to supplement your Basic Life Amount.

Employee Coverage Amount

You may elect Supplemental Life coverage in units of \$10,000, from \$10,000 up to a maximum of \$400,000.

All late applications and requests for coverage increases are also subject to medical underwriting approval. Employees can increase coverage at Annual Enrollment by \$10,000 without medical underwriting.

Spouse Coverage Amount

This coverage is available in units of \$5,000, from \$10,000 up to a maximum of \$250,000, but not to exceed 100% of your combined Basic and Supplemental Life coverage if elected at any time other than your hire date.

If you elect an amount for your spouse greater than \$25,000 at the time of your hire date, the excess will be subject to medical underwriting approval. All late applications and request for coverage increases will also require medical underwriting approval. You may increase coverage at Annual Enrollment by \$5,000 without medical underwriting.

Coverage Amount for Children

You may elect Dependent Life Insurance for your eligible children in units of \$2,500, from \$2,500 up to \$10,000. The amount may not exceed 100% of your combined Basic and Supplemental Life coverage. All late applications will be subject to medical underwriting approval.

For additional information see The Standard's Additional Life Coverage Highlights in your new hire packet.

AD&D INSURANCE

Jefferson County gives you the option of purchasing accidental death and dismemberment (AD&D) insurance for yourself, your spouse, and your dependent children. This insurance plan is also administered by Standard Life.

You pay for the cost of AD&D insurance through payroll deductions on an after-tax basis.

The benefit amount you receive if you or your dependents die or become injured as a result of an accident varies according to the type of loss you incur.

You may buy AD&D insurance for you and your eligible dependents, as follows:

Benefit	Coverage
Employee AD&D Insurance	\$10,000 increments, up to \$400,000 maximum
Spouse AD&D Insurance	50% of employee's AD&D coverage in effect 40% of employee's AD&D coverage in effect if Spouse & Child are covered
Child AD&D Insurance*	10% of employee's AD&D coverage in effect 5% of employee's AD&D coverage in effect if Spouse & Child are covered

*For your unmarried children who are under age 26

You are automatically the beneficiary for any dependent AD&D coverage you elect.

LONG TERM DISABILITY

Long Term Disability Insurance pays a benefit for a disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration. There is a 90 day elimination period and the maximum benefit duration is age 65 or Social Security Normal Retirement Age.

You can choose the amount of income you want to insure up to 60% of your earnings. Amounts of coverage available: a minimum of \$500 per month up to \$6,000 per month (in \$100 increments).

For more information, see the Reliance Standard Disability Income Protection Insurance handout in your new hire packet.

COMPASS HEALTHPRO ADVISER

Jefferson County provides The Compass HealthPro to Cigna medical plan participants. This is a free service to help you make informed, cost-effective health care choices. You are enrolled automatically if you are enrolled in the Cigna medical plan.

Think of Compass as your personal healthcare concierge service. Here's how they can support you:

- Compare cost for the treatment/procedure your doctor is recommending and provide you with other lower cost choices for the same care
- Unlimited access to a healthcare expert who will talk with your physician to get complete information for you
- Unbiased in-network doctor recommendations based on your specifications and review of doctor credentials
- Hospitals and quality information
- Bill reconciliation support
- Money-saving information and cost comparisons
- General health care guidance

When you need support and information to help you make smart healthcare decisions, call The Compass HealthPro at 1-800-513-1667.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Jefferson County provides all employees with *Total Life Assistance* tools. They are designed to help you and your family members successfully manage life's challenges by identifying options and making informed decisions.

Issues commonly addressed through your EAP benefit include:

- Family conflict – divorce, custody, blended family, domestic violence issues
- Grief – accidents, illness, victim of crime, loss of a loved one
- Changes at home, work, or school – relocation, job stress, interpersonal problems, empty nest, aging parents
- Personal growth – interpersonal skills (relationship and/or communication) for work or family
- Dependence or codependence issues – alcohol, drugs, gambling

Assistance for short-term problems may be provided under the EAP. If a problem is long-term, please consult your CIGNA medical plan.

Your EAP is a completely FREE and CONFIDENTIAL source of assistance. The services provided are:

- Counseling Services
- Legal Services
- Financial Services
- Online Work/Life and Wellness Resources

For more detailed information, please refer to the EAP pamphlets in your new-hire packet.

457 DEFERRED COMPENSATION RETIREMENT ACCOUNT

In addition to the TCDRS Retirement Plan, all full-time employees may also choose to set up a separate, supplemental account earmarked for retirement. Much like the TCDRS Retirement Plan, you have the option to defer paying taxes on the amounts you contribute—as well as any earnings on those amounts—until you receive an account distribution. This is a voluntary plan, funded entirely by your contributions.

Contact the Payroll Department if you are interested in enrolling.

HOW TO MAKE CHANGES & ENROLL

Go Online

Using any computer with Internet access, go to

www.benefitsinsight.com

- Click on **REGISTER NOW**

Employee Verification

- Enter your Social Security Number
- Enter your Date of Birth
- Enter your Zip Code
- Click on **SAVE & CONTINUE>**

Choose your User Name/Password

- Follow the prompts to set-up your User Name, Password & Security Question
- Click on **SAVE & CONTINUE>**

Add/Update Personal and Family Information

- Confirm your personal and family profile

NOTE: You must furnish Social Security numbers for all enrolled dependents.

Choose Your Benefits

- Follow the prompts to add or update your benefits

Complete Your Enrollment

- Review your Benefits Selection. If you are satisfied with your elections, click “**Submit Your Selections**”
- **Print your Confirmation** (Click “View Your Benefit Selections as a PDF”) for your records. This is a summary of your elections and not a guarantee of coverage.
- **Be sure to submit all required documentation (birth certificates, marriage license, etc.) to the Risk Management Department.**

**WORKERS' COMPENSATION
NOTIFICATION FORM**

TO: ALL JEFFERSON COUNTY EMPLOYEES

Jefferson County has workers' compensation coverage through Tristar Risk Management to protect you. The County has a program, which covers all employees including full-time, part-time, and temporary for any job-related injury, illness, or occupational disease.

You can get more information about your worker's compensation rights from any local Division office or by calling 1-800-252-7031.

You may elect to retain your common law right of action, if no later than five days after beginning employment, or within five days after receiving written notice from Jefferson County that Jefferson County has obtained workers' compensation insurance coverage, you notify Jefferson County in writing that you wish to retain your common law right to recover damages from personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured.

**HIPAA
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY
ACT OF 1996**

Notice to Members of the Southeast Texas Government Employee Benefits Pool

Federal law gives the Plan sponsor of a non-federal governmental plan the right to exempt the Plan in whole or in part from the requirements described below. Therefore, Jefferson County, Plan sponsor for the Southeast Texas Government Employee Benefits Pool, has elected to exercise its option as a non-federal governmental Plan to be exempt from these provisions of the "Health Insurance Portability Act" (HIPAA):

- Standards relating to benefits for mothers and newborns (section 2704 of PHS Act).
- Parity in the application of certain limits to mental health benefits (section 2705 of the PHS Act).

Notwithstanding an election to be exempt from the requirements above, Jefferson County, as Sponsor of a non-federal governmental Plan, must provide for certification and disclosure of creditable coverage under the Plan with respect to participants and their Dependents in accordance with Section 45CFR 146.115.

HIPAA NOTICE OF PRIVACY PRACTICES

Our Responsibilities

We are required by federal and state law to maintain the privacy of your protected health information. “Protected health information” (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this guide.

Uses and Disclosures of Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or other health care provider providing treatment to you. We may use or disclose your PHI to a physician or other health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility of coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Health care operations include the business functions conducted by a health plan. These activities may include providing customer services, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the plan sponsor of a group health plan.

We may also in our health care operations disclose PHI to business associates (a person or entity who performs or assists us with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules) with whom we have written agreements containing terms to protect the privacy of your PHI.

We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, case management and care coordination, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

Personal Representative: We will disclose your PHI to your personal representative when properly designated by you and documented to us through a written authorization.

Disaster Relief: We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health Related Services: We may use your PHI to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. We may use or disclose your PHI to encourage you to

purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA-regulated product or activity, and to employers regarding work-related illness or injury as required by law;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To avert a serious threat to health or safety;
- To the military and to federal officials for lawful intelligence, counter-intelligence, and national security activities;
- To correction institutions regarding inmates; and
- As authorized by and to the extent necessary to comply with state workers' compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- To coroners, medical examiners, and funeral directors;
- To an organ procurement organization;
- In connection with certain research activities;
- In connection with marketing purposes;
- For the sale of PHI; and
- Other uses and disclosures not described in this notice.

Use and Disclosure of Certain Types of Medical Information. For certain types of PHI we may be required to protect your privacy in ways more strict than discussed in this notice. We must abide by the following rules for use or disclosure of certain types of PHI:

- *Communicable Disease Test Results.* We may not disclose the result of any communicable disease test, unless the disclosure is required by law or the disclosure is to you, your

personal representative, a physician or other person who ordered the test, or a health care worker who has a legitimate need to know the results of the test for safety purposes, or pursuant to an authorization signed by you.

- *HIV Test Results.* We may not disclose the result of any HIV test unless required by law or the disclosure is to you, your personal representative, a physician or other person who ordered the test, or a health care worker who has a legitimate need to know the results of the test for safety purposes, or pursuant to an authorization signed by you providing us permission to disclose to an insurance medical information exchange, a reinsurer, or to our attorneys.
- *Genetic Information.* We may not disclose genetic information unless the disclosure is authorized under state or federal criminal law and the disclosure relates to identifying an individual in the course of a criminal or judicial proceeding; is required under specific order of a state or federal court; is authorized under state or federal law to establish paternity; is made to a blood relative of a decedent for purposes of medical diagnosis; or is made to identify a decedent. We are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.
- *Status as Victim of Family Violence.* We may not disclose your status as a victim of family violence unless the disclosure is to you; to a physician or health care provider for the provision of health care services; to a licensed physician designated by you; as required by law or pursuant to an order of the Texas Insurance Commissioner or a court order; to our attorneys; or when necessary for our payment and health care operations if to a reinsurer, or to a medical and claims personnel we contract with, providing we cannot without undue hardship first segregate the medical information in a way that does not disclose your status as a victim of family violence.
- *Mental Health Information.* We may not disclose your mental health information except for the same purposes for which we received the information or as may be required by law. Most uses and disclosures of psychotherapy notes (where appropriate), require authorization.
- *Confidential Communications from a Physician.* We may not disclose confidential information about you that we receive

from a physician for any purpose other than for which we received the information or as may be required by law.

- *Medical Information We Receive While Performing Utilization Review.* If we collect or receive your medical information while performing utilization review activities, we may not disclose that information unless the disclosure is required by law or to an individual or entity that we have contracted with to aid us in performing utilization review.

Individual Rights

You may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

Access: You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. A “designated record set” contains records we maintain such as enrollment, claims processing, and case management records. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI and may obtain a request form from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Disclosure Accounting: You have the right to receive a list of instances since April 14, 2003 in which we or our business associates disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fee structure at your request. Affected individuals have a right to be notified following a breach of unsecured PHI.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you want amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting the Jefferson County Risk Management Office.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services (see information at its Web site: www.hhs.gov or , if you request, we will provide you with the address to file your complaint.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

COBRA

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

This information is being provided to you at this time because you have recently become, or you are about to become, covered under a group health plan being maintained by the plan administrator. A group health plan includes any medical, dental, vision, health FSA or any other plan that provides medical care. For simplicity, any such health plan is referred to in this notice as the "Plan." This notice generally explains health insurance continuation coverage, when it may become available, and what you need to do to protect the right to receive it. It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents. If you have any questions about Plan information or your rights to continuing your health insurance in the future, please contact the plan administrator listed below.

In addition, the notice contains some general information about other health insurance options if you lose your group health insurance with the plan administrator. You may be eligible to buy an individual plan through the **Health Insurance Marketplace** or enroll in another group health plan through special enrollment procedures. This alternative coverage may or may not be less expensive than health insurance continuation coverage.

Different Address? A single notice is being provided, since based upon information provided by you to the Plan Administrator, all individuals live at the same address. If there is a plan participant whose legal residence is not the above address, immediately provide written notification to the plan administrator with the additional address so a separate notice can be sent to them as well. A failure on your part to notify can result in a loss of continuation coverage rights. Should you add additional dependent children in the future, notice to the covered employee and spouse at this time will be deemed notification to the newly covered dependent.

What Is Health Insurance Continuation Coverage - The right to health insurance continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Should you lose your health insurance in the future because of one of the below listed qualifying events, covered employees and covered family members (called qualified beneficiaries) will be offered the opportunity for a temporary extension of health coverage (called "Continuation Coverage) at group rates which you will be required to pay. This notice is intended to inform all plan participants, in a summary fashion only of your potential future options and obligations under the continuation coverage provisions of federal law. Should an actual qualifying event occur in the future, you will be provided additional information and the appropriate election notice at that time. **Please take special note, however, of your notification obligations and procedures, which are highlighted in this notification!**

Qualifying Events For Covered Employee * - If you are the covered employee, you will become a qualified beneficiary and have the right to elect health insurance continuation coverage **if** you lose your health coverage because of a termination of your employment (for any reason other than gross misconduct on your part), or any reduction in your hours of employment.

Qualifying Events For Covered Spouse * - If you are the covered spouse of an employee, you will become a qualified beneficiary and have the right to elect health plan continuation coverage for yourself **if** you lose health coverage because of any of the following reasons:

1. A termination of your spouse's employment for (any reason other than gross misconduct on the employee's part) or any reduction in your spouse's hours of employment;
2. The death of your spouse;
3. Divorce, or if applicable, legal separation from your spouse; or
4. Your spouse becomes enrolled in Medicare benefits (Part A, Part B, or both).

Under federal law, the term "spouse" includes a person you are married to (same or opposite sex) and the marriage is recognized by the state in which you reside. In some cases a Plan may allow a "domestic partner" to be covered by the Plan, if they lose health insurance as a result of one of the above listed events, the individual will not be offered the opportunity to continue health insurance as an individual qualified beneficiary.

Qualifying Events For Covered Dependent Children * - If you are the covered dependent child of an employee, you will become a qualified beneficiary and have the right to elect continuation coverage for yourself if you lose group health coverage because of any of the following reasons:

1. A voluntary or involuntary termination of the employee's employment (for any reason other than gross misconduct on the employee's part) or any reduction in the employee's hours of employment;
2. The death of the employee;
3. Parent's divorce or, if applicable, legal separation;
4. The employee becomes enrolled in Medicare benefits (Part A, Part B, or both); or
5. You cease to be eligible for coverage as a "dependent child" under the terms of the group health plan.

*Rights similar to those described above may apply to covered retirees, and their covered spouses, and dependents if the plan administrator commences a bankruptcy proceeding under title 11 of the United States code and these individuals lose coverage within one year of or one year after the bankruptcy filing.

Employer Notification Responsibilities: If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare benefits (Part A, Part B, or both), or if retiree coverage is provided a commencement of a bankruptcy proceeding, the employer must notify the Plan Administrator of the qualifying event within a maximum period of 30 days. Once notified, the plan administrator will then notify you of your continuation coverage rights within 14 days. If the employer is also the plan administrator, then you will receive notice within a maximum period of 44 days from the date of the qualifying event.

**IMPORTANT EMPLOYEE/COVERED DEPENDENT NOTIFICATION RESPONSIBILITIES!
60 DAYS TO NOTIFY OF A DIVORCE OR A DEPENDENT CHILDREN CEASING TO BE A DEPENDENT**

Under Plan rules and COBRA law, the employee, spouse, or other family member must notify the Plan Administrator of a divorce, legal separation, or a dependent child losing dependent status under the plan. To protect your continuation coverage rights in these two situations, notification of a qualifying event must be made within a maximum period of 60 days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event.

Notification procedures are provided below to assist you in making proper and timely notice. A specific form **NOTIFICATION OF A COBRA QUALIFYING EVENT** is included and is to be used as part of your notification procedures. Use of the form removes any uncertainty about how to comply with the plans requirements. You must provide this form to the Benefits Department Jefferson County.

1. Completely fill out the **NOTIFICATION OF A QUALIFYING EVENT** form.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event.
4. Mail the notification form and documentation to the address listed on the form and document your mailing.
5. Call the Plan Administrator within 10 days to verify the notification form has been received.

Any individual who is either the covered employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary may provide the notice, and notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

If this notification is not completed according to the outlined procedures and within the required 60 day notification period, the individual will be notified they have forfeited their health insurance continuation coverage rights. In addition, keeping an individual covered by the health plan beyond what is allowed by the plan will be considered insurance fraud on the part of the employee. **NO LATE NOTIFICATIONS WILL BE ACCEPTED!**

How is continuation coverage provided? - Once the plan administrator learns a qualifying event has occurred, the administrator will notify qualified beneficiaries of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights, so for example, a covered employee may elect health insurance coverage on behalf of their spouse, and parents may elect on behalf of their children. More specific information regarding the maximum 60 day election period will be provided to the qualified beneficiary at the time of the qualifying event. If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the health insurance, plus a 2% administration fee. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well. **NO LATE ELECTIONS WILL BE ACCEPTED!**

Length Of Continuation Coverage - 18 or 24 Months. If the event causing the loss of coverage is a voluntary termination or involuntary termination of employment (other than for reasons of gross misconduct) or any reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for a maximum period of 18 months. If you are a reservist and are called to active duty, each qualified beneficiary will have the opportunity to continue coverage for a maximum period of 24 months. Exception: If you are participating in a health flexible spending account (FSA) at the time of the qualifying event, you will only be allowed to continue the health flexible spending account until the end of the current plan year in which the qualifying event occurs.

There are three ways in which the 18 or 24 month period of continuation coverage can be extended.

Social Security Disability Extension - The 18 or 24 months of continuation coverage can be extended to a maximum of 29 months, for all qualified beneficiaries if the

Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act. The disability would have to have started at some time prior to the date of the qualifying event or within the first 60 days of continuation coverage and must last until the end of the 18 or 24 month period of continuation coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination within 60 days after the date of determination and before the original 18 or 24 months expire. It will be the qualified beneficiary's responsibility to notify the plan administrator of a second event. Procedures for making proper and timely notice the Plan Administrator of a social security disability will be detailed in the election notice when a qualifying event occurs. **NO LATE NOTIFICATIONS WILL BE ACCEPTED!**

Secondary Event Extension - Another extension of the 18 or above mentioned 29 month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second qualifying event takes place such as a divorce, legal separation, death, Medicare entitlement (under Part A, Part B, or both), or a dependent child ceasing to be a dependent. A second event can only occur if the second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Continuation coverage will be extended to a maximum 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. It will be the qualified beneficiary's responsibility to notify the plan administrator of a second event. Procedures for making proper and timely notice of a second event will be detailed in the election notice when a qualifying event occurs.

Special Medicare Entitlement Rule For Dependents Only - If the employee is entitled to Medicare benefits prior to the date of the original 18-month qualifying event, then the dependent qualified beneficiaries are eligible for the 18 months of continuation coverage, or 36 months measured from the date of the Medicare entitlement, whichever is greater. For example, if a covered employee becomes entitled to Medicare eight (8) months prior to the date on which employment terminates, the dependent qualified beneficiaries will be offered 28 months of continuation coverage ($36 - 8 = 28$).

Length Of Continuation Coverage - 36 Months. If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child, then each dependent qualified beneficiary will have the opportunity to continue coverage for a maximum 36 months from the date of the qualifying event.

Cancellation Of Continuation Coverage

Continuation coverage will end before the expiration of the 18, 29 or 36 month continuation period for any of the following reasons:

1. Jefferson County ceases to provide and group health plan to any of its employees.
2. Any required premium for continuation coverage is not paid in a timely manner as described.
3. A qualified beneficiary becomes, after the date of election, covered under any other group health plan, not maintained by the employer.
4. A qualified beneficiary becomes, after the date of election, entitled to Medicare benefits (under Part A, Part B, or both).
5. A qualified beneficiary notifies SETGEBP/Jefferson County Risk Management they wish to cancel continuation coverage.

6. For cause, on the same basis that the plan eliminates for cause the coverage of similarly situated non-COBRA participants.

Eligibility, Premiums, And Potential Conversion Rights - A qualified beneficiary must have been actually covered by the plan on the day before the event to be eligible for continuation coverage. A qualified beneficiary will be required to pay the full premium equal to 100% plus a 2% administration charge. At the end of the 18, 24, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual conversion health if an individual conversion plan is available at that time.

SPECIAL RIGHT TO ENROLL IN THE HEALTH INSURANCE MARKETPLACE OR WITH ANOTHER EMPLOYER SPONSORED GROUP HEALTH PLAN

Upon the occurrence of a qualifying event, there will be another health insurance coverage options available for you at that time. First, you will be able to buy individual health insurance through the **Health Insurance Marketplace** without a pre-existing condition limitation or exclusion. In the Marketplace, you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll and purchase a plan. In addition, you could be eligible for a new tax credit that lowers your monthly premiums right away.

60 Day Marketplace Enrollment Period: You must enroll in an individual plan through the Marketplace within 60 days of the exhaustion of your health insurance continuation coverage as indicated above. A failure on your part to enroll within this 60 day period may result in you having to wait until the next Marketplace open enrollment period which will not begin until November 15, 2014 and going without health insurance until that time. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov or call **1-800-318-2596**.

30 Day Enrollment In Another Group Health Plan: Secondly, upon exhaustion of your health insurance continuation coverage, you may qualify for a special enrollment opportunity for another group health plan sponsored by another employer for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. This special enrollment period also lasts for 30 days from the exhaustion of your continuation coverage. If you are eligible for another employer sponsored group health plan, please contact their benefits department immediately for plan information and procedures for enrollment. One of these options may cost less than health insurance continuation coverage with the plan administrator.

Notification Of Address Change - In order to protect your health insurance continuation coverage rights and to insure all covered individuals receive information properly and efficiently, you are required to provide written notice to the Benefits Department of Plan Administrator of any address change as soon as possible. Failure on your part to do so will result in delayed notifications or a loss of continuation coverage options.

Any Questions? - This notice is a summary of your potential future continuation coverage options only and not a description of your actual health plan or full COBRA rights. For any health plan questions, you should review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area. Addresses and phone numbers

of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa. Should you have any continuation coverage questions regarding the information contained in this or any future notice, you should contact the parties listed below. Keep in mind the information below may change between the time you become covered by the Plan and the time of a qualifying event.

Insurance Plan Information

This notice does not provide any information regarding actual health plan benefits. For actual plan coverage information such as deductibles, co-pays, and eligible expenses, contact each individual insurance carrier. Please refer to your insurance card(s) for telephone numbers and plan/group numbers.

Health Plan Administrator:

Southeast Texas Government Employee Benefits Pool/
Jefferson County Risk Management
215 Franklin Street, Suite 202
Beaumont TX 77701



Important Notice from Jefferson County About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Jefferson County** has determined that the prescription drug coverage offered by the **SETGEBP** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **Jefferson County** coverage **will** be affected.

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

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

You should also know that if you drop or lose your current coverage with **Jefferson County** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not

Starting January 1, 2006, prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Jefferson County** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the **Medicare & You** handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 09/08/15
Name of Entity/Sender: Jefferson County
Contact – Position/Office: Risk Management
Address: 215 Franklin, Suite 202, Beaumont, TX 77701
Phone Number: (409) 835-8672

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Jefferson County Risk Management..

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Jefferson County		4. Employer Identification Number (EIN) 74-6000291	
6. Employer Address 215 Franklin Street, Suite 202		7. Employer Phone Number 409-835-8672	
8. City Beaumont	9. State Texas	10. Zip 77701	
11. Who can we contact about employee health coverage at this job? Jefferson County Risk Management			
12. Phone Number (if different from above)		12. Email Address kisaacs@co.jefferson.tx.us	

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

As your employer, we offer a health plan to:

- All employees.
- Some employees: Eligible employees are: full-time Employees

With respect to dependents:

- We do offer coverage. Eligible dependents are:
 - your lawful spouse; and
 - any child of yours who is:
 - less than 26 years old.
 - 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan or while covered as a dependent under a prior plan with no break in coverage.

Proof of the child's condition and dependence must be submitted within 31 days after the date the child ceases to qualify above.

- We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

CONTACT INFORMATION

PHONE NUMBERS, WEB ADDRESSES

The following list of contacts, telephone numbers and web site addresses may be helpful throughout the plan year:

COVERAGE	ADMINISTRATOR	PHONE/WEB SITE
Jefferson County Employee Benefits	Jefferson County Risk Management	409-835-8672 www.co.jefferson.tx.us
Cigna Medical, Prescription Drug Plan & Dental	Cigna	1-800-CIGNA24 24 hours a day, 7 days a week www.Cigna.com before enrollment www.myCigna.com after enrollment
Cigna Vision	Cigna	1-877-478-7557 www.Cigna.com before enrollment www.myCigna.com after enrollment
Life & AD&D Insurance Plans	Jefferson County Risk Management (for Standard Insurance)	409-835-8672
Long Term Disability	Jefferson County Risk Management (for Reliance Standard)	409-835-8672
Flexible Spending Accounts	CIGNA	1-800-CIGNA24 24 hours a day, 7 days a week www.Cigna.com before enrollment www.myCigna.com after enrollment
Employee Assistance Program	Interface EAP	1-800-324-4327 www.4eap.com
COMPASS HealthPro Adviser	COMPASS	1-800-513-1667
457 Deferred Compensation	Nationwide Retirement Solutions	1-877-677-3678