PUTNAM COUNTY BOARD OF COMMISSIONERS

Employee Benefits Handbook

Plan Year July 1, 2023 - June 30, 2024

Photo by George Dissmeyer

What's inside:

Medical Plans | Dental Plan | Vision Plan | Basic and Voluntary Life Insurance | Voluntary Disability | Aflac | Texas Life Universal Life

Welcome to your new Employee Benefits Enrollment Guide. This guide is your summary of the benefit options that are available to eligible employees of the **Putnam County Board of Commissioners**. Each benefit is designed to protect your health and well-being as well as provide valuable financial protection.

Each section of the Employee Benefits Enrollment Guide is structured to provide you with plan highlights as well as detailed, descriptive instructions to assist you in navigating through the web-based enrollment portal.

While the Employee Benefits Enrollment Guide is an important component in the benefit communication process, your dedicated NFP service team continues to provide annual enrollment meetings in addition to being available for questions and concerns regarding benefits throughout the plan year.

Please review the plans contained in the Employee Benefits Enrollment Guide and see how these plans can work for you and your eligible dependents. Your participation in the plans is voluntary. The benefit plans have been chosen to provide a continuation of protection that complements the **Putnam County** leave policies and retirement plans. **The plan year is in effect from July 1, 2023 to June 30, 2024.**

This Employee Benefits Enrollment Guide is intended for orientation purposes only. It is an abbreviated overview of the plan documents. Please refer to the Certificate Booklet (the contract) available from the plan carriers for complete details. Your Certificate Booklet will provide detailed information regarding copayments, coinsurance, deductibles, exclusions and other benefits. The certificate booklet will govern should a conflict arise relating to the information contained in this summary. This summary does not establish eligibility to participate in or receive benefits from any benefit plan.

NOTICE: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 28 for more details.

Table of Contents

This guide describes the benefit plans available to you as an eligible Employee of Putnam County Board of Commissioners. The details of these plans are contained in the official Plan Documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in your Summary Plan Descriptions (SPD) (as described by the Employee Retirement Income Security Act).

If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the Plan Documents, the formal wording in the Plan Documents will govern.

Please note the benefits described in this guide may be changed at any time and do not represent a contractual obligation on the part of Putnam County Board of Commissioners and NFP.

Putnam County Board of Commissioners 2023/2024 Benefits Open Enrollment will be held from Tuesday, May 30, 2023 through Thursday, June 1, 2023.

You have 3 ways to enroll:

- Face to Face enrollment during one of these days.
- Enrolling yourself through the NFP enrollment portal (Bswift).
- Contacting the NFP Service Center 1-800-994-7429.

All flexible benefits enrollment (i.e. medical, dental, vision) will be processed through bswift, our online enrollment system serviced by NFP. It's as easy as logging into **www.putnamcounty.bswift.com.** Employees will be able to review their current benefits and other important information.

Please carefully weigh the plans available and choose the option that's best for you. If you have questions or need help, please contact the NFP Service Center (1-800-994-7429) or your Human Resources office.

The following benefits will take effect 7/1/2023:

Enrollment Requirements

- Dependent SSN and DOB are required to meet ACA requirements.

Medical Plans/Prescriptions

- Coverage will remain with Anthem, no changes to the plan benefits.

Brella

- Voluntary supplemental coverage to help cover medical cost.

Dental Plan

- The dental coverage will be moving to Anthem with a new buy up option.

Vision Plan

- Coverage will be remaining with Anthem

Basic and Voluntary Life

- Coverage will be moving to Anthem.

Disability

- Disability – Long Term Disability will be available at no cost to employees and Short Term Disability is offered voluntarily.

Aflac

- Critical Illness
- Accident
- Hospital Indemnity

Texas Life Permanent Life Insurance

Eligibility and Making Changes

Eligibility
Full-time employees are eligible for health and flexible benefits.

Eligible dependents are classified as:

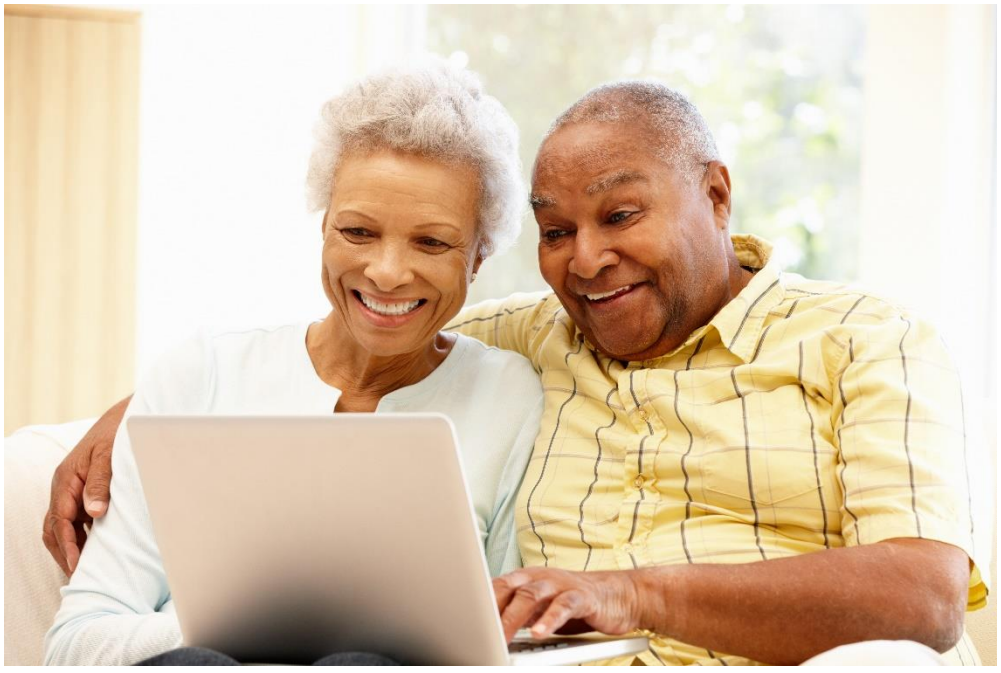
- Your legal spouse
- Biological children up to age 26
- Step-child(ren) as long as the biological parent remains in the employee's household to age 26
- Foster child(ren) or adopted child(ren) up to age 26

Making Changes to Your Benefits
To make benefit changes as a result of your Life Status Change or Family Status Change as allowed under Section 125 of the IRS Code, you must:

- Notify the NFP Service Center within 30 days of the date of the qualifying event.
- Provide proof of your status change event

The Most Common Status Changes:

- Marriage, divorce, legal separation
- Birth or adoption
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in dependent eligibility status
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order, or other court order
- Death of your spouse or covered child



Before You Enroll – Things to Know

You are REQUIRED to **provide the below information/documentation** for all dependents/beneficiaries:

- Name
- Date of Birth
- Social Security Number

HOW TO ENROLL

Go to www.putnamcounty.bswift.com.

At this time, make sure to disable your pop-up blocker.

At the enrollment website enter your Username and Password.

- **Username is the first letter of your first name, your last name, and last 4 digits of your Social Security number (ex. jdoe4567).**
- **Password is the last 4 digits of your Social Security number (ex. 4567).**

You will then be prompted to create a permanent password..

Attention New Hires:

- Please contact NFP at 800-994-7429 to speak with a Benefit Consultant if you need assistance with your enrollment.

Failure to enroll within the enrollment time period will result in the forfeiture of your eligibility for enrollment until the next annual enrollment period unless you experience an eligible qualifying event

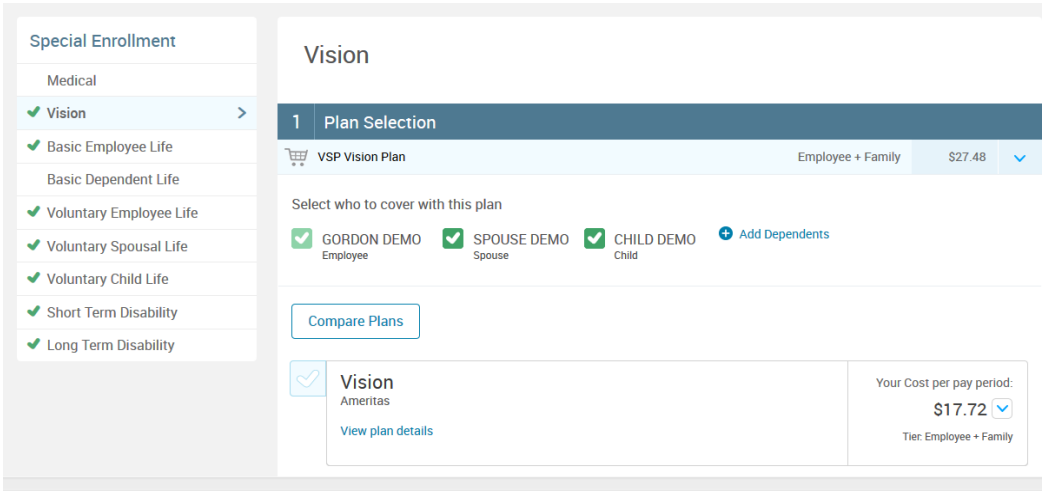
How To Enroll

To Begin:

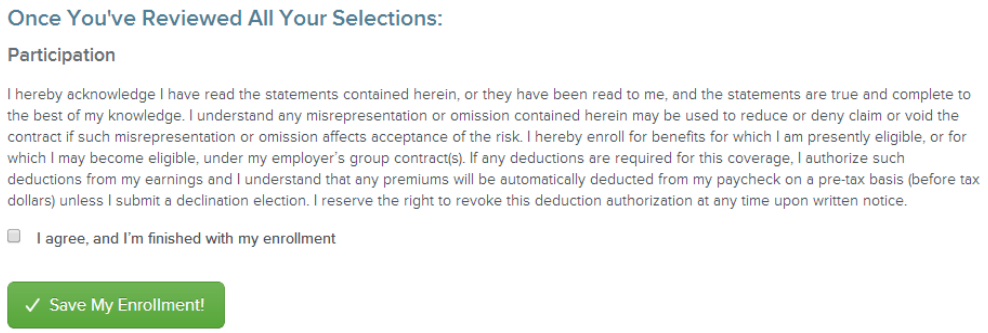
1) From the “Home Page” click on the “Enroll Now” link, to begin the election process.

2) On the “Personal & Family Page”, verify your information is accurate and “Add” all eligible dependents you wish to cover under any benefits.

3) To make a plan selection, select the button beside the newly elected plan. If you are covering dependents, make sure to “Select” them by checking off next to their name under “Select who to cover with this plan.” Then press “Next” at the bottom of the screen.



4) Once you have reviewed and completed your enrollment, click on “I Agree and I am finished with my enrollment”, then click on “Save My Enrollment”.



5) You will now be taken to the final confirmation page to either print or email

Note: The enrollment images within this guide are for illustrative purposes only.

Medical Coverage – Base

Putnam County Board of Commissioners offers the following medical plan through Anthem. To locate an in-network provider log into your personal account at www.anthem.com. A one-time registration is required.

Benefit	In-Network	Out of Network
Lifetime Maximum	Unlimited	
Deductible	$5,000 per person $10,000 per family	$15,000 per person $30,000 per family
Coinsurance	70% plan / 30% member	50% plan / 50% member
Maximum Annual Out of Pocket Limit	$7,900 per person $15,800 per family	$23,700 per person $47,400 per family
	The Out-of-Pocket Maximum includes deductible, coinsurance and all copays - Office Visits, Urgent Care, Emergency Room and Prescriptions.	
Routine Preventive Care	Member pays 0%	Member pays 50%
Office Visits: Primary Care Physician Specialty Care Physician Chiropractic Care, Physical, Speech, and Occupational Therapy	 $30 copay $60 copay Not Covered	 Member pays 50% Member pays 50% Not Covered
Urgent Care Center	$75 copay	Member pays 50% after deductible
Inpatient Facility Services; Daily room, board and general nursing care at semi-private room rates, physician services	$500 copayment per admission; then member pays 30% after deductible	Member pays 50% after deductible
Outpatient Facility Services; Surgery facility/hospital charges, x-ray and lab services, physician services	Hospital: 30% after deductible Freestanding Surgical Center: $200 copay then 30%	Member pays 50% after deductible
Emergency Room Services: life-threatening illness or serious accidental injury only	$350 copayment and 30% coinsurance. Copay waived if admitted	
Diagnostic Laboratory Services Office Setting Facility setting	Member pays 30% after deductible	Member pay 50% after deductible
Prescription Drugs: Tier 1 30 day/mail order 90 Tier 2 Preferred Brand Tier 3 Non-Preferred Brand Tier 4 Specialty Drugs	 $15 (Mail Order $40) 100% Coinsurance 100% Coinsurance 100% Coinsurance	 $15 100% Coinsurance 100% Coinsurance 100% Coinsurance

Refer to your Summary Plan Description and Policy Certificate available on the Benefits Resource Center for complete details

Medical Coverage – Buy Up

Putnam County Board of Commissioners offers the following medical plan through Anthem. To locate an in-network provider log into your personal account at www.anthem.com. A one-time registration is required.

Benefit	In-Network	Out of Network
Lifetime Maximum	Unlimited	
Deductible	$5,000 per person $10,000 per family	$15,000 per person $30,000 per family
Coinsurance	100% plan / 0% member	50% plan / 50% member
Maximum Annual Out of Pocket Limit	$7,900 per person $15,800 per family	$23,700 per person $47,400 per family
	The Out-of-Pocket Maximum includes deductible, coinsurance and all copays - Office Visit, Urgent Care, Emergency Room and Prescriptions.	
Routine Preventive Care	Members pays 0%	Member pays 50% after deductible
Office Visits: Primary Care Physician Specialty Care Physician Chiropractic Care: 20- visit limit Physical, Speech, and Occupational Therapy	$30 copayment $60 copayment $30 copayment $30 copayment	Member pays 50% after deductible
Urgent Care Center	$75 copayment	Member pays 50% after deductible
Inpatient Facility Services; Daily room, board and general nursing care at semi-private room rates, physician services	Member pays 0% after deductible	Member pay 50% after deductible
Outpatient Facility Services; Surgery facility/hospital charges, x-ray and lab services, physician services	Hospital: 0% after deductible Freestanding Surgical Center: $200 copay	Member pays 50% after deductible
Emergency Room Services: life-threatening illness or serious accidental injury only	$350 copayment; Copay waived if admitted	
Diagnostic Laboratory Services Office Setting Facility setting	Included in office copay 0% after deductible	Member pay 50% after deductible
Prescription Drugs: Tier 1 Preferred Value/Generic Tier 2 Preferred Brand Tier 3 Nonpreferred Tier 4 Preferred Specialty	$15 $35 (Mail Order $70) $60 (Mail Order $180) 25% up to $350/RX	$15 $35 $60 25% up to $350/Rx

Refer to your Summary Plan Description and Policy Certificate available on the Benefits Resource Center for complete details

Medical Coverage Cost

Medical Costs per pay period (24)

Tier of Coverage	Employee Cost Base Plan	Employee Cost Buy Up Plan
Employee	$5.00	$20.00
Employee + Spouse	$123.71	$185.90
Employee + Children	$113.43	$168.04
Employee + Family	$177.94	$264.28

Refer to your Summary Plan Description and Policy Certificate available on the Benefits Resource Center for complete details

Anthem

Engagement Package 700

Give your employees extra support to reach their personal health goals

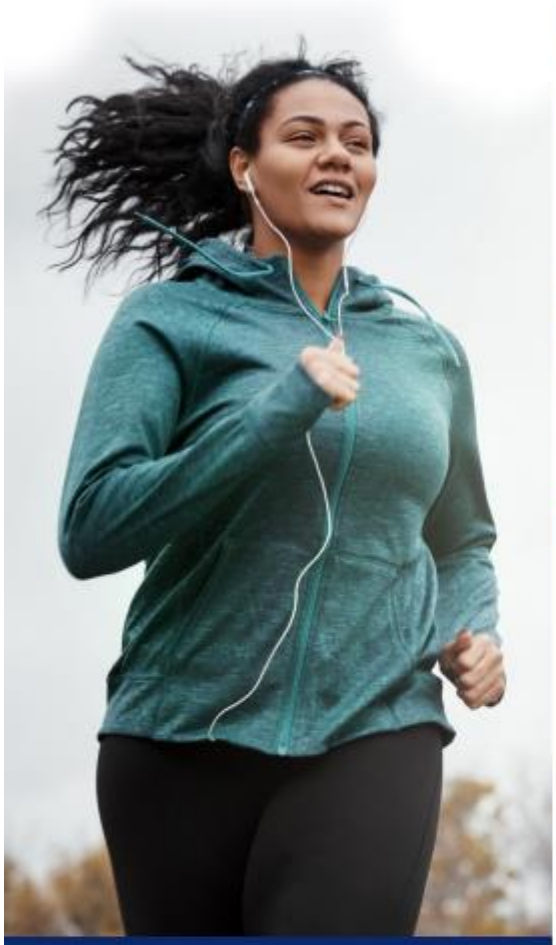
For employers with 100+ subscribers

We understand that every employee has their own approach to achieving their wellness goals. Engagement Package 700 rewards employees up to $700 in retailer gift cards when they take part in a wide variety of condition management, preventive care, and wellness activities that offer them options to meet those goals.

Employees can follow their progress and rewards earned through **anthem.com** or the **Sydney℠ Health** app.[1] Sydney Health serves as our fully integrated digital platform to help foster the most personalized, optimal experience possible.

Your employees can earn a maximum of $700 by participating in or completing certain activities, such as:

Activity Type	Activity	Tracking	Amount
Preventive care	Annual eye exam	Claims[1]	$20
	Annual adult wellness exam or well woman exam	Claims[1]	$20
	Cholesterol test	Claims[1]	$5
	Colorectal cancer screening	Claims[1]	$25
	Flu shot	Claims[1]	$10
	Mammogram	Claims[1]	$25
Condition management	ConditionCare	Completion	$225
	Building Healthy Families	Completion	$125
	Well-being Coach Telephonic – Tobacco	Completion	$60
	Well-being Coach Telephonic – Weight	Completion	$60
Wellness	Having action plans	Tracked	$20
	Syncing devices	Tracked	$5
	Taking the Health Assessment	Tracked	$20
	Logging in to our website or app	Tracked	$5
	Tracking steps	Tracked	$60
	Updating contact information	Tracked	$15
	Using Well-being Coach Digital	Tracked	$20



Employees with incentives are:[2]

3.8x
more likely to get their annual wellness exam and flu shot

1.4x
more likely to take part in condition management programs

Health Reimbursement Arrangement

Putnam County Board of Commissioners is actively participating in a Health Reimbursement Arrangement. You are ultimately responsible for your full deductible, but through this program you will be reimbursed a portion of your deductible incurred (see below for amounts)

If you have services rendered that are subject to your deductible, you can submit your Explanation of Benefits (EOB). **Remember, you can only be reimbursed based on EOBs, not bills from the provider.** Copays and coinsurance are not eligible for reimbursement.

This program runs calendar year, and all claims incurred during the 2023 plan year must be submitted to Admin America by March 31, 2024, to be eligible for reimbursement.

EOBs can be accessed by going to www.anthem.com and logging into your account. If you need assistance logging in, please call the NFP call center at 1-800-994-7429.

Reimbursements work on a calendar year and not the plan year. **Example: Deductibles work on calendar year January 1 to December 31 ($1,500 employee deductible) then next $1,500 deductible eligible for in network HRA.**

If you have questions on your reimbursement, please call Admin America at 1-800-366-2961.

If you have further questions or would like more information on the Health Reimbursement Arrangement, please feel free to contact NFP at 1-800-994-7429.

Base Plan Tier	Base Plan Deductible	EE Portion	HRA Portion
Employee	$5,000	$1,500	$3,500
All Dependents	$10,000	$3,000	$7,000

Buy Up Plan Tier	Buy Up Deductible	EE Portion	HRA Portion
Employee	$5,000	$500	$4,500
All Dependents	$10,000	$1,000	$9,000

HRA CLAIM FOR REIMBURSEMENT FORM

Your Employer's Name: _____

Your Full Name: _____

Your Social Security Number: _____

PLEASE LIST EACH MEDICAL EXPENSE ON A SEPARATE LINE IN THE TABLE BELOW. SIGN THE FORM AND ATTACH A COPY OF THE EXPLANATION OF BENEFITS FROM YOUR INSURANCE CARRIER. USE MULTIPLE FORMS AS NEEDED TO RECORD ADDITIONAL EXPENSE ITEMS.

Date Medical Expense Incurred *(mm/dd/yyyy)*	**Medical Expense Description** (Please provide **the name of the individual** the service was provided for, that person's **relationship** to you, and **general nature of the service** provided: i.e., emergency room visit, annual physical, etc.)	**Net Medical Care Expense Incurred** $	**Do not write in this**
	Expense: _____ Name: DOB: / /	$	☐
	Expense: _____ Name: DOB: / /	$	☐
	Expense: _____ Name: DOB: / /	$	☐
	Expense: _____ Name: DOB: / /	$	☐

Please Review The Instructions On The Back Of This Form
Insufficient Documentation Will Result In A Delay Of Your Claim Reimbursement

I certify that: 1) each of the above medical care expenses are for services provided while I was covered under my Employer's Health Reimbursement Arrangement, 2) all medical expenses listed above have not been reimbursed or are not reimbursable from any other source, and 3) all expenses were incurred for the medical care of me, my spouse or qualified dependent. I acknowledge that I am fully responsible for the accuracy and veracity of all information relating to this claim. If an expense for which I am reimbursed is later disallowed by the Internal Revenue Service, I understand that I will be liable for payment of any related income or payroll taxes relating to such improper expense reimbursement.

_____

Employee's Signature **Date**

PLEASE MAKE A COPY OF ALL DOCUMENTATION PRIOR TO SENDING TO ADMIN AMERICA

Admin America
770-992-5959 or 1-800-366-2961

Mail Claims:
Admin America
P.O. Box 1209
Alpharetta, GA 30009

Fax Claims: 770-992-0723

Email Claims:
claims@adminamerica.com

24/7 Internet Account Information:
www.adminamerica.com

Date Last Modified: 2/20/2013

Preventive Care Coverage

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you[1]. When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care
What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care
Preventive physical exams
Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24, with fair skin, about ways to lower their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening[2] when done as part of a preventive care visit

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

This sheet is not a contract or policy with Anthem. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.

Preventive Care Coverage

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[3]
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)[4,5]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[5]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[5]
- Pelvic exam and Pap test, including screening for cervical cancer

Adult preventive care

- *Preventive physical exams*
- *Screening tests:*
- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Depression screening
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years[6]
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles) for those 60 years and older

Preventive Care Coverage

A word about pharmacy items:

For 100% coverage of over-the-counter (OTC) drugs and other pharmacy items listed below, the person receiving the item(s) must meet the age and other specified criteria. You need to work with your in-network doctor or other health care provider to get a prescription for the item(s) and take the prescription to an in-network pharmacy. Even if the item(s) do not "need" a prescription to purchase them, if you want the item(s) covered at 100%, you have to have the prescription.

Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old
- Fluoride supplements for children from birth through 6 years old
- Iron supplements for children 6-12 months

Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco cessation products including select generic prescription drugs, select brand-name drugs with no generic alternative, and FDA-approved over-the-counter products, for those 18 and older
- Vitamin D for men and women over 65

Women's preventive drugs and other pharmacy items — age appropriate:

- Contraceptives including generic prescription drugs, brand-name drugs with no generic alternative, and over-the-counter items like female condoms or spermicides[5,7]
- Low dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women 55 years old or younger
- Breast cancer risk-reducing medications following the U.S. Preventive Services Task Force criteria (such as tamoxifen and raloxifene)[6]

1. The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Customer Service number on your ID card.
2. Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.
3. Check your medical policy for details.
4. Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.
5. This benefit also applies to those younger than 19.
6. You may be required to get prior authorization for these services.
7. A cost share may apply for other prescription contraceptives, based on your drug benefits

Supplemental Health

The Supplemental Health plan complements your health insurance and helps ease the burden of unexpected medical expenses. Even with great health insurance, most people have a deductible and copays – which means an unexpected health issue could run up bills that drain your savings or end up on a credit card.

This coverage is offered voluntary to employees and dependents through Brella.

Brella pays cash if you're diagnosed with any of 13,000+ conditions.

How it Works:

File a claim if you're diagnosed with a covered condition. If approved, you'll get a payout within 72 hours. Use the cash for anything you need from medical bills to groceries. Payout will be based on over 13,000+ conditions across three benefit categories.

Benefit Category	Benefit Amounts
Moderate	$200
Severe	$500
Catastrophic	$1,000

What's Covered:

Moderate Conditions – Over 6,000 covered conditions like acute kidney infection, kidney stones, cracked tooth, pneumonia, dehydration, concussions, lacerations, meningitis, migraines (intractable), open bites, puncture wounds and simple fractures.

Severe Conditions – Over 5,600 covered conditions like acute pancreatitis, appendicitis, torn ACL, bacterial meningitis, chronic tonsillitis, cleft palate, congestive heart failure, gallstones, detached retina, open or compound fractures, and acute respiratory failure.

Catastrophic Conditions – Over 1,500 covered conditions like heart attack, stroke, cancer, ALS (Lou Gehrig's disease), Alzheimer's, end stage renal failure, HIV, leukemia, Parkinson's disease, sepsis, spina bifida, multiple sclerosis and ventricular fibrillation.

Refer to your Summary Plan Description and Policy Certificate for full details on the plan.

Dental

Dental coverage will be moving to Anthem for 2023. You will have a base or buy-up option to choose from. Keep in mind that you will pay less if you use an in-network dentist. To locate participating providers, go to www.anthem.com, and click on Find Care.

Benefit	Base	Buy-Up
Annual Maximum	$1,000 per person	$2,000 per person
Deductible (Single / Family)	$50 / $150	$50 / $150
Diagnostic/Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Orthodontia	Not Covered	50% ; Up to $1,500 lifetime maximum per child under 19

***Deductible does not apply to diagnostic/preventive services**

Plan Sample Procedure Listing

Type 1 (100%)	Type 2 (80%)	Type 3 (50%)
Oral Exams (2 per year)	Fillings (limited to once per surface per tooth in any 24 months)	Crowns (1 per tooth in 7 years)
Full Mouth X-rays (1 in 3 years)	Oral Surgery (surgical extractions)	Bridges (1 in 7 years)
Bitewing X-rays (adult/child) (1 in a year)	Simple Extractions	Dentures (1 in 7 years)
Prophylaxis – Cleanings (2 in a year)	Space Maintainers (1 per lifetime in absence of primary teeth for members through age 15)	Implant Services (1 in 7 years)
Topical Fluoride Applications (1 in a year – Children through age 18)		Periodontal Scaling and Root Planning (limited to 1 in 24 months per quadrant)
Sealants (1 in 36 months – Children through Age 15)		Endodontics Root Canal (1 per tooth per lifetime)

Dental Costs per pay period (24)

Tier of Coverage	Base	Buy-Up
Employee	$0.00	$9.17
Family	$18.60	$24.81

Refer to your Summary Plan Description and Policy Certificate available on the Benefits Resource Center for complete details

Vision

Vision Coverage will be provided by Anthem for the 2023. To locate a participating provider, visit www.anthem.com. The network is the Blue View Vision Plan.

Benefit	In-Network	Out-of-Network (Reimbursement)	Frequency
Vision Exam	$20 Copay	Up to $42	Once Every Calendar Year
Contact Lenses* Conventional Disposables Medically Necessary	 $130 Allowance $130 Allowance Covered in Full	 Up to $105 Up to $105 Up to $210	Once Every Calendar Year
Contact Lens Fit & Follow Up Standard Premium	 Up to $55 10% off retail	 N/A N/A	Once Every Calendar Year
Standard Plastic Lenses Single Bifocal Trifocal	 $25 Copay $25 Copay $25 Copay	 Up to $40 Up to $60 Up to $80	Once Every Calendar Year
Frames	$130 Allowance, 20% off balance over $130	Up to $45	Once Every 2 Calendar Years

*Note: The plan covers either contact lenses or lenses for your glasses once every 12 months.

Additional Savings Available Through Anthem's Special Offers Program

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at **anthem.com,** select discounts, then Vision, Hearing, & Dental.

Vision Costs per Pay Period (24)

Tier of Coverage	Employee Cost
Employee	$2.76
Employee & Spouse	$5.24
Employee & Child(ren)	$6.14
Employee & Family	$8.63

Refer to your Summary Plan Description and Policy Certificate available on the Benefits Resource Center for complete details

Basic Life/AD&D and Voluntary Life Insurance

Basic Term Life Insurance provides valuable financial protection for your family. Putnam County Board of Commissioners is pleased to offer $30,000 Basic Life Insurance and AD&D to all full time benefit eligible employees through Anthem. This coverage is provided at no cost to you.

Voluntary Term Life Insurance is also available to provide additional financial protection for your family. You are eligible to enroll in the Voluntary Term Life Insurance program underwritten by Anthem.

Your premium will be based on the coverage amount you elect and your age. Premiums will be paid through the convenience of a payroll deduction.

Employees must have coverage on themselves in order to have coverage on dependents.

Benefit	Coverage
Employee Amount	$10,000 increments, not to exceed the lesser of $300,000 or 5x salary.
Employee Guarantee Issue Amount for New Hires	$150,000
Spouse Amount	$5,000 increments, up to $150,000 not to exceed 50% of employee amount
Spouse Guarantee Issue Amount for New Hires	$30,000
Child(ren) Amount	Elect $5,000 or $10,000 for eligible children between the ages of 6 months to age 26. Children from birth to age 6 months are covered for $1,000 if child(ren) coverage is selected.

New Hires: Are allowed to purchase life insurance on a guarantee issue up to certain limits.

Late Entrants: If you do not elect coverage when initially eligible and wish to elect coverage during this open enrollment, you will be subject to health questions. Additionally, any employee increasing coverage will be required to answer health questions on an evidence of insurability form and be approved by the insurance carrier before the excess can become effective.

Benefit Reduction: Benefits will reduce at age 70 to 50% of original amount. Once you enter into the reduction stage, you will be unable to increase your benefit.

Basic Life/Ad&D and Voluntary Life Insurance

Important Terms to Understand:

Evidence of Insurability Evidence of Insurability is a request to verify good health and is often in the form of a questionnaire. This is required when you are requesting insurance that is over the guaranteed issue amount or if you are enrolling after your initial enrollment.

Guarantee Issue Guarantee Issue is the amount of life insurance that you can elect without having to provide Evidence of Insurability. The Guarantee Issue period is 31 days from the date you first become eligible for the plan from your date of hire. If you choose not to enroll when you are first eligible and enroll at a later date, the entire amount of insurance will be subject to Evidence of Insurability.

Child(ren) Unit	Rate per Unit
$5,000	$1.00
$10,000	$2.00

Rate per $1,000 of Coverage		
Age	Employee Rate	Spouse Rate
< 25	$0.064	$0.064
25-29	$0.064	$0.064
30-34	$0.071	$0.071
35-39	$0.097	$0.097
40-44	$0.146	$0.146
45-49	$0.229	$0.229
50-54	$0.365	$0.365
55-59	$0.564	$0.564
60-64	$0.768	$0.768
65-69	$1.235	$1.235
70-74	$2.078	$2.078
75+	$6.153	$6.153

***Rates shown in chart above are monthly cost**

Short Term Disability Benefits

Short Term Disability provided through Anthem

Putnam County Board of Commissioners provides you the option to elect Short Term Disability (STD) income benefits through convenient payroll deductions. Short Term Disability insurance provides you with a portion of your weekly income if you are unable to work or have a reduced income due to an illness or injury unrelated to your occupation.

Benefit	Voluntary STD
Benefit Amount	60% or weekly earnings
Maximum Benefit	$1,000 per Week
Benefits Begin After (Elimination Period)	14 Days Accident 14 Days Sickness
Maximum Benefit Duration	24 Weeks
Pre-Existing Condition Exclusion	3/12

Age	STD Rate per $10
0-19	$0.507
20-24	$0.507
25-29	$0.501
30-34	$0.527
35-39	$0.524
40-44	$0.587
45-49	$0.664
50-54	$0.806
55-59	$1.027
60-64	$1.225
65-69	$1.379
70-74	$1.793
75+	$2.331

***Rates shown to the right are monthly cost**

Late Entrant: If you did not take advantage of the Short Term Disability when it was first offered or as a new hire, you will be able to elect coverage without answering health questions. Preexisting condition will apply.

Preexisting Conditions: Any condition for which a Person has received medical treatment or consultation; taken or were prescribed drugs or medicine; or received care or services, including diagnostic measures at any time during the 3 months immediately prior to the Person's Individual Effective Date of Insurance, whether or not that condition was diagnosed at all or was misdiagnosed during that period of time will not be covered until you have been enrolled in the policy for 12 months.

Exclusions: Benefits will not be payable for any disability caused by: an intentionally self-inflicted injury; an act of war (declared or undeclared); commission of a felony; sickness covered by workers' compensation or other workers' disability law; cosmetic surgery (some exceptions apply). For a comprehensive list of exclusions, limitations, and any applicable benefit offsets, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

Integration of Benefits: Your benefits may be reduced by benefits received from state disability or worker's compensation programs. The total of all benefits received from this policy, state disability plans, worker's compensation programs and your employer's sick pay plan may not exceed 100% of your income prior to disability.

You must be under the regular care of a physician in order to be considered disabled.

Refer to your Summary Plan Description and Policy Certificate available on the Benefits Resource Center for complete details

Long Term Disability Benefits

The Long Term Disability insurance will be provided through Anthem.

Putnam County Board of Commissioners will provide the Long Term Disability (LTD) income benefits at no cost for all benefit eligible employees.

Benefit	Voluntary LTD
Percentage of Income	60%
Maximum Benefit	$5,000 per Month
Benefits Begin After (Elimination Period)	180 Days Accident 180 Days Sickness
Maximum Benefit Duration	Social Security Normal Retirement Age (SSNRA)
Pre-Existing Condition Exclusion	3/12

Elimination Period: The elimination period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits.

Limitations:

- Mental/Nervous Illness Limitation – 24 months
- Drug and Alcohol Abuse Limitation – 24 month
- Special Conditions – 24 months

Pre-Existing Conditions: Any condition for which a Person has received medical treatment or consultation; taken or were prescribed drugs or medicine; or received care or services, including diagnostic measures at any time during the 3 months immediately prior to the Person's Individual Effective Date of Insurance, whether or not that condition was diagnosed at all or was misdiagnosed during that period of time will not be covered until you have been enrolled in the policy for 12 months.

Exclusions: Benefits will not be payable for any disability caused by: an intentionally self-inflicted injury; an act of war (declared or undeclared); commission of a felony; sickness covered by workers' compensation or other workers' disability law; cosmetic surgery (some exceptions apply). For a comprehensive list of exclusions, limitations, and any applicable benefit offsets, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

Benefit offset: Your benefits may be reduced by benefits received from state disability or worker's compensation programs. The total of all benefits received from this policy, state disability plans, worker's compensation programs and your employer's sick pay plan may not exceed 100% of your income prior to disability.

You must be under the regular care of a physician in order to be considered disabled.

Refer to your Summary Plan Description and Policy Certificate available on the Benefits Resource Center for complete details

Critical Illness with Cancer Rider – Supplemental Benefits through AFLAC

Critical Illness Benefits are payable for specified conditions and can help to cover the costs of your treatments and related expenses, regardless of your major medical insurance coverage. *(If currently in treatment for cancer, you can only purchase a $10,000 benefit.)*

BENEFITS **This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions.**		
COVERED CRITICAL ILLNESSES:[1]	CANCER (Internal or Invasive) 100% HEART ATTACK (Myocardial Infarction) 100% STROKE (Ischemic or Hemorrhagic) 100% MAJOR ORGAN TRANSPLANT 100% CORONARY ARTERY BYPASS SURGERY[2] 25%	RENAL FAILURE (End-Stage) 100% COMA, SEVERE BURNS, PARALYSIS, LOSS OF SIGHT, LOSS OF SPEECH, LOSS HEARING, BENIGN BRAIN TUMOR- 100% CARCINOMA IN SITU[2] 25% (if has not spread) SKIN CANCER- $250 PCY ADVANCED ALZHEIMER & PARKINSON DISEASE- 25%
FIRST-OCCURRENCE BENEFIT	After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts available from $5,000 to $50,000. Spouse coverage is also available in benefit amounts up to $25,000. If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase Spouse coverage.	
ADDITIONAL OCCURRENCE BENEFIT	If an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered critical illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months.	
RE-OCCURRENCE BENEFIT	If an insured collects full benefits for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 6 months, or for cancer, 12 months treatment free. Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless the Insured has gone treatment free for 12 months.	
CHILD COVERAGE AT NO ADDITIONAL COST	Each Dependent Child is covered at 50 percent of the primary insured amount at no additional charge.	
$50 HEALTH SCREENING BENEFIT (Employee and Spouse only, 30 day waiting period from date of enrollment)	After the waiting period, an insured may receive a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under your certificate. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the certificate remains in force. This benefit is payable for the covered Employee and Spouse. This benefit is not paid for Dependent Children.	
COVERED HEALTH SCREENING TESTS INCLUDE:	• Mammography • Colonoscopy • Pap smear • Breast ultrasound • Chest X-ray • PSA (blood test for prostate cancer) • Stress test on a bicycle or treadmill • Bone marrow testing• CA 15-3 (blood test for breast cancer) • CA 125 (blood test for ovarian cancer)	• Flexible sigmoidoscopy • Hemocult stool analysis • Serum protein electrophoresis (blood test for myeloma) • Thermography • Fasting blood glucose test • Serum cholesterol test to determine level of HDL and LDL • CEA (blood test for colon cancer)

[1] All covered conditions are subject to the definitions found in your certificate.

[2] If a benefit is paid for Carcinoma in Situ, the Internal Cancer benefit will be reduced by 25 percent. If a benefit is paid for Coronary Artery Bypass Surgery, the Heart Attack benefit will be reduced by 25 percent.

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. Definitions, waiting period, pre-existing condition limitation, limitations and exclusions, benefits, termination, portability, etc., may vary based on your employer's home office. Please see your agent for the plan details specific to your employer.

Refer to your Summary Plan Description and Policy Certificate for full details on the plan

Group Accident – Supplemental Benefits through AFLAC

The group Accident Advantage Plus plan from Aflac means that your family has access to added financial resources to help with the cost of follow-up care as well.

The Aflac group Accident Advantage Plus plan benefits:

- Transportation and Lodging benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma paralysis
- An Accidental – Death Benefit
- A Dismemberment Benefit

Features:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four business days.

Tier of Coverage	Employee Cost Per Pay Period (24)
EMPLOYEE	$ 6.45
EMPLOYEE & SPOUSE	$ 10.53
EMPLOYEE & DEPENDENT CHILDREN	$ 12.86
FAMILY	$ 16.94

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Refer to your Summary Plan Description and Policy Certificate for full details on the plan

Group Hospital Indemnity – Supplemental Benefits through AFLAC

Why Offer Group Hospital Indemnity Insurance?
A sudden hospitalization might stop employees in their tracks, but their bills — mortgages, utilities, groceries and out-of-pocket costs — will keep on coming. Aflac Group Hospital Indemnity insurance can help cover the costs associated with the treatment of a covered sickness or accident. More importantly, the plan helps your employees focus on getting better, not worrying about how they'll pay their bills. Because Aflac pays cash benefits directly to the insured, our Group Hospital Indemnity plan gives your employees the flexibility to use their benefits anyway they see fit either on costs related to treatment or to help with everyday living expenses.

Plan Features:

- Benefits are paid directly to the insured, unless otherwise assigned
- Benefits are paid for covered sicknesses and accidents
- Coverage is available for all family members
- Guaranteed-issue coverage is available (which means your employees may qualify for coverage without having to answer health questions)
- Premiums are paid through convenient payroll deduction
- There are no pre-existing condition limitations
- The plan doesn't have a waiting period for benefits
- Benefits do not reduce as insureds get older
- There's a two-year rate guarantee
- Coverage is portable
- Benefits are paid regardless of any other medical insurance

Dependent Children Coverage:
Dependent children under the age of 26 can be covered. To apply for dependent child coverage, ***the employee must also apply*** and be issued coverage.

If an employee does not have dependent child coverage, a newborn/newly adopted child will be automatically covered for 60 days from the date of birth or placement for adoption. To continue coverage beyond 60 days, the employee must apply for coverage for the child and pay any required premium.

Limitations and Exclusions:
Wi will not pay for loss due to: Self-Inflicted injuries, racing, suicide, war, illegal occupation, sports, custodial care, treatment for being overweight, service performed by a family member, Services related to sex or gender change, elective abortion, dental service or treatment, cosmetic surgery. Please see policy for a full list of limitations and exclusions.

Tier of Coverage	Employee Cost Per Pay Period (24)
EMPLOYEE	$ 12.26
EMPLOYEE & SPOUSE	$ 23.41
EMPLOYEE & DEPENDENT CHILDREN	$ 16.95
FAMILY	$ 28.10

Refer to your Summary Plan Description and Policy Certificate for full details on the plan

Life Insurance Highlights
For the employee

PURELIFE-plus

Flexible Premium Life Insurance to Age 121
Policy Form PRFNG-NI-10

Voluntary permanent life insurance can be an ideal complement to the group term and optional term your employer might provide. This voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term, on the other hand, typically are not portable if you change jobs and, even if you can keep them after you retire, usually cost more and decline in death benefit.

The policy, PURELIFE-plus, is underwritten by Texas Life Insurance Company, and it has the following features:

- **High Death Benefit.** With one of the highest death benefits available at the worksite,[1] PURELIFE-plus gives your loved ones peace of mind.
- **Minimal Cash Value.** Designed to provide a high death benefit at a reasonable premium, PURELIFE-plus provides peace of mind for you and your beneficiaries while freeing investment dollars to be directed toward such tax-favored retirement plans as 403(b), 457 and 401(k).
- **Long Guarantees.**[2] Enjoy the assurance of a policy that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time.[3]
- **Refund of Premium.** Unique in the marketplace, PURELIFE-plus offers you a refund of 10 years' premium, should you surrender the policy if the premium you pay when you buy the policy ever increases. *(Conditions apply.)*
- **Accelerated Death Benefit Due to Terminal Illness Rider.** Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit, minus a $150 ($100 in Florida) administrative fee in most states. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply.) (Form ICC07-ULABR-07 or Form Series ULABR-07)*

You may apply for this permanent, portable coverage, not only for yourself, but also for your spouse, children and grandchildren by answering just 3 questions:[4]

During the last six months, has the proposed insured:

a. Been actively at work on a full time basis, performing usual duties?
b. Been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
c. Been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment, or treatment for alcohol or drug abuse?

Like most life insurance policies, Texas Life policies contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please contact a Texas Life representative for costs and complete details.

[1] Voluntary and Universal Whole Life Products, Eastbridge Consulting Group, October 2012
[2] Guarantees are subject to product terms, exclusions and limitations and the insurer's claims-paying ability and financial strength.
[3] After the guaranteed period, premiums may go down, stay the same, or go up.
[4] Coverage and spouse/domestic partner eligibility may vary by state. Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships, and legally recognized familial relationships. Coverage not available on children and grandchildren in Washington.

See the PURELIFE-plus brochure for details.

TEXASLIFE INSURANCE COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

16M009-C 1006 R0916 (exp0118)

PURELIFE-plus is not available in NJ, NY or PA.

Disclosure Notice – Prescription Drug and Medicare Notice

Important Notice from the Putnam County BOC 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 the Putnam County BOC 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. The Putnam County BOC has determined that the prescription drug coverage offered by the Anthem Blue Open Access POS OAP5 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 Putnam County BOC coverage will not be affected.
If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the Putnam County BOC benefit plan during an open enrollment period under the Putnam County BOC benefit plan.

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 the Putnam County BOC 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 Putnam County BOC 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).

From: July 1, 2023 to June 30, 2024
Name of Entity/Sender: Putnam County Board of Commissioners
Contact Person: Cynthia Miller

Disclosure Notice – Prescription Drug and Medicare Notice

Non-creditable

Important Notice from the Putnam County BOC 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 the Putnam County BOC 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Putnam County BOC has determined that the prescription drug coverage offered by the OAP 12 5000/30%/7900C is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the OAP 12 5000/30%/7900C. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Blue Essential Open Access POS OAP 12 5000/30%/7900C. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 **Putnam County BOC** coverage will not be affected.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the **Putnam County BOC** benefit plan during an open enrollment period under the **Putnam County BOC** benefit plan.

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 the **Putnam County BOC** 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 **Putnam County BOC** 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).

From: July 1, 2023 to June 30, 2024

Name of Entity/Sender: Putnam County Board of Commissioners

Contact Person: Cynthia Miller

Other Disclosure Notices

Unless otherwise noted, a paper copy is available, free of charge, by calling NFP at 800-994-7429.

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION 125 PRE-TAX BENEFIT AUTHORIZATION NOTICE:
Before-tax deductions will lower the amount of income reported to the federal government. This may result in slightly reduced Social Security benefits. If you do not enroll eligible dependents at this time, you may not enroll them until the next open enrollment period. You may not drop the coverage you elected until the next open enrollment period. You may only make a change or drop coverage elections before the next open enrollment period under the following circumstances:
A change in marital status, or
A change in the number of dependents due to birth, adoption, placement for adoption or death of a dependent, or
A change in employment status for myself or my spouse, or
Open enrollment elections for my spouse, or
A change in dependents eligibility, or
A change in residence or worksite.
Any change being made must be appropriate and consistent with the event and must be made within 30 days of when the event occurred. All changes are subject to approval by your Employer/Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE:
The Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breast, prostheses, and complications resulting from a mastectomy, including lymph edema.

NEWBORNS' ACT DISCLOSURE:
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96) hours.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION: This Notice describes how the Plan(s) may use and disclose your protected health information ("PHI") and how you can get access to your information. The privacy of your protected health information that is created, received, used or disclosed by the Plan(s) is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice is available on the web at: www.putnamcounty.bswift.com. A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan."

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS*:* On April 7, 1986, a federal law was enacted (Public Law 99272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. If you or your eligible dependents enroll in the group health benefits available through your Employer you may have access to COBRA continuation coverage under certain circumstances. Therefore, your plan makes available to you and your dependents the General Notice Of COBRA Continuation Coverage Rights. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The full Notice is available on the web at: www.putnamcounty.bswift.com . A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their spouse/dependents covered under the group health plan.

SUMMARY OF BENEFITS AND COVERAGE (SBC): As an employee, the group health (medical) benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC) which summarizes important information about any health coverage option in a standard format to help you compare across options. The SBC is available on the web at www.putnamcounty.bswift.com. A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan.

HEALTH INSURANCE MARKETPLACE NOTICE (a.k.a. Exchange Notice): When key parts of the health care law took effect in 2014, a new way to buy health insurance became available through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, the Marketplace notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer. This notice is available on the web at www.putnamcounty.bswift.com. A paper copy is also available, free of charge, by calling your Employer.

CHIP Disclosure Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https//www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp. Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx Phone: 1-800-541-5555	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: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)	NEBRASKA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2023, 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

Why Should I Contact the NFP Service Center?

Order ID Cards: We can contact the insurance carrier directly and have your replacement card in ten to fifteen business days.

Claim Resolution and Research: We can help you understand your Explanation of Benefits (EOB) as well as contact the insurance carriers on your behalf. We can assist in appealing a denied claim or help you request a Prior Authorization (PA) from your physician as it may be required by your medical carrier. We can also help you file out-of-network claims and assist with reimbursement if you require medical assistance while traveling outside of the United States.

Locate In-Network Providers: Staying in network saves everyone money. Our Service Center can help you locate In-Network Providers for medical, dental and vision coverage whether you are at home or away.

Request Copies of Any Necessary Forms: Medical claim forms, out-of-network claim forms, evidence of insurability forms, short- and long-term disability claim forms and any other applicable forms are always available if the need should arise.

Understanding Your Benefits: We can assist you with questions regarding deductibles, copayments and coinsurance. We can explain waiting periods, elimination periods and eligibility rules.

Explain Qualifying Events: Most benefit plans require that you have a Qualifying Event (like marriage, birth of a child or other life event) to make a change in your election anytime other than during open enrollment. We work with your employer to ensure that your change follows the rules of the plan, that your request is allowed within the appropriate timeframes, and that you provide proper documentation of the event.

Annual Enrollment Information: We can provide details about when open enrollment begins and ends and if your plan designs or payroll deductions are changing.

Enrollment Assistance: The Service Center Representative can walk you through every step of the enrollment process. Whether it's an online enrollment or paper enrollment form, your Service Center Representative is available to help.

Confirmation Statements: We can provide copies of your online enrollment confirmation statement or a copy of your paper enrollment form at any time.

The Service Center is available from 8:30 a.m. to 5:00 p.m. Monday through Friday to assist you. We have an after-hours voice mailbox and will return your call the next business day.

800-994-7429
NFPseCustomerService@nfp.com

Contact Information

Plan	Administrator	Website	Phone Number
Benefit / Enrollment Questions	NFP	www.nfp.com	(800) 994-7429
Medical Benefits	Anthem	www.anthem.com	(855) 397-9267
Supplemental Health	Brella	www.joinbrella.com	(888) 300-5382
Dental Benefits	Anthem	www.anthem.com	(855) 397-9267
HRA	Admin America	www.adminamerica.com	(800) 366-2961
Vision Benefits	Anthem	www.anthem.com	(855) 397-9267
Life and AD&D Insurance	Anthem	www.anthem.com	(855) 397-9267
Short Term Disability	Anthem	www.anthem.com	(855) 397-9267
Long Term Disability	Anthem	www.anthem.com	(855) 397-9267
Supplemental	AFLAC	www.aflacgroupinsurance.com	(800) 433-3036
Universal Life	Texas Life	www.texaslife.com	(800) 283-9233
Human Resources	Cynthia Miller	https://ess.tyler-incode.com/putnamcountyga	(706) 485-1885