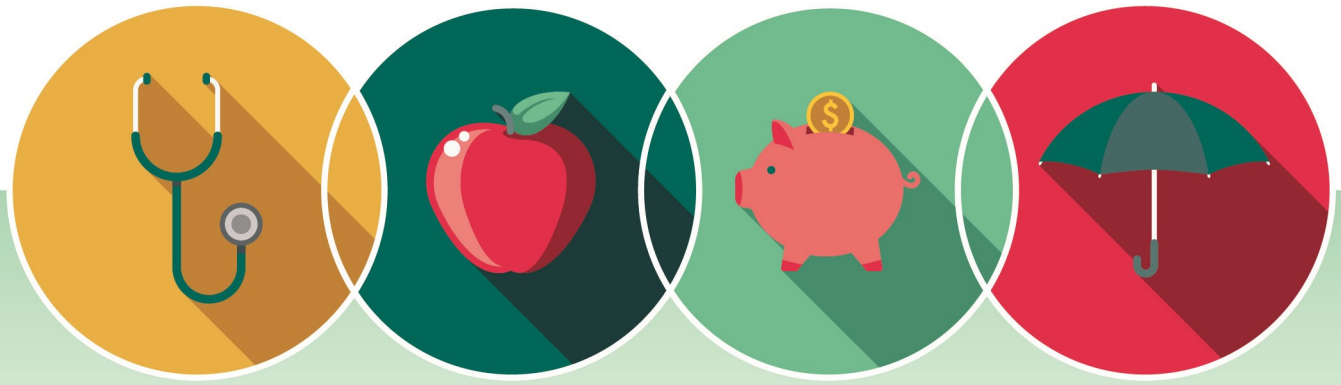
2022 Annual Enrollment

Benefits Guide



Health • Financial • Work-Life

October 15—29, 2021

Welcome

Annual Enrollment is the only opportunity you have to make changes to your 2022 Benefit Plans, unless you have a qualifying event. This guide provides an overview of Jefferson County's benefits and the changes effective January 1, 2022, so be sure to review all the benefits offered and carefully make your elections to ensure you and/or your family have the coverage you need. There will be no Annual Enrollment Meetings held this year.

Enrollment

Re-enrolling in coverage during Annual Enrollment is optional. However, it is important to review your current elections and your eligible dependents. It is your responsibility to remove a dependent who no longer meets eligibility requirements (divorced spouse, child attained age 26, etc.). Please note the following:

- **If you take no action by October 29, 2021,** you and your dependents will receive the same medical, dental, life insurance and long term disability insurance benefits you had in 2021.
- **To make FSA contributions in 2022**, you MUST make a new election. Your per paycheck deduction ***must*** be an even dollar amount (no cents) or your enrollment will reject when it uploads to UHC.
- **Adding new dependents** will require supporting documentation to show proof of eligibility before enrollment in 2022 plans.
- **To make changes**, follow the instructions on this page of the guide. Once you have elected your 2022 benefits, review your elections and print, or save, your confirmation to verify your enrollment. Be sure to submit your supporting documentation if you are adding dependents.
- **Changes made during Annual Enrollment** are effective January 1 - December 31, 2022.
- Annual Enrollment meetings will not be held this year, so please read this guide and go to the Risk Management page of the County website for full benefits information.

What's Changing for 2022?

- Medical Premiums are increasing
- UHC OnlinEnroll Benefits Portal has been updated
- New United Healthcare (UHC) Medical ID cards will be mailed out the first of the year

How to Make Changes

You must make changes through the UHC OnlinEnroll benefits portal. Be prepared to submit supporting documentation for adding dependents, such as a marriage license, birth certificate, etc. by October 29, 2021.

1. Access **OnlinEnroll** through the JC Risk Management page of the County website, click on the OnlinEnroll Quick Link at the bottom of the home page.
2. Your Username = the first letter of your first name, followed by your last name, then the first four digits of your Social Security Number and the last four digits of your Social Security Number.
3. Your Password = first five digits of your Social Security Number (passwords are reset each year at Annual Enrollment).
4. You must enter the Company Name: **Jefferson County**.
5. Be sure to Print or Save your confirmation statement and submit your dependent documentation.

Inside

Enrollment

Go to http://www.co.jefferson.tx.us/riskman/RMIndex.htm Follow the instructions under How to make Changes and be sure to print or save your confirmation statement and submit your dependent supporting documentation by the enrollment deadline.

Medical Plan

Medical coverage will continue with United Healthcare (UHC).

IMPORTANT — Freestanding ER Copay

After you meet your plan deductible, you'd pay a $500 copay plus 20% coinsurance for a single visit to a freestanding ER. You also have a separate Out-of-Pocket Max of $2,000 (this is in addition to the $3,000 individual Out-of-Pocket Max). If you need to be admitted to the hospital and have to be transported, you would incur additional costs versus going straight to a hospital-based ER.

However, the copay for care in a hospital-based ER is $250.

- **Use the ER wisely**—Visit the ER for ***life-threatening emergencies only***
- **Go to the right place for care—**Use urgent care or walk-in clinics for non-life-threatening emergencies
- **Use the UHC myNurseLine**—Call the 24-hour Nurse Line at 1-888-567-4659 to get guidance from a trained nurse if you are not sure where to go for care
- **Have a Virtual Visit with a board-certified physician 24/7**—Schedule a Virtual Visit on **myuhc.com** for **$0** copay
- **Use the Employee Health Clinic**—Call and schedule an appointment with the Employee Health Clinic for **$0** copay

What's a Freestanding ER?

- Freestanding ERs aren't typically in-network. Freestanding ERs usually aren't affiliated with a hospital; they are often owned by independent groups or individuals.
- Because they're not contracted with UHC, you're not protected by a negotiated rate like you are if you use a hospital-affiliated ER that is in-network.

How can you tell it's a Freestanding ER?

- Freestanding ERs aren't attached to hospitals and are required by law to have the word "Emergency" in their signage.

UHC Virtual Visits

A Virtual Visit lets you see & talk with a doctor from your laptop or mobile device. You have access to a network of Virtual Visit provider groups. Log in to **myuhc.com** or the United Healthcare Health4Me App. Once you choose a Virtual Visit provider group, you'll be directed to their website or app to access care.

Virtual Visits are covered under the plan at 100% .

UHC myNurseLine

Call the member number on your UHC Medical ID card to speak with an experienced registered nurse at no cost to you. They will provide personalized information that is right for you. Needs they can help with include:

- Choosing appropriate medical care
- Finding a doctor, hospital, or specialist is in your network

MyUHC.com

Myuhc.com helps you maximize your benefits and easily find many health care answers. Use it to:

- Check claims & account balances
- Review your benefits and who is covered
- Print a temporary ID card or request a replacement card
- Estimate cost

UnitedHealthcare App

Download the UnitedHealthcare App on your smart phone. With the UnitedHealthcare App you can:

- Find nearby care and pricing
- Video chat with a doctor 24/7 — without leaving the app
- View & share ID cards
- Estimate procedure cost

UHC Advocate4Me

This is a team of people dedicated to helping you. From understanding your claims to estimating costs ahead of time, they're there to help. How they can support you:

- Help with determining if a treatment is covered
- Help with understanding your claims
- Help with estimating costs for procedures
- Help with understanding your benefits
- Help with finding a doctor or facility

UHC Real Appeal

Real Appeal is a digital weight loss program customized to what works for you.

- Free to members enrolled in UHC Medical
- Weekly online group sessions with a Transformation Coach
- One full year of weight loss support
- A Success Kit containing step-by-step guides, workout DVDs, gear, recipes, and more, comes after your first group session
- Enroll at: enroll.realappeal.com

Medical Plan

Following is a high-level overview of the coverage available and what you pay. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Medical Benefits	UHC PPO In-Network Only
Deductible (per calendar year)	
Individual / Family	$750 / $2,250
Out-of-Pocket Maximum (per calendar year)	
Individual / Family	$3,000 / $5,500
Covered Services	
Employee Health Clinic	$0
On-Site Neuromuscular Program (NCS)	$0
Doctor Virtual Visit	$0
Office Visits (physician/specialist)	Deductible then 20%
Routine Preventive Care	No charge
Outpatient Diagnostic (lab/X-ray)	Deductible then 20% (Preferred Lab paid at 100%)
Complex Imaging	Deductible then 20%
Ambulance	Deductible then 20%
Emergency Room	$250 copay for Hospital ER / $500 copay for Free Standing ER, Deductible then 20% ($2,000 ER Copay Maximum)
Urgent Care Facility	$100 copay
Inpatient Hospital Stay	Deductible then 20%
Outpatient Surgery	Deductible then 20%

Express Scripts Prescription Drug

Prescription Drug coverage will continue through Express Scripts. Visit www.ExpressScripts.com to learn more about the plan.

Drug Type	Retail 30 Day Supply	Retail 90 Day Supply	Express Scripts Mail Order
$0 Copay Generic Drugs	$0 copay for generic statins and generic oral anti-diabetic drugs		
Over-the-Counter Drugs	$2	$6	$6
Generic	The greater of: $10 or 20%	The greater of: $30 or 20%	$20
Preferred Brand	The greater of: $25 or 30%	The greater of: $70 or 30%	$85
Non-Preferred Brand	The greater of: $50 or 40%	The greater of: $130 or 40%	$160
Specialty	$60 Copay with a 30-day supply limit. Must be filled through Express Scripts Specialty Pharmacy, Accredo.		

The plan covers **OTC Nasal Sprays: Flonase Allergy OTC, Nasacort Allergy 24HR and Rhinocourt OTC; **Non-sedating Antihistamines**: Allegra, Claratin, Xyzal Allergy & Zyrtec; **Proton Pump Inhibitors**: Nexium 24 hr, Prevacid 24 hr, Prilosec OTC and Zegerid OTC. Your prescription must state "OTC" for the drugs to be covered for $2 copay. **Mandatory Generic**—If you or your provider request a brand drug when a generic is available, you will pay the brand copay plus the cost difference between the brand & generic.*

Dental Plans

You have a choice between two different dental plans with United HealthCare*. Following is a high-level overview of the coverage available and what you pay.

Key Dental Benefits	Basic Dental	High Dental
Deductible (per calendar year)		
Individual / Family	$50 / $150	$50 / $150
Benefit Maximum (per calendar year; Preventive, Basic, and Major Services combined)		
Per Individual	$1,500	$1,500
Covered Services		
Preventive Services	No charge	No charge
Basic Services	Deductible then 20%	Deductible then 20%
Major Services	Not Covered	Deductible then 50%
Orthodontia	Not Covered	Deductible then 50%; $1,500 Max. Benefit

* Neither plan requires you to use an in-network provider; however, If you use an in-network provider, you will receive a greater discount for services.

Vision Plan

A Vision Plan is provided at no additional cost for those members enrolled in the UHC Medical Plan.

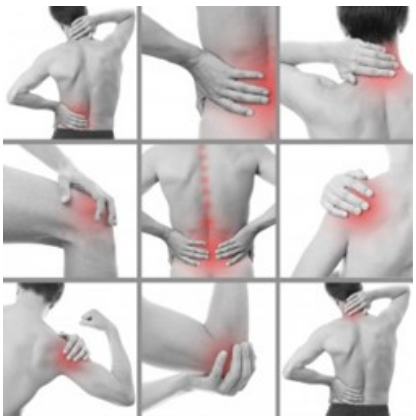
The **Vision Plan is a separate network from the medical network.** The vision plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the Vision network.

Following is a high-level overview of the coverage available.

Key Vision Benefits	In-Network	Out-of-Network Reimbursement
Exam Copay (once yearly)	$0	N/A
Exam Allowance	Covered 100%	Up to $52

NCS Musculoskeletal Program

NCS can resolve most problems in less than 4 treatment sessions (sessions are 15 minutes). Treatment is done by a board certified chiropractor, at an onsite County location, and is free to employees and their dependents (MUST be enrolled in the UHC Medical Plan in order to participate).



NCS can treat the following:

Sciatica	Hip Pain	Elbow Pain	Leg Pain	Back Pain	Foot Pain
Shoulder Pain	Ankle Pain	Knee Pain	Neck Pain	Wrist Pain	Other Pain

Make an appointment at:

- www.nmcsonline.com/SETGEBP
- Select “Create New Account” and complete the on-screen form
- Select “Appointment” and choose your preferred location/date/time and make a minimum of 4 appointments (appointments cannot be on consecutive days)
- Questions? Contact NCS at 817-380-4183

Flexible Spending Accounts

You have an opportunity to participate in up to two different flexible spending accounts (FSAs) administered through UHC. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

Health Care FSA

For 2022, you may contribute up to $2,750 to cover qualified health care expenses incurred by you, your spouse and your children up to age 26. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Prescriptions
- Dental treatment
- Orthodontia
- Eye exams/eyeglasses
- Lasik eye surgery

For a complete list of eligible expenses, visit **www.irs.gov/pub/irs-pdf/p502.pdf**.

Note: Your payroll deductions for FSA must be an even dollar amount.

Dependent Care FSA

For 2022, you may contribute up to $5,000 (per family) to cover eligible dependent care expenses ($2,500 if you and your spouse file separate tax returns). Some qualified expenses include:

- Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers
- Care of a household member who is physically or mentally incapable of caring for him/herself and qualifies as your federal tax dependent

For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p503.pdf.

Note: Your payroll deductions for FSA must be an even dollar amount.

FSA Rules

YOU MUST ENROLL EACH YEAR TO PARTICIPATE

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

Health care FSA: Unused funds from one year, can carry over to the following year, but must be used by March 15th. Carryover funds will not count against or offset the amount that you can contribute annually.

Dependent care FSA: Unused funds will NOT be returned to you or carried over to the following year.

You can incur health care expenses through March 15, 2023, and must file claims by March 31, 2023.

Life and AD&D Insurance

Life/AD&D Insurance

Life Insurance provides your named beneficiary(ies) with a benefit in the event of your death.

Accidental Death and Dismemberment (AD&D) Insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot, or eye). In the event that your death occurs due to a covered accident, both the Life and the AD&D benefit would be payable.

Basic Life/AD&D (Company-paid)

This benefit is provided at NO COST to you through Standard Insurance.

Benefit Amount	1 times your base salary, up to a $100,000 maximum

Supplemental Life/AD&D (Employee-paid)

If you determine you need more than the basic coverage, you may purchase additional coverage for yourself and your eligible family members.

Benefit Option		Guaranteed Issue*
Employee	$10,000 increments; minimum of $10,000 up to $400,000	$150,000
Spouse	$5,000 increments; minimum of $10,000 up to $250,000 (not to exceed 100% of your basic and additional life coverage)	$25,000
Child(ren)	Under age 26 - Up to $10,000	$10,000

*During Annual Enrollment, you may increase your Supplemental Life amount by $10,000 ($5,000 for your spouse) up to the Guaranteed Issue amount without providing Evidence of Insurability (EOI). If EOI is required, you must submit the form to Standard Insurance (do NOT submit to Risk Management).

Disability Insurance

Long Term Disability (LTD) insurance provides benefits that replace part of your lost income when you become unable to work due to a covered injury.

Long-Term Disability	
Benefits begin…..	After 90 days of disability
The plan pays…...	Up to 60% of your monthly earnings Limit: $6,000/monthly
Benefits generally continue….	Until your disability ends or you reach age 65 or Social Security Retirement Age

If you are increasing your benefit amount or enrolling for the first time, you must complete an Evidence of Insurability form and submit it to Reliance Standard (do NOT submit to Risk Management).

Special Enrollment

After declining health coverage—If you are declining enrollment for yourself or your dependents (including spouses) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependent's coverage ends (or after the employer stops contributing to the other coverage).

New Dependents—If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Government Programs—You may be able to enroll yourself or your dependents in this plan if:

- You or your dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
- You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined.

If you have a special enrollment event and want to enroll in health coverage, contact Risk Management at 409-835-8672, Option #1.

Cost of Benefits

Medical	Total Monthly Premium	Monthly County Pays	Monthly Employee Pays	Employee Payroll Deduction
Employee Only	$755.40	$755.40	$0.00	$0.00
Employee & Spouse	$1,737.90	$1,378.90	$359.00	$165.69
Employee & Children	$1,530.09	$1,247.04	$283.05	$130.64
Employee & Family	$1,992.42	$1,540.47	$451.95	$208.59

Basic Dental	Total Monthly Premium	Monthly County Pays	Monthly Employee Pays	Employee Payroll Deduction
Employee Only	$20.62	$20.62	$0.00	$0.00
Employee & Spouse	$43.11	$20.62	$22.49	$10.38
Employee & Children	$43.11	$20.62	$22.49	$10.38
Employee & Family	$66.58	$20.62	$45.96	$21.21

High Dental	Total Monthly Premium	Monthly County Pays	Monthly Employee Pays	Employee Payroll Deduction
Employee Only	$30.72	$20.62	$10.10	$4.66
Employee & Spouse	$66.23	$20.62	$45.61	$21.05
Employee & Children	$66.23	$20.62	$45.61	$21.05
Employee & Family	$112.60	$20.62	$91.98	$42.45

Medicare Part D Notice of Credible Coverage

Important Notice from Southeast Texas Government Employee Benefits Pool About Your Prescription Drug Coverage and Medicare

This notice applies to members who are eligible for Medicare benefits and who are participating in the Southeast Texas Government Employee Benefits Pool (SETGEBP) Health Plan.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SETGEBP and prescription drug coverage available for people who are eligible for Medicare. An individual generally becomes eligible for Medicare at age 65, so if you are covered by a SETGEBP Health Plan for individuals over age 65, this notice applies to you. Individuals also can become eligible for Medicare due to disability or end-stage renal disease. So, if you are covered under a SETGEBP Health Plan for active employees or for retirees under age 65, it is possible that you or a dependent may become eligible for Medicare for one of these reasons, in which case, this notice will also apply to you.

This notice explains the options available to Medicare-eligible individuals under Medicare prescription drug coverage. If you or a dependent is eligible for Medicare, this notice can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help making decisions about your prescription drug coverage.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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.

SETGEBP has determined that the prescription drug coverage offered by the SETGEBP Health Plan for all plan participants, on average, is expected to pay out as much as the standard Medicare prescription drug coverage will pay. This means that the coverage is considered “Creditable Coverage”.

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

If you are currently eligible for Medicare, you should compare your current SETGEBP Health Plan coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. You should also note what happens to your SETGEBP Health Plan coverage if you choose to enroll in a Medicare prescription drug plan:

If you are an active employee and you decide to enroll in a Medicare prescription drug plan and drop your SETGEBP Health Plan prescription drug coverage, you and your dependents may not be able to re-enroll in the SETGEBP Health Plan coverage until the next annual enrollment period.

If you are a retiree and you decide to enroll in a Medicare prescription drug plan and drop your SETGEBP Health Plan prescription drug coverage, you and your dependents will not be able to re-enroll in the SETGEBP Health Plan coverage in the future..

Also, note that under the SETGEBP Health Plan you are automatically enrolled for prescription drug coverage if you are enrolled for medical coverage. You cannot drop the prescription drug coverage unless you also drop medical coverage. Please contact SETGEBP for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with your SETGEBP Health Plan and don’t enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You’ll have to pay this higher premium as long as you have Medicare prescription drug coverage.

In addition, you may have to wait until the following November to enroll. For more information about this notice or your current prescription drug coverage, call the person listed below.

You will receive this notice annually and at other times in the future, for example if your SETEGBP Plan prescription drug coverage changes. You also may request a copy of the notice. More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Eligible individuals usually receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

Visit www.medicare.gov
Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for the telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

REMEMBER: Keep this Credible Coverage Notice. If you enroll in a Medicare-approved plan that offers prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount (penalty).

Date:	October 3, 2021
Name of Entity/Sender:	Southeast Texas Government Employee Benefits Pool
Contact/Office:	Kim Isaacs/Jefferson County Risk Management
Address:	215 Franklin Street, Suite 202, Beaumont, TX 77701
Phone:	(409) 835-8672