2023 EMPLOYEE BENEFIT GUIDE

POPE COUNTY
ARKANSAS

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WHAT YOU NEED TO KNOW

Employees who work a minimum of 30 hours per week are eligible to enroll themselves and their qualified dependents in employee benefits. Employees must be actively at work to enroll in benefits.

Checklist of what to bring for open enrollment for each dependent that you are enrolling in eligible benefits:

Social Security Number
Address
Date of Birth
Step-Child(ren) dependent verification required, must have copy of divorce decree or court-ordered custody arrangement

Having these items will expedite the completion of all enrollment forms, beneficiary cards, etc.

If you are a current employee (not a new hire), please keep the following information in mind:

- You cannot make any changes until the annual "open enrollment period", which allows employees, who may have previously declined to enroll, the opportunity to enroll in new coverage. (Certain restrictions and limitations may have employees who initially declined coverage when they first became eligible to enroll.)
    - However, there are certain qualifying events that allow current employees to make benefit changes. These include, but are not limited to:
        - marriage, divorce, adoption or birth of child, death of a spouse or other eligible dependent.

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ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Locate your enrollment/change forms
- Fill out any necessary personal information
- Make your benefit choices
- If you have questions or concerns, please contact your HR department.

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student or marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer states otherwise
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes unpaid leave of absence
- You or your spouse has a change in employement status
- Your spouse dies
- You become ineligibile for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

PACKAGE OVERVIEW & CONTACT INFORMATION

Pope County offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.
Effective January 1, 2023:

- Medical benefit plan with Municipal League
- Dental benefit plan with Delta Dental of AR
- Vision benefit plan with Principal Financial
- Basic Life / AD&D and Voluntary Life & AD&D with The Standard Insurance Company
- Long-Term disability plan with The Standard Insurance Company

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards. In the meantime, you can look up providers for your health plan at the following Preferred Provider Directory web address: https://www.arml.org/provider_search/index.php

Phone Numbers

501-978-6137 MHBP Direct Line
978-6137, Option 6. MHBP Customer Service Line
888-295-3591 Pre-Certification Line

Electronic Claims Filing Number (EDI): 81883

Pharmacy Benefit Information

Member Assistance:
For members having general questions about the Fund's prescription drug coverage should call the Optum Rx Customer Service at 855-253-0846 available 24/7.

HR at Pope County:
Terrie Duvall, HR Director
humanresources@popecountyar.gov

Rhonda Elliott, Chief Deputy Treasurer
rhonda.elliott@popecountyar.gov

Annita Davis, Payroll Deputy
annita.davis@popecountyar.gov

Tracy Stanek, Deputy Treasurer
tracy.stanek@popecountyar.gov

(479) 968-2194 office

GLOSSARY OF INSURANCE TERMS

Annual Maximum - The total dollar amount that a plan will pay for care incurred by an individual enrollee or family (under a family plan) in a specified benefit period.

Benefit Year - A period in which covered expenses are accrued and are counted toward the annual maximums, deductibles, and/or out-of-pocket limits.

Benefits - Items or services covered under an insurance plan.

Beneficiary - A person or entity entitled to receive the claim amount and other benefits upon the death of the benefactor or on the maturity of the policy.

Broker - An individual agent or agency who represents the buyer, rather than the insurance company, and tries to find the buyer the best policy. The broker can make specific recommendations about which plans best suit you and your family's needs.

COBRA - A federal law that may allow the insured to temporarily keep insurance coverages after employment ends.

Claim - A request for payment under an insurance plan. A claim will list the services rendered, the date of service, and an itemization of cost.

Coinsurance - Insurance in which the insured is required to pay a fixed percentage of the cost of expenses after the deductible has been paid.

Copayment (Copay) - A fixed amount that the insured is required to pay before receiving the service.

Deductible - An out-of-pocket amount that an insured must pay prior to an insurance plan paying a claim.

Dependent - A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.

Elimination Period - A period of continuous disability which must be satisfied before you are eligible to receive benefits.

Evidence of Insurability (EOI) - Part of the application process for an insurance policy during which an applicant provides health information. Coverage does not become effective until approval of the EOI.

Flexible Spending Account (FSA) - A type of account that provides the account holder with specific tax advantages on qualified medical and/or dependent care expenses (ex. Medical Reimbursement, Dependent Care, and/or Limited Purpose FSA).

Guaranteed Issue - A predetermined benefit amount allowed by an insurance plan without requiring Evidence of Insurability (EOI). GI allows you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. This does not, however, preclude the application of the pre-existing condition exclusions.

Limited Purpose FSA - A type of account to be used with an HSA. It is reserved for the payment of dental and vision expenses only.

Long-Term Care - A range of services and supports you may need to meet your personal care needs in the event of a chronic illness or disability.

Medically Necessary - A covered health service or treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice.

Network - The facilities, providers and suppliers your insurance plan has contracted with to provide health care services (i.e. "in-network").

Non-Preferred Provider - A provider who does not have a contract with your insurance carrier or plan to provide services to you. You'll pay more to see a non-preferred provider. (i.e. "out-of-network").

Out-of-Pocket Maximum - The maximum amount of money you may pay for services in a benefit year.

Pre-Existing Condition - A medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the insurance company.

Premium/Rate - The amount you pay for your insurance premiums each month.

Qualifying Life Event (QLE) - A change in your situation that can make you eligible for a special enrollment period, allowing you to enroll in an insurance plan outside the yearly open enrollment period. (ex. Loss of coverage, getting married or divorced, having a baby/adopting a child, or a death in the family).

HEALTH INSURANCE

Arkansas Municipal League is our health insurance provider. Arkansas Muncipal League provides health insurance plan benefits for office visits, preventive care, prescription drugs, and hospital services.

COPAY (BUY UP PLAN)	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
Individual	$1,200	
Family	$6,000	
OUT-OF-POCKET MAXIMUM		
Individual	$4,000	N/A
Family	$8,000	N/A
Coinsurance	80%	50%
Lifetime Benefit Maximum	Unlimited	Unlimited
COVERED SERVICES AND BENEFITS		
OFFICE VISITS		
Primary Care Physician	$20*	$20*
Specialist	$20*	$20*
Telemedicine 1-877-308-3362	$0 Copay	$0 Copay
EMERGENCY MEDICAL CARE		
Emergency Room	$250 copay + Deductible + 20% coinsurance	
Urgent Care Center	$20*	
Ground Ambulance	Limited to two trips per year	
Air Ambulance ($10,000/trip)		
HOSPITAL SERVICES		
Inpatient Services	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Services	Deductible + Coinsurance	Deductible + Coinsurance
PRESCRIPTIONS		
Generic Brand	$10	N/A
Preferred Brand	$30	N/A
Non Preferred Brand	$50	N/A

*co-pay amounts cover all charges billed under CPT Codes 99201 through 99215. Any charges outside these ranges will be subject to deductible and co-insurance.

MEDICAL BENEFITS AND LIMITATIONS

Major Medical Schedule of Benefits

Individual Medical Coverage	Lifetime	No Maximum Dollar Limit
Acute Inpatient Habilitation/Rehabilitation	Annual	30 Days
Sub-Acute Inpatient Habilitation/Rehabilitation		15 Days
Habilitative Services		15 Days
Bariatric Weight Loss Program*		
Chemical Dependency Treatment	Lifetime	1 Treatment Plan **
Diabetic Training	Annual	1 Day Session
Non-Emergency Surgical Procedures	Annual	2
Requiring Precertification (Hospital or Ambulatory Surgery Center)		
Hearing Aids	One per ear one (1) time every three (3) years	
Home Health Services	Annual	20 Visits
Hospice Care	Lifetime	90 Days
Inpatient Hospital Services	Annual	30 Days
Mental/Nervous Disorders		
Inpatient	Annual	10 Days
Individual Therapy Sessions	Annual	24 Visits
PET Scans Annual 2 Each		
Nutritional and Weight Counseling	Annual	2 Visits
Outpatient Occupational, Physical, Speech, Habilitative Therapy and Chiropractic Services (Combined Benefit)	Annual	40 Visits Combined
Organ Transplant Benefits	Lifetime	2 Transplants***
Custom Molded Foot Orthotics	Annual	2 Pairs
Diabetic Related Footwear/Shoes	Annual	2 Pairs
Prosthetic Bra for Oncology Covered Members	Annual	2 Each
Wound Care and Hyperbaric Oxygen Treatment	Annual	20 Visits
Sleep Study	Annual	1 Visit****

*These services will be covered exclusively through the Metabolic & Bariatric Surgery Accreditation & Quality Improvement Program (MBS-AQIP). All services must be pre-authorized and must be performed at a MBS-AQIP designated Treatment Center. For more information call 888-295-3591.

**Services must be rendered at MHBF Chemical Dependency Treatment Center to be covered. For details regarding this benefit, call 888-295-3591.

***Transplants must be performed at MHBF Designated Transplant Centers to be covered. For more information call 888-295-3591.

****Sleep study must be completed in one night. The Fund will not cover a second night

Stop Loss for Major Medical

When In-State, In-Network covered charges reach $20,000 for the covered individual or $40,000 for the covered family and the calendar year deductible(s) are met, the Fund will pay 100 percent of all covered services above that amount for the remainder of the calendar year, unless excluded or modified by other portions of this Fund Booklet. This is called a Stop Loss Provision or Out-of-Pocket Maximum. Out-of-State In-Network Provider and Non-PPO provider charges do not count toward the Out-of-Pocket Maximum(s) and the Fund will not pay 100 percent of Out-of-State In-Network Provider and Non-PPO provider charges. In addition, penalty deductible(s), and the emergency room services copayments, and prescription drug copayments do not count toward the Out-of-Pocket Maximum(s). The Fund will not pay 100 percent of the emergency room service charges even though provider retains the patient for observation. The copayment may be waived for an inpatient hospital room admission.

Pre-certification, Penalty Deductibles, and Utilization Review

It is the member's responsibility to pre-certify the following services by calling 888-295-3591. A $1,500 penalty deductible will be assessed for failure to pre-certify any services requiring precertification, per occurrence. Pre-certification requirements apply even if the Fund is a secondary payer. A covered member must pre-certify the following services including but not limited to:

- Ambulatory Surgical Procedures (whether they are performed in a hospital, ambulatory surgery center or doctor's office)
- Bariatric Weight Loss Program
- Chemical Dependency Treatment
- Durable Medical Equipment (if purchase price or annual rental exceeds $2,000)
- Home Health Care Services (care in a home setting)
- Hospice Care
- Inpatient Hospital Confinements (including Inpatient Mental Health and Rehabilitation)
- Organ Transplant Services
- Outpatient Observation lasting more than 23 hours (all outpatient stays lasting more than 24 hours will be reimbursed as Inpatient Confinements, and/or charges will be reduced to 23 hours of observation)
- PET Scans
- Prosthetic Devices (if purchase price exceeds $2,000)
- Wound Care & Hyperbaric Oxygen Treatments

If you have any doubt whether or not a procedure or service requires precertification, please call 888-295-3591.

Non-Emergency Surgical Procedures — Annual Maximum of 2
(hospital or ambulatory surgery center)

For a comprehensive list of non-emergency surgical procedures, please call 888-295-3591. Members are allowed a yearly maximum of two procedures.

Non-Emergency Surgical Procedure means a medical procedure to improve health or quality of life when the medical condition is not considered immediately life-threatening. Non-emergency surgical procedures are pre-scheduled for a specific date and are not considered emergent in nature.

Please call 888-295-3591 anytime to verify if precertification will be needed.

Surgical Procedures

Precertification is required for surgical procedures regardless of where they are performed.

Utilization Review Program

The Fund has adopted a Utilization Review Program. The Utilization Review Program is the critical examination of healthcare services to patients to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the health benefit plan. The Utilization Review Program is provided directly by the Fund, which is a licensed review agent. The Utilization Review Program can include, but is not limited to pre-admission review, preauthorization/precertification, concurrent review, retrospective review, case management, and discharge planning. All claims are subject to the Utilization Review Program.

In certain cases, the Review Program requires certification prior to treatment, as well as concurrent review, discharge planning, cost effectiveness, and medical case management. A $1,500 penalty deductible will be assessed for failure to precertify with the Utilization Review Program where the Fund requires pre-certification.

Once a service has been pre-certified, the services must be rendered within 30 days of the pre-certified date of service. If the services are not rendered within the 30-day time period, the pre-certification process must be started again.

You or your doctor must pre-certify by calling the Utilization Review Program at 888-295-3591. The ultimate responsibility to pre-certify rests with the covered Member.

Inpatient Admission

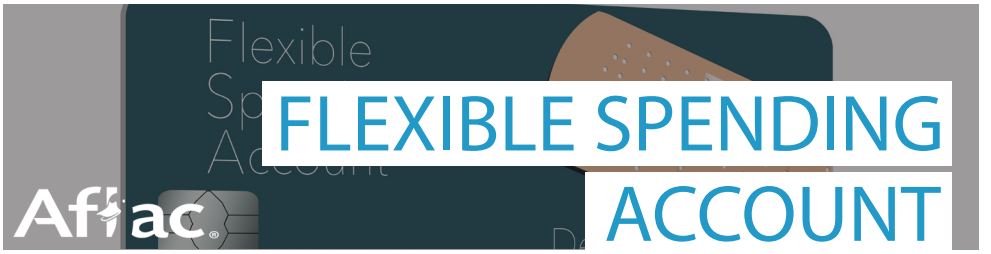
You must notify the Utilization Review Program of a scheduled admission prior to the date of service. As soon as you know you will be hospitalized, you or your physician must pre-certify your care by calling the Utilization Review Program at 888-295-3591. Inform the Utilization Review Program that you are covered under the Fund and provide the Utilization Review Program with your doctor's name and telephone number. Failure to notify the Utilization Review Program prior to admission will result in the assessment of a $1,500 penalty deductible.

If your admission is due to an emergency, you or your family or physician will have until 5:00 p.m. the next business day to notify the Utilization Review Program of that admission. Direct admissions from your physician's office are not considered emergencies and must be pre-certified by you or your physician within twenty-four (24) hours. Failure to do so will result in the assessment of $1,500 penalty deductible.

Outpatient observations lasting more than 23 hours may be considered as an inpatient admission and/or reduced to the 23-hour observation limit. No benefits will be paid for any charges related to non-certified days or services. Any observations lasting more than 23 hours must be pre-certified. Failure to do so will result in the assessment of a $1,500 penalty deductible.

Exception for Childbirth

The Fund does not restrict the duration of hospital stay for the mother or newborn child up to a stay of 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. The Utilization Review Program must be notified for stays in excess of 48 hours or 96 hours at 888-295-3591.



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FLEXIBLE SPENDING ACCOUNTS (FSA)

Who is Eligible and When

All Full-Time Employees working at least 30 hours each week. Please check with your HR representative or Aflac Respresentative for specific eligibility requirements.

Benefits You Receive

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses and prescriptions not covered by their insurance plan with pretax dollars. There are limits on salary reduction contributions to a health FSA offered under a cafeteria plan and is applicable to both grandfathered and non-grandfathered health FSAs. This limit will be indexed for cost-of-living adjustments. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA

The Dependent Care FSA lets employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

DENTAL INSURANCE

Delta Dental is a dental insurance provider. Having dental insurance contributes to your total well-being. With this plan, you have comprehensive dental coverage at affordable rates.

COVERED DENTAL SERVICES
• ORAL EXAMINATIONS, INCLUDING PROPHYLAXIS, BUT NOT MORE THAN TWO EXAMINATIONS IN ANY CALENDAR YEAR.
• Topical application of sodium or stannous fluoride and the application of sealants.
• Dental X-rays.
• Fillings, extractions, space maintainers, and oral surgery.
• Anesthetics administered in connection with covered dental services.
• Injection of antibiotic drugs by the attending dentist.
• Treatment of periodontal and other diseases of the gums and tissues of the mouth.
• Endodontic treatment, including root canal therapy.
• Repair or re-cementing of crowns, inlays, bridgework or relining or repair of dentures.
• Initial installation (including adjustments for the six-month period following installation) of partial or full removable dentures to replace one or more natural teeth extracted while covered under these provisions
• New Dentures or Bridgework:
• Inlays, gold fillings, crowns (including precision attachments for dentures), and initial installation of fixed bridgework (including inlays and crowns to form abutment) to replace one or more natural teeth extracted while covered
• Orthodontic treatment, including correction of malocclusion - Children to age 19 Only
• Temporomandibular Joint Dysfunctions (TMJ)

Delta Dental is a dental insurance provider. Having dental insurance contributes to your total well-being. With this plan, you have comprehensive dental coverage at affordable rates.

DENTAL EXCLUDED SERVICES
No benefits are payable for charges a covered member is not required to pay or which would not be made if benefits did not exist, or for expenses incurred:
• THE REPLACEMENT OF A LOST OR STOLEN PROSTHETIC DEVICE.
• Charges made by a provider other than a dentist, or charges for treatment by a provider other than a dentist,except for a prophylaxis, which may also be performed by a licensed dental hygienist working under the supervision of a dentist.
• Incurred due to a medical condition
• Services performed in a hospital or out-patient surgery setting
• Prosthetic devices (including bridges, crowns and appliances) and the fitting thereof which were ordered for an individual prior to his becoming covered under these provisions
For care, treatment, services, and supplies that are:
a. Furnished primarily for cosmetic purposes.
b. Provided by someone who is an immediate relative as defined in the "Definitions" sections of

Dental Care Coverage Maximums and Deductible	Frequency	Amount
Dental Calendar Year Deductible	Annual	$50
Dental Procedures	Annual	$1,500
Orthodontic	Lifetime	$1,000
Temporomandibular Joint Dysfunction	Annual	$1,000

Principal is our vision insurance provider. Vision insurance provides enhanced benefits for materials, frames, lenses and contacts.

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK COST REIMBURSEMENT
COPAYS		
Exams	$10	Up to $45
Frames Any available frame at provider location.	$130 allowance	Up to $70
Contact Lenses: Contact Lens allowance includes materials only.		
Elective	$130 allowance	Up to $210
Medically Necesssary	$25 Copay	Up to $210
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $65

SERVICES	FREQUENCY
Exam	12 months
Lenses	12 months
Frames	24 months
Contacts	12 months

INSURANCE RATES

HEALTH, DENTAL AND VISION RATES

Pope County contributes to the cost of the medical plan for you.

HEALTH RATES

Tier	Municipal Health Monthly Cost	Your Monthly Cost	Your Per Pay Period Cost (26 pay periods)
Employee	$467.50	$ -	$ -
Employee + Spouse	$1027.50	$560.00	$258.46
Employee + Child(ren)	$1027.50	$560.00	$258.46
Employee + Family	$1027.50	$560.00	$258.46

DENTAL RATES

Tier	Delta Dental Monthly Cost	Your Monthly Cost	Your Per Pay Period Cost (26 pay periods)
Employee	$25.58	$25.58	$11.81
Employee + Spouse	$51.16	$51.16	$23.61
Employee + Child(ren)	$68.04	$68.04	$31.40
Employee + Family	$98.16	$98.16	$45.30

VISION RATES

Tier	Principal Vision Monthly Cost	Your Monthly Cost	Your Per Pay Period Cost (26 pay periods)
Employee	$10.66	$10.66	$4.92
Employee + Spouse	$17.06	$17.06	$7.87
Employee + Child(ren)	$17.42	$17.42	$8.04
Employee + Family	$28.07	$28.07	$12.96

EMPLOYER PAID BENEFIT	
Life Benefit	$25,000
AD&D Benefit	$25,000
Guaranteed Issue Amount	$25,000
Conversion Privilege	Included
Waiver of Premium	Included

VOLUNTARY GROUP TERM LIFE & AD&D

The Standard is our voluntary group term life provider. This coverage provides you and your dependents with additional protection for those who depend on you financially.

Life Benefit	Employee	Spouse	Dependent
Amount	6x annual salary, not to exceed $300,000	50% of the approved employee benefit amount, not to exceed $150,000	Up to a maximum of $5,000
Guaranteed Issue (for Newly Eligible Employees)	$200,000	30,000	$5,000
Accelerated Death Benefit	75% of life benefit		
Included	Waiver of Premium, Portability		
Reduction	Benefits reduce to 65% at Age 65, to 50% at Age 70, and to 35% at age 75.		

VOLUNTARY AD&D COVERAGE

BENEFIT HIGHLIGHTS	
Rates	Employee Only= $0.04 per $1,000 of coverage Spouse= $0.035 per &1,000 Child= $0.03 per $1,000

The Standard is our long term disability provider. Disability insurance provides income protection in the event that you miss work due to an accident or illness.

LONG-TERM DISABILITY - EMPLOYER PAID

BENEFIT	BENEFIT DETAILS
BENEFIT AMOUNT	66 2/3% of covered monthly earnings, up to a maximum of $6,000
MAXIMUM MONTHLY BENEFIT	$6,000
BENEFITS BEGIN ON	91st Day
MAXIMUM BENEFIT DURATION	Social Security Normal Retirement Age
PRE-EX PERIOD	N/A
WAIVER OF PREMIUM	Included
OWN OCCUPATION PERIOD	24 Months

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program1 (EAP) which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)2 and all household members can contact master's-degreed clinicians 24/7 by phone, online, live chat, email and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three face-to-face assessment and counseling sessions per issue. EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation

Contact **EAP**

888.293.6948
TDD: 800.327.1833
24 hours a day,
seven days a week

workhealthlife.com/Standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

WorkLife Services
WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, travel, daily living and care for your pet, child or elderly loved one.

Online Resources
Visit workhealthlife.com/Standard3 to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

MEDICAL TRANSPORT SOLUTIONS (MASA)

The high cost of emergent and non-emergent transportation results in unexpected out of pocket expenses. MASA protects members from these expenses related to emergency air transportation and ground ambulance charges.

ANY GROUND. ANY AIR. ANYWHERE. ™

BENEFITS	EMERGENT PLUS	PLATINUM
Family Included	Yes	Yes
Emergent Ground Transportation (U.S. & Canada)	Yes	Yes
Emergent Air Transportation (U.S. & Canada)	Yes	Yes
Repatriation (Worldwide)	Yes	Yes
Non-Emergent Interfacility Transportation (Worldwide)	Yes	Yes
Return Transportation (Worldwide)	No	Yes
Vehicle Return (Basic Coverage Area)	No	Yes
Organ Transplant Transportation (U.S. & Canada)	No	Yes
Pet Return (Basic Coverage Area)	No	Yes
Minor Children/Grandchildren Return (Basic Coverage Area)	No	Yes
Mortal Remains Transportation (Worldwide)	No	Yes

MASA Medical™ Transport Solutions

- Global Reach Emergent Plus (US 50/ Canada), Platinum (up to worldwide)
- Leading company in the Industry
- The only plans that cover at home and away
- MASA steps in where insurance falls short by helping protect families against uncovered costs
- MASA also provides many benefits not covered by insurance
- Any Ground. Any Air. Anywhere TM Simply contact 911 for Emergency Transport
- Covers any of the 1,500+ Air Ambulances in US with 300 different Provider Companies
- Covers any of the 21,000 Ground Ambulance Providers in the US
- US Based Support, Local Reps, Simple Enrollment, Easy Claims, and Online access

FREE Online and Telephone Access to Medical Professionals

No Co-pay Telemedicine

☎ 1-877-308-3362

In the State of Arkansas, it is currently law that the first consultation with a licensed telemedicine physician must be a live video consultation. This will require the patient to be logged into the eDocAmerica telemedicine portal where the video consultation will take place.

Once a patient has been through the first initial video consultation, the patient can choose to have future telemedicine consultations by phone or by video. If you are out of state, your first consultation can be by telephone.

- Call the toll-free number to schedule your confidential telephone or video consultation.
- Use it when you travel, available in all 50 states.
- If the physician writes a prescription, it will be called into your pharmacy of choice.
- Treat common ailments like colds, flu, allergies, pink eye, UTIs, sinus infections, headaches, sore throats, nausea, etc.

FREE Online Medical Team

eDocAmerica.com

Emailing a specialist is perfect for all your non-urgent, everyday life questions and needs. Ask anything, anytime and get a personal response on average within three hours.

- Go to www.eDocAmerica.com
- Click the "Sign In" button (top right corner)
- Either sign in or register your account
- In the center of the screen you will see the "Message A Specialist" option - click the "Start A Conversation Now"
- Choose the specialist and send in your question

Specialists available include primary care, psychologists, pharmacists, dentists, dietitians, trainers, pediatricians, dermatologists, women's health, and more...

Services are unlimited and for the entire family. All interactions are completely private and confidential.

eDocAmerica.com
1-866-525-eDoc (3362)

Online Smartphone Telephone

WOMEN'S HEALTH and CANCER RIGHTS ACT NOTICES

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;
- ✓ Prostheses; and
- ✓ Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

CALENDAR YEAR DEDUCTIBLE		
Individual	$1,200	
Family	$6,000	
OUT-OF-POCKET MAXIMUM		
Individual	$4,000	N/A
Family	$8,000	N/A
Coinsurance	80%	50%
Lifetime Benefit Maximum	Unlimited	Unlimited

In compliance with Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

To request additional information, contact Terrie Duvall, 100 West Main Street, Russellville AR 72801, (479) 968-2194 or via HumanResources@popecountyar.gov

NEWBORNS' and MOTHERS' HEALTH PROTECTION ACT NOTICE

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).

Contact Terrie Duvall, 100 West Main Street, Russellville AR 72801, (479) 968-2194 or via HumanResources@popecountyar.gov with any questions or for more information.

SPECIAL ENROLLMENT RIGHTS NOTICE

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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing 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 and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid assistance, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Terrie Duvall, 100 West Main Street, Russellville AR 72801, (479) 968-2194 or via HumanResources@popecountyar.gov.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Terrie Duvall 479-968-2194 humanresources@popecountyar.gov.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
POPE COUNTY	71-6010879
5. Employer address	**6. Employer phone number**
100 West Main Street	(479) 968-2194

7. City	8. State	9. ZIP code
Russellville	AR	72801

10. Who can we contact about employee health coverage at this job?	
Terrie Duvall	
11. Phone number (if different from above)	**12. Email address**
(479) 968-2194	humanresources@popecountyar.gov

Here is some basic information about heal

- As your employer, we offer a health p

☐ All employees. Eligit

☒ Some employees. Eligible employees are:

All full−time employees working a minimum average of 30 hours per week. All variable−hour employees determined to have met ACA full−time status in the applicable tracking period by working a minimum average of 30 hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal dependents by marriage, birth, adoption or guardianship. Dependents are covered through end of 26th birth month.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

EMPLOYEE NOTICES

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 July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – 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	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – 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.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – 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: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – 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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms 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	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

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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To see if any other states have added a premium assistance program since July 31, 2020, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

EMPLOYEE NOTICES

EMPLOYEE RIGHTS UNDER THE FAMILY and MEDICAL LEAVE ACT - FMLA

Leave Entitlements

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

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

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

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

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

Benefits & Protections

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

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

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

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

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

EMPLOYEE NOTICES

Eligibility Requirements

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

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

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

Requesting Leave

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

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

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

Employer Responsibilities

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

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

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor I Wage and Hour Division

EMPLOYEE NOTICES

GENERAL COBRA RIGHTS NOTICE

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

EMPLOYEE NOTICES

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ✓ Your hours of employment are reduced, or
- ✓ Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ✓ Your spouse dies;
- ✓ Your spouse's hours of employment are reduced;
- ✓ Your spouse's employment ends for any reason other than his or her gross misconduct;
- ✓ Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- ✓ You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- ✓ The parent-employee dies;
- ✓ The parent-employee's hours of employment are reduced;
- ✓ The parent-employee's employment ends for any reason other than his or her gross misconduct;
- ✓ The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- ✓ The parents become divorced or legally separated; or
- ✓ The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Pope County, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

EMPLOYEE NOTICES

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- ✓ The end of employment or reduction of hours of employment;
- ✓ Death of the employee;
- ✓ Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- ✓ The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

You must provide this notice to:

Contact--Position/Office: Terrie Duvall, HR Director, Human Resources Department
Address: 100 West Main Street, Russellville AR 72801
Phone Number/E-Mail: (479) 968-2194 or via HumanResources@popecountyar.gov

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov

EMPLOYEE NOTICES

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

The month after your employment ends; or
The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Contact--Position/Office: Terrie Duvall, HR Director, Human Resources Department
Address: 100 West Main Street, Russellville AR 72801
Phone Number/E-Mail: (479) 968-2194 or via HumanResources@popecountyar.gov

MEDICARE PART D CREDIBLE COVERAGE NOTICE

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pope 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. Pope County has determined that the prescription drug coverage offered by the Pope County Health and Welfare 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 Pope County coverage will be affected. Plan Participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group plan will coordinate with the Medicare Part D prescription drug coverage. If plan participants drop the group health plan, they can get it back during the next open enrollment.

If you do decide to join a Medicare drug plan and drop your current Pope 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 Pope 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 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).

Contact--Position/Office: Terrie Duvall, HR Director, Human Resources Department

Address: 100 West Main Street, Russellville AR 72801

Phone Number/E-Mail: (479) 968-2194 or via HumanResources@popecountyar.gov

YOUR RIGHTS UNDER USERRA
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — April 2017

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JTSFINANCIAL
INTENTIONALLY DIFFERENT.

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