



2024-2025 | Jackson County, IA

Benefits Guide

Your Benefits, Your Choice



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The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.



Welcome!

We understand that your life extends beyond the workplace. That’s why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

We encourage you to read this guide, share it with your family members, and ask any questions you may have.

When to Enroll

Current Employees: Open enrollment happens each year in May. New benefits become effective on July 1st. Open Enrollment is your chance to make changes to your benefits and add or drop dependents. You will not get another chance to do this until the next Open Enrollment, unless you experience a qualifying life event.

New Hires: Your benefit elections will become effective the first of the month following 31 days of continuous, active, employment. You must make your elections and return your enrollment forms prior to your starting date so that we are able to begin your coverage when you reach the eligibility date. If you don’t take action now, you will not have the opportunity to enroll again until the next open enrollment period, unless you experience a qualifying life event.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Qualifying life events include:

- Marriage, divorce, legal separation or death of a spouse
- Birth or adoption of a child
- Change in child’s dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan.

Questions? They’re here to help...

Benefit Contact	Phone	Email
Becki Chapin	(563) 652-1710	bchapin@jacksoncounty.iowa.gov

Coverage	Carrier	Phone Number
Medical	Wellmark BCBS	(800) 524-9242
PSF	SISCO	(888) 242-9428
Telemedicine	Doctor on Demand	(800) 997-6196
Dental	SISCO	(800) 457-4726
Vision	VSP	(800) 877-7195

Eligibility

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have 30 days from your initial start date to enroll in benefits.

Permanent part-time employees *scheduled* 20 hours or more per week are also eligible for benefits. Contact the Human Resource Office for specific details.

Coverages will take effect on the first of the month following 31 days of employment*

***IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. The below definitions refer to **Medical, Dental, and Vision Coverages**.

- Your legal spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, “spouse” shall not mean a common law spouse or domestic partner.
- The employee’s dependent children until the end of the month, in which, they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee’s children (or children of the employee’s spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent’s marital or tax exemption status changes and they are no longer eligible for continued coverage.

Monthly Employee Contributions

Effective 07/01/2024



Medical

Employee	\$185.90
Family	\$433.63

Dental

Employee	\$7.05
Family	\$17.62

Vision (24 Months)

Employee	\$1.46
Family	\$3.14

Vision (12 Months)

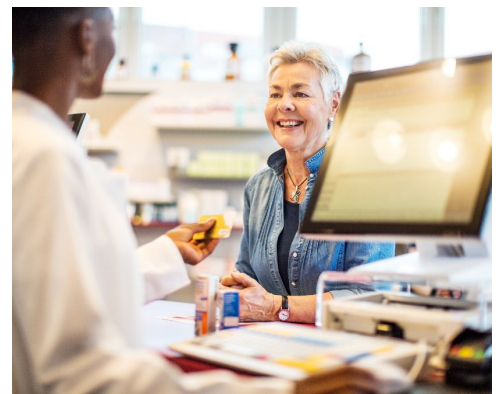
Employee	\$2.65
Family	\$5.69

Medical

Wellmark BCBS of IA | (800) 524-9242

This coverage allow you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider. Please refer to your Health Insurance Summary Plan Description to find a provider.

Medical	Wellmark buy down with SISCO	
	In-Network	Out-of-Network
Annual Deductible With PSF		
Individual	\$250	\$250
Family	\$500	\$500
Annual Deductible Before PSF		
Individual	\$6,000	\$7,500
Family	\$12,000	\$15,000
Coinsurance		
Plan Pays	90%	80%
You Pay	10%	20%
Annual Out-of-Pocket Maximum With PSF		
Individual	\$500	\$500
Family	\$1,000	\$1,000
Annual Out-of-Pocket Maximum Before PSF		
Individual	\$8,500	\$17,000
Family	\$17,000	\$34,000
Services	In-Network	Out-of-Network
Preventive Care	100% covered	20% after deductible
Primary Care Office Visit	\$20 copay	20% after deductible
Urgent Care	\$20 copay	20% after deductible
Emergency Room	10% after deductible	20% after deductible
Hospitalization	10% after deductible	20% after deductible
Prescription Drugs	In-Network	Out-of-Network
Tier 1	\$10	\$10
Tier 2	\$25	\$25
Tier 3	\$40	\$40
Tier 4	\$85	\$85
Benefit Cost	Employee-paid	



Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Medical Resources

Consider these resources when you need healthcare. You might even save a little money along the way!

Partial Self Fund

SISCO | Available to all employees enrolled on Jackson County Health Insurance

PSF provides an employer and employee funded amount of money to cover out-of-pocket medical expenses while working to meet your Wellmark plan deductible and out of pocket maximum.

How Does the PSF Work?

- When you use medical services such as a doctor’s office visit or hospital admission from a Wellmark provider, the first bill and EOB you will receive shows what Wellmark paid. You should not pay any amount from this bill.
- Wellmark sends the bill to SISCO and Jackson County pays its portion of your bill from your PSF.
- SISCO sends you a new EOB, detailing how much Jackson County paid and how much you still owe to your provider (if any).
- Your provider should send you a revised bill that matches this EOB. If you owe any money at this point, you pay it directly to your healthcare provider.

What if my provider needs proof that I have PSF funds?

Have your provider call SISCO at: (888) 242-9428

You can check your remaining deductible and/or out-of-pocket maximum balances by logging into SISCO’s Benefit Information Network (BIN) at www.SISCObenefits.com

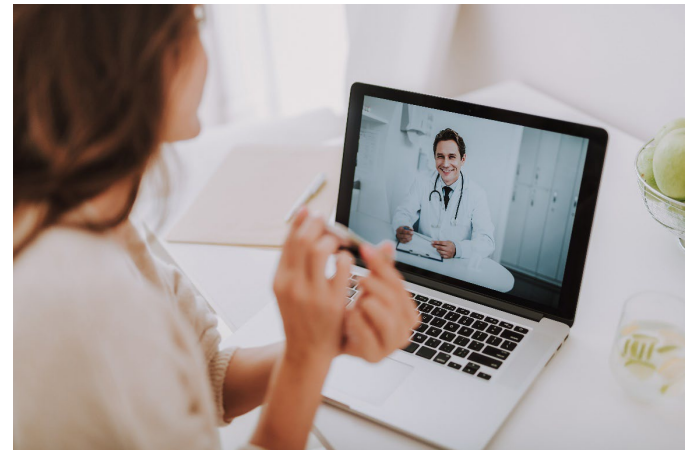
Please direct other questions to Wellmark at www.Wellmark.com or 1 (800) 524-9242.

Telemedicine

Doctor on Demand | (800) 997-6196 | doctorondemand.com

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency conditions.

Telemedicine	
Medical Visit	\$0 copay if enrolled on the company-medical plan \$45+ if not on the medical plan
Commonly Treated Medical Conditions	Allergies Colds and flu Ear infections Sore throat Pink eye Urinary tract infections And more!
Benefit Cost	Included with Medical coverage



When should I visit the doctor, urgent care or ER?

Watch the video below for more information:
<http://www.cottinghambutler.com/KnowWhereToGo/>

Medical Resources

How To Read Your Explanation Of Benefits (EOB)

- 1 Employer name and return address for the EOB.
- 2 This is not a bill. You may receive a bill from your provider for any amount in the You May Owe column.
- 3 Date the EOB was mailed, Your Group Number and Name, and the EOB number.
- 4 Employee name and mailing address.
- 5 SISCO's customer service contact information and hours.
- 6 Name of the participant who received services and the SISCO claim number. Each claim submitted by your providers will have a unique claim number. EOBs may include multiple claims.
- 7 The name of the provider who rendered services.
- 8 Deductible/Out-of-Pocket Summary: The amounts that have been applied to the deductible and out of pocket during the year. Overview of how the claim the claim was processed.
 - Dates of Service: Date the services were rendered
 - Procedure Description: The service rendered by your provider
 - Charge Amount: The total amount submitted by the provider for the services rendered
- 9
 - Ineligible Amount: Non-Covered expenses under your health plan.
 - Discount Amount: The amount of the charge that the provider is contractually obligated to write off.
 - Remark Code: The code will correspond to a message in the remark code description field.
 - Deductible Amount: Amount applied toward the participant's deductible. This amount is participant liability.
 - Coinsurance Amount: Amount applied toward the participant's co-insurance. This amount is participant liability.
 - R&C: The amount over the Usual, Reasonable, and Customary rates of the plan.
 - Paid Amount: Amount the health plan paid on the claim.
 - Paid To: The entity the health plan has paid.
 - You May Owe: The participant's liability.
- 10 Remark Code Description: The remark description will correspond to a number in the remark code field of the claim line. The remark will explain any discounts or ineligible amounts.
- 11 Your Right to Appeal: Explanation of your right to appeal the payment or denial of the claim.

1 ABC COMPANY
PO BOX 389
DUBUQUE IA 52004-0389

Forwarding Service Requested

4 JOHN SMITH
123MAIN STREET
DUBUQUE, IA 52004

2 ***** THIS IS NOT A BILL *****

3 **Customer Service**

Date: 03/23/17
Group: 999 ABC COMPANY
EOB#: 9999999999

Claim status and verification of benefits available 24 hours a day. Call Interactive Voice Response at 800-809-9665 or 563-587-5482 or on our Benefit Information Network at www.siscobenefits.com

5 **Questions?**
Please contact SISCO Customer Service at 800-457-4728 or 563-587-7344
Email address: sisco.service@SISCOBenefits.com

Explanation of Benefits

** SISCO Customer Service Representatives are available from 7:00 am to 7:00 pm Monday thru Thursday and 7:00 am to 5:00 pm on Friday, all times are CST **

Patient Name: JOHN SMITH 6
Claim Number: 201703025420

7 Provider: MICHAEL JONES MD

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Remark Code	Deductible Amount	Co-ins Amount	R & C	Paid Amount	Paid To	You May Owe			
02/23-02/23/2017	OFFICE OUTPT EST 25 MIN	\$155.00	\$0.00	\$54.00	1	\$20.00	\$0.00	\$0.00	\$81.00	PROVIDER	\$20.00			
CLAIM TOTALS									\$155.00	\$0.00	\$54.00	\$20.00	\$0.00	\$0.00
Total Payment									\$81.00		\$20.00			

8 **Deductible/Out-of-Pocket Summary**

Member Name	Description	Year	Amount
JOHN	Medical Out-Of-Pckt	2017	\$20.00

10 **Remark Code Description**

Code	Description
1	PPO discount. Patient not liable.

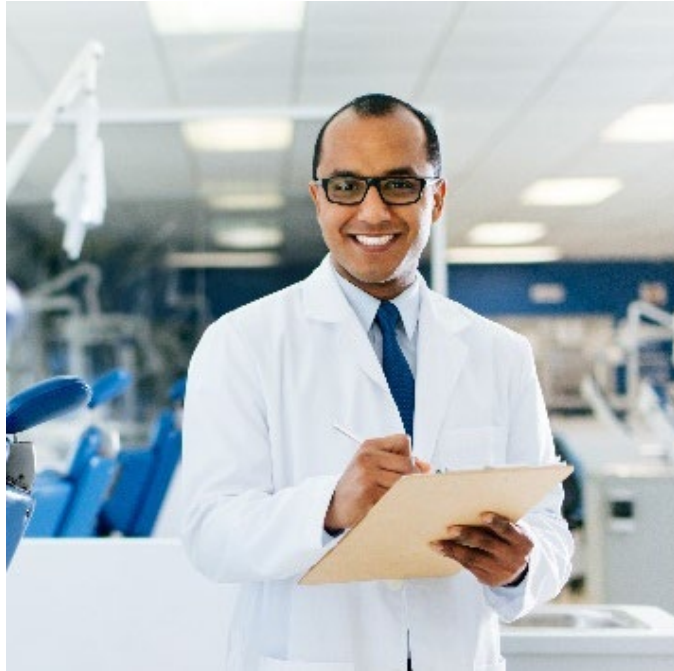
11 **Your Right to Appeal**

You and/or your representative may submit a written request for a review within 180 days of this notice which should include the date of your request, your printed name and/or the printed name of your representative, the information from the top portion of your Explanation of Benefits, and the date of service in question. You should include the specific reason for your appeal and provide any other documentation to support your appeal. Send this information to Self Insured Services Company (SISCO) Attn: Patient Advocate at PO Box 389, Dubuque IA 52004-0389. SISCO will provide a written reply to your request for review within 60 days of receipt.

Please call the number located above if you need diagnosis and/or treatment code information for this claim.

Dental

SISCO | (800) 457-4726



Dental	In-Network
Annual Deductible	
Individual	\$25
Family	\$75
Annual Benefit Max	\$1,000 (\$2,000 per family)
Lifetime Orthodontia Max (Per child up to age XX)	\$1,500
Services	In-Network
Preventive Care	20% after deductible
Basic	20% after deductible
Major	50% after deductible
Orthodontia	50% after deductible
Benefit Cost	Employee-Paid

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

See plan documents for out-of-network coverages.

Vision

VSP | (800) 877-7195



Vision	In-Network	Out-of-Network
Exam	\$10 copay	\$50 allowance
Lenses	\$25 copay	See Fee Schedule
Frames	\$130 allowance	\$70 allowance
Contact Lenses	\$130 allowance	\$105 allowance
Frequencies		
Exams	1 per 12 months	
Lenses	1 per 12 months	
Frames	1 per 24 months	
Contact Lenses	1 per 12 months (in lieu of lenses/frames glasses)	
Benefit Cost	Employee-paid	

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Discount Program

PerkSpot | <https://cottinghambutler.perkspot.com>

All Employees Are Eligible For The Discount Program

Through our partnership with Cottingham & Butler, we have access to the PerkSpot Employee Discount Program at no cost to you!

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL
- Founded in 2006
- 750+ clients nationwide
- 15 million members
- 30,000+ discount offers

Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alters: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category
- Local Discounts: shop by location

Create Your Account

- Visit <https://cottinghambutler.perkspot.com>
- Click "Create an Account"
- Enter your Name, Email, Gender, Zip Code and create a Password
- Sign up for email updates
 - Weekly Perks: Stay up to date on the best discounts and exclusive offers available to you
 - theLOOP: PerkSpot's weekly resource for how to excel in the 21st century workplace. Providing insights into workplace trends, lifestyle practices, and strategies for success
- Click "Register"
- Browse discount offers from over 25 categories

Shop for a Variety of Coupons & Deals from these Categories:

- Apparel
- Automotive
- Beauty & Fragrance
- Books, Movies, & Music
- Cell Phones
- Education
- Electronics
- Financial Wellness
- Health & Wellness
- Hobbies & Creative Arts
- Home & Garden
- Insurance & Protection Services
- Jewelry & Watches
- Tickets & Entertainment
- Toys, Kids & Babies
- Travel
- And More!

Popular Discounted Brands*:

- Avis
- Canon
- Casper
- Columbia
- Dell
- Enterprise
- Holiday Inn
- Home Chef
- HP
- Ray-Ban

*All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at <https://cottinghambutler.perkspot.com>

Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

If an Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they

think they (or any of their dependents) might be eligible for either of these programs, they can contact the State Medicaid or CHIP office or dial **1-877-KIDS NOW** or visit www.insurekidsnow.gov to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.

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

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of January 31, 2024. V 0.3.0. The most recent CHIP notice can be found at <https://www.dol.gov/agencies/ebsa/la-ws-and-regulations/laws/chipra>. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://dhss.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:

<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website:
<https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
<https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
<https://www.flmedicaidprecovery.com/>
[/flmedicaidprecovery.com/hipp/index.html](https://www.flmedicaidprecovery.com/hipp/index.html)
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website:
<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
<https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website:

<https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or

www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or

1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:

https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine Relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:

<https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email:

masspreassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

<https://mn.gov/dhs/people-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website:

<http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcnp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website:

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll-free number for the HIPP program:

1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

[/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)

Medicaid Phone: 609-631-2392

CHIP Website:

<http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:

<https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid

Website:

<http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>

<https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>

Phone: 1-800-692-7462

CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>

<https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347 or

401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website:

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website:

<https://medicaid.utah.gov/>

CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

VERMONT – Medicaid

Website:

<https://dvha.vermont.gov/members/medicaid/hipp-program>

<https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website:

<https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/>

<https://dhhr.wv.gov/bms/>

<http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone:

1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

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

Patient Protection Notice

If the Jackson County generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their

representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

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

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

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

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

* 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% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first

month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)

If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The Jackson County Group Medical Plan (the "Plan"), which includes medical HRA and dental coverages offered under the Jackson County Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability

Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Jackson County has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care

Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:

As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor

to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:

When required to do so by any federal, state or local law.

4. Health Oversight Activities:

To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:

As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings:

In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:

To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors:

For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:

If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:

For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:

As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related

Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach

Jackson County is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does

Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information.

However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to

Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses

and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for

services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Jackson County, 201 W Platt St, Maquoketa, IA 52060, (563) 652-3144.

Right to Inspect and Copy Individual

Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Jackson County, 201 W Platt St, Maquoketa, IA 52060, (563) 652-3144. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health

Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Jackson County, 201 W Platt St, Maquoketa, IA 52060, (563) 652-3144. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures:

An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health

information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Jackson County, 201 W Platt St, Maquoketa, IA 52060, (563) 652-3144. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential

Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Jackson County, 201 W Platt St, Maquoketa, IA 52060, (563) 652-3144. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice:

Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Jackson County, 201 W Platt St, Maquoketa, IA 52060, (563) 652-3144 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person:

If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with

the Plan, they must contact the HIPAA Contact Person, at Jackson County, 201 W Platt St, Maquoketa, IA 52060, (563) 652-3144. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Jackson County about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Jackson 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. Jackson County has determined that the prescription drug coverage offered by the Jackson County Plan 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 October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) 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 Jackson County coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Jackson County coverage, be aware that you and your dependents will 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 Jackson 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 have that coverage. For example, if you go nineteen 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 October 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 Jackson 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.

