2023 Employee Benefits

DCH Health System®

CHAMPIONS FOR YOUR HEALTH

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Overview of Your Flexible Benefits

You're working hard to provide the best care and services so our patients can be as healthy as possible. As part of how we reward you for all you do, DCH offers a comprehensive selection of benefits from which to choose so you can ensure you and your family are healthy, too.

Each year, DCH sets aside a certain amount of money for your benefits. Some of that money is used to provide basic term life insurance, basic long-term disability coverage, DCH's portion of health insurance coverage for employees and dependents and to fund the DCH pension plans. We offer:

- Accidental death & dismemberment insurance
- Accident Advantage Insurance
- Cancer insurance
- Dental insurance
- Health insurance
- Employee Workforce Clinic
- Vision care insurance
- Life insurance
- Wondr Health Wellness Porgram
- Short-term disability coverage
- Long-term disability coverage
- Medical and dependent care tax-free spending accounts
- Pet Insurance
- A two-part retirement program

This booklet has all the information you need to make the most of your benefits options. See the remainder of this booklet for details on enrolling in plans, paying for coverage and using your benefits effectively.

Note: If you are currently eligible for Medicare or will become eligible for Medicare in the coming year, please refer to and carefully review the DCH Notice of Creditable Coverage on page 14 concerning prescription drug coverage under Medicare.

Enrolling, Making Changes and Paying for Coverage

Enrollment Opportunities

You are eligible to enroll yourself and your eligible dependents, with required documentation, in any of the benefits offered by DCH within 30 days of your benefits eligibility date. An employee must be classified as a .7 FTE (56 hours per pay period) or above to meet benefit eligibility requirements. Employees who were a .5 or .6 FTE and enrolled in benefits on April 1, 2022, are grandfathered as benefit eligible. Grandfathered employees can only change their FTE except to a .7 or higher in order to maintain their benefited status. For further information on eligibility, please contact the Human Resources Department at 205-333-4772. You will need Social Security numbers and dates of birth to enroll your eligible dependents, along with the required documentation listed in the next section.

As a new enrollee, your coverages will be effective the first day of the month following your benefits eligibility date if you enroll within 30 days. Eligible changes made due to a family status change will be effective the date of the family status change as long as the changes are made within the appropriate time frame. If you wait longer than 30 days, there will be restrictions as to when you can enroll and you may be required to complete medical underwriting for some benefits.

Whom You May Enroll

Your eligible dependents are:

- Your legal spouse.
- A child* under age 26, regardless of marital or student status.
- An incapacitated child, if the incapacity occurred before age 26.

*The child may be a natural child, stepchild, legally adopted child, child placed for adoption or any other child for whom you have permanent legal custody or that you or your spouse are court-ordered to cover. The child does not have to qualify as your dependent for purposes of Sections 105 and 106 of the Internal Revenue Code.

A grandchild is only eligible if he or she meets all of the following guidelines:

- You or your spouse has legal guardianship.
- He or she is under 26 years of age.

For grandchildren, the child must also qualify as your dependent for purposes of Sections 105 and 106 of the Internal Revenue Code. For more information, see Internal Revenue Service (IRS) Publication 502, which is available at **www.irs.gov/publications**.

To enroll your dependents, you must provide documentation that they are eligible for coverage.

How to Certify Dependents

STEP 1: Match each dependent you intend to enroll to the list below and have Social Security numbers and dates of birth available.
STEP 2: Gather all the necessary documents and bring copies to Human Resources when you submit your enrollment forms.

DOCUMENTATION REQUIREMENTS AND THINGS TO REMEMBER:

- Submit only the first page of your prior year federal tax return that shows your dependents (no state tax returns accepted).
- Documents proving joint ownership are: mortgage statements, credit card statements, bank statements and leasing agreements listing both parties' names as co-owners. *The joint ownership may be established prior to the current year; however, the statement provided must be issued within the last six months.*
- Proof of marriage must be a state-issued marriage license or marriage certificate (not a church-issued certificate) including the date of your marriage.
- Birth certificates must be state-issued birth certificates (not hospital-issued certificates).

Please be aware that your dependents will not be covered by DCH benefits until this documentation is provided. This information must be provided within 30 days of your benefits eligibility date or during our annual open enrollment. While covered by the DCH Total Rewards Benefits Program, you will be permitted to add newborn or newly adopted dependents within 60 days of birth/adoption/placement for adoption.

Dependent Certification Table		
ID	**Dependent Type**	**Required Documentation**
LS	Legal Spouse	One of the following: ▪ State-issued marriage certificate **AND joint** federal tax return within the last year. ▪ State-issued marriage certificate **AND** proof of joint ownership issued within last six months if no joint tax return available. ▪ State-issued marriage certificate only (if married in the last 30 days).
BC	Biological Child (under age 26)	▪ State-issued birth certificate only. ▪ May be added within 60 days of birth.
DBC	Disabled Biological Child (over age 26) *Must be medically certified as disabled before age 26*	▪ State-issued birth certificate **AND** annual proof of Social Security disability. ▪ May continue coverage past age 26 if no other coverage available.
AC	Adopted Child (under age 26)	One of the following: ▪ Adoption placement agreement **AND** petition for adoption. ▪ Adoption certificate only. ▪ May be added within 60 days of adoption or placement for adoption.
DAC	Disabled Adopted Child (over age 26) *Must be medically certified as disabled before age 26*	One of the following: ▪ Adoption placement agreement**,** petition for adoption **AND** annual proof of Social Security disability. ▪ Adoption certificate **AND** annual proof of Social Security disability. ▪ May continue coverage past age 26 if no other coverage available.
SC	Stepchild (under age 26)	One of the following: ▪ State-issued birth certificate, state-issued marriage certificate (for child's parent and employee) **AND joint** federal tax return within the last year. ▪ State-issued birth certificate, state-issued marriage certificate (for child's parent and employee) **AND** proof of joint ownership issued within last six months if no joint tax return available. ▪ State-issued birth certificate **AND** state-issued marriage certificate (for child's parent and employee) only (if married in the last 30 days).
DS	Disabled Stepchild (over age 26) *Must be medically certified as disabled before age 26*	One of the following: ▪ State-issued birth certificate, state-issued marriage certificate (for child's parent and employee), joint federal tax return within the last year **AND** annual proof of Social Security disability. ▪ State-issued birth certificate, state-issued marriage certificate (for child's parent and employee), proof of joint ownership issued within last six months if no joint tax return available **AND** annual proof of Social Security disability. ▪ State-issued birth certificate, state-issued marriage certificate (for child's parent and employee) only (if married in the last 30 days) **AND** annual proof of Social Security disability. ▪ May continue coverage past age 26 if no other coverage available.
LW	Legal Ward (under age 26)	▪ State-issued birth certificate **AND** court-ordered documentation of legal guardianship. ▪ May be added within 60 days of obtaining legal guardianship.
DW	Disabled Legal Ward (age 26 and over)	▪ State-issued birth certificate, court-ordered documentation of legal guardianship **AND** annual proof of Social Security disability.

Dependent Certification Table		
ID	**Dependent Type**	**Required Documentation**
	Must be medically certified as disabled before age 26	▪ May continue coverage past age 26 if no other coverage available.
QM	Qualified Medical Support Order (age 19 and under)	▪ Qualified Medical Child Support Order (for the employee or the employee's spouse).

How Long Coverage is Effective

The choices you make within 30 days of your benefits eligibility date will remain in effect during your employment except for flexible-spending accounts which must be renewed each year. Each fall, we give you an opportunity to update your benefit selections during our annual open enrollment period to be effective January 1 of the next year.

Making Changes During the Year

According to IRS regulations, you can only change or drop your benefit elections during the year when your family status changes due to one of the following reasons:

- You get married.
- You legally separate or divorce.
- Your child is born or you adopt a child.
- Your spouse or dependent dies.
- Your or your spouse's employment status changes (termination, layoff, reduction in hours, etc.)
- One or more of your dependents become ineligible for health insurance, dental, vision or life insurance coverage.

To make a benefits change, you must notify a Benefits Representative in Human Resources within 30 days of the change except when your child is born or you adopt a child. In those cases, you have 60 days to add the newborn or newly adopted child by notifying Human Resources. You will be required to provide documentation of the change. For example, to add a newborn, the bassinet card from the hospital will be satisfactory; if you marry, a copy of your marriage certificate is necessary; if you divorce, a copy of your final divorce papers is required.

Any changes you make in your benefits elections must be consistent with your change, as defined by the IRS. To enroll dependents in any of the benefits offered by DCH, you must provide documentation of your dependents' eligibility. Please see the Dependent Certification Table on page 5 for required documentation.

Paying for Coverage

When you elect optional benefits, you will pay for some of them with pre-tax dollars and some with after-tax dollars.

Health, dental, vision, cancer and accident insurance, as well as dependent care and medical spending accounts are pre-tax deductions. Optional life insurance, optional long-term disability insurance, short-term disability insurance, and long-term care insurance are after-tax deductions. Pet insurance is billed and paid directly to the provider.

Pre-tax premium payments may affect your Social Security benefits. If your earnings are lower than the Social Security taxable wage base, you will pay less in Social Security taxes because your taxable income will be reduced. As a result, the Social Security benefits you receive at retirement may be slightly less. In most cases, the immediate tax savings provided through purchasing benefits pre-tax will more than offset any slight reduction in your future Social Security benefits. Please consult your tax advisor to learn more about how you may be directly affected.

Designating Your Beneficiaries

A beneficiary may be listed for term life insurance and PTO/PIB benefits. It's important to keep your beneficiary choices current. Events such as marriage, divorce, or the birth or death of someone in your immediate family may require a beneficiary change. You may change your beneficiary at any time by completing a new form, available on the DCH intranet. If you do not list a beneficiary for your term life insurance and your PTO/PIB, the benefits will be paid to your estate.

Life Insurance

Primary beneficiaries receive the benefit amount listed if you die. Contingent beneficiaries receive the benefit amount listed **only** if all primary beneficiaries have also passed away. If there is more than one beneficiary but your beneficiary form does not specify their shares, they will share equally. If there is more than one primary beneficiary, and one or more of them have passed away before you, the amount listed will be divided among the remaining primary beneficiaries.

The primary beneficiary must be someone who is at least 19 years old. Both primary and contingent beneficiaries may be listed for the term life/AD&D insurance.

CTO and/or PIB

In addition to the beneficiary designation that you make for life insurance, you may also list a primary beneficiary for your CTO and/or PIB balances. The beneficiary rules are the same as above.

Supplemental Retirement Program

If you participate in the supplemental retirement program, you will need to provide beneficiary information to Transamerica. You can contact Transamerica at 1-800-755-5801.

Your Benefits Options

DCH Workforce Health Clinic: On-site medical clinic open to all employees and their dependents covered under DCH medical insurance. There are no copays applicable to services.

Health Insurance – Blue Cross Blue Shield of Alabama – PPO Group 74371

DCH health insurance for new enrollees will be provided by the Blue Cross/Blue Shield PPO Plan. You may elect employee, employee + child, employee + children, employee + spouse or family coverage.

Refer to Blue Cross PPO Plan Summary beginning on page 25.

Your bi-weekly cost for each option is listed on the Total Rewards Benefits Package Enrollment Form and on the DCH intranet. The plan features lower per pay period premium costs if everyone covered on your health insurance are non-tobacco users. To receive the lower contribution amount, you must complete and submit a Tobacco Declaration along with any required documentation to Human Resources. The Tobacco Declaration is available from Human Resources or on the DCH intranet.

Enrolling in the Plan/Late Enrollments

If you do not enroll in the DCH PPO health insurance plan within 30 days of your benefits eligibility date, you may not be able to obtain health insurance coverage through DCH unless you experience a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or a qualifying family status change.

If you decline coverage under the DCH health insurance plan for yourself or your eligible dependents because you have health insurance coverage elsewhere, a description of your special enrollment rights under HIPAA is available in the special enrollment section of the Blue Cross plan books provided by DCH.

These rights allow you to enroll yourself or your eligible dependents in this plan in the future, provided that you request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, you may be able to enroll yourself, your spouse and/or your new dependent child, provided that you request enrollment within 30 days after the marriage. If you have a new dependent as a result of birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and/or your new dependent child if you request enrollment within **60 days**. No other late enrollments will be accepted. (Special limited open enrollment opportunities may apply.)

Coverage While You Are Traveling

Both health insurance options offer the benefit of the nationwide Blue Cross PPO. This means that if you use a Blue Cross provider nationwide, you will not be balance-billed if you require medical attention while traveling outside Alabama. Both options also include Blue Cross Air Medical Transport Services. If you or your covered dependent are hospitalized more than 150 miles away from home, air medical services provides air ambulance transport to a DCH facility. A simple injury or illness that can be treated without hospital admission would not qualify; however, a case manager will decide if air ambulance is an appropriate way to transport. Air transport must be from hospital to hospital.

Blue Cross PPO Plan Prescription Drug Coverage – Coverage provided by Optum/Rx

There is a $100 deductible per family member on prescription drugs. Once the $100 deductible is met, the copay will apply.

- Non-maintenance prescriptions may be filled at any OptumRx or DCH Preferred Pharmacy. DCH has partnered with a network of area pharmacies to offer lower prescription co-pays. The Pharmacy Network is available on the DCH intranet.
- OptumRx Pharmacy / DCH Network Pharmacy

	OptumRx Pharmacy	DCH Network Pharmacy
Generic:	$ 20	$ 20
Preferred:	$ 55	$ 35
Non-preferred:	$ 80	$ 60
Specialty drugs:	$175	$100

- **Maintenance prescriptions must be filled at a CVS retail pharmacy, DCH Pharmacy, Walmart in Fayette or through Optum Rx Mail Order.** All maintenance prescriptions must be written and filled as a 90-day supply. Cost for a 90-day maintenance fill will be two and a half times the cost and/or copay (whichever is the least).
- You are encouraged to use generic drugs, when possible. You will notice that the generic co-pay is consistent between the Network Pharmacy and any OptumRx Pharmacy. If you request a brand-name drug when a generic substitute is available that has been approved by your physician, you must pay the brand name co-pay plus the difference in cost between the generic and the brand name drug. Generic drugs are chemically equivalent to their brand name counterparts, are approved by the FDA and are safe and effective.
- Specialty drugs must be filled at either the DCH Pharmacy or by Optum Rx mail order. Beginning Jan. 1, 2023, members must apply for a copay assistance card when one is available for the specialty drug being filled. Your physician or pharmacist will advise when a copay assist card is available.

Updated lists of formulary drugs are provided to physicians' offices quarterly. In addition, you can go to the Optum Rx website at **OptumRX.com**.

Employee Assistance Program (EAP)

A confidential counseling service provided through River Oaks is available for all employees and their immediate family members at no cost. Counseling services include:

- Crisis Intervention
- Workplace Services
- Workshops and Training

River Oaks can be contacted at (205) 650-0576.

Diabetes Wellness Program

DCH offers a free diabetes management program to all employees and their dependents, who have a diabetes diagnosis and are covered by the DCH medical plan. Participants in the plan will be entitled to a free Contour Next glucometer and one

full year of free testing strips and lancets. Participation requirements and enrollment instructions can be found on The Loop.

Wondr Health

Offered free of charge to employees and their dependents 19 or older and covered by DCH medical plan, Wondr Health is a digital behavioral counseling program for metabolic syndrome reversal, weight management and diabetes prevention. Enrollment instructions can be found on The Loop.

Required Health Insurance Notices

Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

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 the DCH Human Resources Service Center at 205-333-4772 or HRServiceCenter@dchsystem.com.

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.

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[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.

Summary of Benefits and Coverage (SBC)

The Department of Health and Human Services requires that all employees have access to a Summary of Benefits and Coverage (SBC). It is a short summary of coverage to provide a snap shot of the medical coverage provided to employees. This form does not replace the medical benefit booklet. Based on guidelines from the Department of Health and Human Services to the SBC cannot be more than eight pages.

You can access the SBC for DCH medical plans on the intranet or pick up paper copies in Human Resources.

State Children's Health Insurance Program (SCHIP)

If you (or your spouse or dependent) become entitled to or cease to be entitled to Medicaid or a state children's health insurance program (SCHIP), you may make a corresponding change to your DCH health benefit elections. Generally, this election must be made within 30 days of that change. However, in the case of a loss of Medicaid or SCHIP coverage, you have up to 60 days following the date that the coverage is lost to make the election. In addition, if you or your dependents become eligible to receive healthcare premium assistance under a Medicaid or SCHIP program, you also have 60 days from the date you or your dependents become eligible for the assistance to elect health benefits under the DCH health insurance plan.

If you have questions regarding the program, contact your State Medicaid or CHIP officer or dial 1-800-KIDSNOW or visit www.insurekidsnow.gov.

Women's Health & Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (Women's Health Act) provides protection for breast cancer patients who elect breast reconstruction in connection with a medically necessary mastectomy. As a result of this legislation, health plans currently offering mastectomy coverage must also provide coverage for associated reconstructive surgery.

Under the DCH Health System health insurance options, coverage will be provided to a member who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- 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 at all stages of the mastectomy, including lymphedemas.

Coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for other medical and surgical benefits. Benefits became effective Oct. 21, 1998, when the Act was signed into law.

Medicare Part D Notice

Important Notice from DCH Health System 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 DCH Health System and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. DCH has determined that the prescription drug coverage offered by Optum Rx and BCBS (PPO) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your DCH prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

If you and your family members are eligible for DCH health coverage and you decide to enroll in a Medicare prescription drug plan, you (and any covered family members) will not lose any DCH coverage that you have.

You should also know that if you drop or lose your coverage with DCH and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage contact DCH HR Service Center for further information at 205-333-4772.

Note: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through DCH changes. You also may request a copy.

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 prescription drug plans. For more information about Medicare prescription drug plans:

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

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

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Blue Cross Blue Shield Preferred Dental Program – Group 81625

Blue Cross Blue Shield Preferred Dental Program pays a set percentage of Blue Cross Blue Shield allowable charges—after you meet your deductible—for services performed by a Blue Cross Blue Shield network dentist. The deductible does not apply to diagnostic and preventive care.

This option provides access to the Dental PPO Network (which includes 74% of the dentists in Alabama) and allows you to use any dentist you choose. Payments for covered services provided by out-of-network dentists in Alabama will be made according to the dental network fee schedule at the same level as in-network services. You may be responsible for the difference between the Blue Cross payment and the dentist's charge (plus any deductible and co-insurance). You may also have to file the claim if your dentist's office will not.

Payments for covered services received outside Alabama will be paid at the lesser of the amount Blue Cross will recognize as the allowed amount or the amount charged by the dentist. To locate a Blue Cross Blue Shield dental provider, go to **www.bcbsal.org**. Click on "Find A Doctor," then "Find A Dentist" and follow the prompts.

Summary of Dental Benefits

Feature or Service	Blue Cross Blue Shield Preferred Dental Program
Annual deductible	$50/individual $150/family
Calendar year maximum benefit per individual	$2,000
Waiting period for major restoration and orthodontia for new enrollees	One year
Preventive care, including: ▪ Initial and periodic oral exams ▪ Emergency office visits ▪ Prophylaxis, cleanings, scaling and polishing ▪ Fluoride application for children ▪ X-rays ▪ Sealants	100% BCBS fee schedule (no deductible)
Basic care, including: ▪ Extractions and removal of impacted teeth ▪ Fillings (amalgam and synthetic restorations) ▪ Endodontics (root canals, treatment of dental pulp) ▪ Recementation of crowns and bridges ▪ Anesthesia (when connected with cutting procedure) ▪ Periodontics adjunctive services and periodontics surgery ▪ Surgery for alveolar or gingival reconstruction	70% BCBS fee schedule (after deductible) 70% BCBS fee schedule (after deductible)
Major restorative, including: ▪ Crowns and inlays ▪ Full and partial dentures and their repair ▪ Repair of crowns and bridges ▪ Pontics and bridge abutment	50% BCBS fee schedule (after deductible) After 12-month waiting period
Orthodontia, including: ▪ Braces ▪ Other dental work needed to straighten teeth	For dependent children under age 26: 50% BCBS fee schedule (after a separate $50 deductible) After 12-month waiting period Lifetime maximum of $1,000 per individual, separate from calendar year maximum

Preventive Care Services	
Feature or Service	Blue Cross Blue Shield Preferred Dental Program
Oral exams	Two visits in a calendar year; must be six months apart
Prophylaxis, cleanings, scaling and polishing	Two visits in a calendar year; must be six months apart
Fluoride application for children	Children through age 18
X-rays	Denture series or panoramic survey every three years
Sealants	Children through age 15

Vision Care – Superior Vision – Group 28651

DCH offers a vision care plan for you and your family members that provides benefits for eye exams, eyeglasses and contact lenses, through a network of independent providers and retail chains.

Using Your Vision Benefits

- Once enrolled in the program, you will receive an ID card at your home address.
- You can locate the nearest provider by going to **www.SuperiorVision.com** for the latest provider directory.
- Call a participating provider, identify yourself as a member of the vision care plan and set an appointment time.
- No paperwork is involved—pay your co-pay and any expenses not covered by the vision care plan.
- The plan provides limited coverage if you choose to use a non-network provider, but it pays a substantially higher benefit when you use the network.
- After you have used the benefits provided by the plan, you can still receive significant savings by using the network providers for additional frames and lenses because most network providers offer discounts. See the vision brochure for details.

Vision Benefits				
Feature or Service	Frequency	Participating Co-Pay	Benefit Using Network Provider	Reimbursement for Using Non-Network Provider
Vision exam	Every 12 months	$15	100%	Up to $34 ophthalmologist Up to $26 optometrist
Single vision lenses	Every 12 months	$15	100%	Up to $26
Bifocal lenses	Every 12 months	$15	100%	Up to $39
Trifocal lenses	Every 12 months	$15	100%	Up to $49
Progressive lenses	Every 12 months	$15	100% up to cost of trifocal lenses	Up to $49
Frames	Every 24 months	$15	100% up to retail value of $125	Up to $63
Contact lenses	Every 12 months instead of eyeglass lenses	Fitting fees apply	100% if medically necessary; up to $120 if elective	Up to $210 if medically necessary; up to $120 if elective
Standard contact fitting fee		$25		No reimbursement
Specialty new user		$25	Up to $50 allowance	No reimbursement

Important Information about Your COBRA Continuation of Coverage Rights

What is COBRA continuation coverage?

A federal law known as COBRA requires that most group health plans (medical, dental, vision and/or medical spending accounts) give employees and their families the opportunity to continue their health plan coverage when there is a "qualifying event" that would result in a loss of coverage under the plan(s). Only persons known as "qualified beneficiaries" may elect to continue their coverage under the plan(s). Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan(s), the covered employee's spouse, and the dependent children of the covered employee. A child of the covered employee or former employee who is receiving benefits under the plan(s) pursuant to a qualified medical child support order is entitled to the same rights under COBRA as a dependent child of the covered employee. A child born to, adopted by or placed for adoption with a former employee during the period of COBRA coverage may also be a qualified beneficiary if the former employee is a qualified beneficiary who has elected COBRA coverage. Continuation coverage is the same coverage that the plan(s) gives to other participants or beneficiaries under the plan(s) who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan(s) as other participants or beneficiaries covered under the plan(s), including special enrollment rights and any open enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce, the employee's becoming enrolled in Medicare or a dependent child ceasing to be a dependent under the terms of the Plan(s), coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became enrolled in Medicare before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare enrollment or 18 months after the date of termination of employment or reduction in hours, whichever period ends last. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Can COBRA coverage terminate early?

Continuation coverage will be terminated **before** the end of the maximum period if:

- any required premium is not paid in full on time,
- after electing continuation coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, (note: there are limitations on plans imposing a pre-existing condition exclusion and such exclusion will become prohibited beginning in 2014 under the Affordable Care Act),
- after electing continuation coverage, a qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both),
- a qualified beneficiary is covered under the additional 11-month disability extension and there has been a final determination by the Social Security Administration that the disabled qualified individual is no longer disabled, or
- the employer ceases to provide any group health plan(s) for its employees.

Continuation coverage may also be terminated for any reason the plan(s) would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum 18-month period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must timely notify the Plan Administrator or its designee of a disability or a second qualifying event, using the notice procedures specified below, in order to extend the

period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage (for a maximum of 29 months of coverage) may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has 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 continuation coverage. In order for this disability extension to apply, you must timely notify the Plan Administrator or its designee in writing (using the notice procedures specified below) of the SSA disability determination before the end of the 18-month period of continuation coverage **and**
within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage would be lost because of the initial qualifying event, or (iii) the date of the SSA disability determination.

SSA Disability Notice Procedures: The SSA disability notices that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand deliver your notice to:

DCH Human Resources – Trustee Hall
809 University Blvd. East
Tuscaloosa AL 35401
Fax: 205-750-5541

Your notice must be received by DCH no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period. The notice you provide must state:

- the name of the plan(s) under which you lost or are losing coverage,
- the name and address of the employee covered under the plan(s),
- the name(s) and address(es) of the qualified beneficiary(ies),
- the qualifying event and the date of the qualifying event,
- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the SSA made its determination of disability.

Your notice must also include a copy of the SSA disability determination. If these procedures are not followed or if the notice is not provided in writing to DCH within the required time period, there will be no disability extension of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify DCH of that fact within 30 days after SSA's determination.

Second Qualifying Event

An extension of coverage for up to 18 months will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months (beginning on the date of the first qualifying event). Such second qualifying events may include the death of a covered employee, divorce from the covered employee, the covered employee's becoming enrolled in Medicare (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the plan(s). These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan(s) if the first qualifying event had not occurred.

For example, the former employee becoming enrolled in Medicare will rarely be a second qualifying event that would entitle the spouse or dependent children to extended COBRA coverage. This is so because, for plans that are subject to both COBRA and the Medicare Secondary Payer (MSP) laws, this event would not cause the spouse or dependent children to lose coverage under the plan(s) had the first qualifying event not occurred.

In order for this extension to apply, you must timely notify the Plan Administrator in writing (using the procedures specified below) of the second qualifying event within 60 days after the second qualifying event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

Qualifying Event Notice Procedures: The notice of the second qualifying event that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or hand deliver your notice to the Plan Administrator at the address listed at the end of this notice. Your notice must be received by the Plan Administrator no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day period. The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies),
- the qualifying event and the date of the qualifying event, and
- the second qualifying event and the date of the second qualifying event.

If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. If the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA coverage as a result of the second qualifying event.

How can you elect COBRA continuation coverage?
To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Failure to do so will result in the loss of the right to elect COBRA continuation coverage. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries. In considering whether to elect continuation coverage you should taken into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?
Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

In the case of an extension of COBRA coverage due to disability, the amount a qualified beneficiary may be required to pay may not exceed 150 percent of the full cost to the plan after the 18th month, assuming that the disabled qualified beneficiary elects to be covered under the disability extension. If the only qualified beneficiaries who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102 percent of the full cost of coverage.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the plan. Your first payment for continuation coverage must include all premiums owed from the date on which COBRA coverage began. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the COBRA Continuation Coverage Election Letter. The periodic payments can be made on a monthly basis. Under the plan(s), each of these periodic payments for continuation coverage is due on the first day of the month for the coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the plan(s) will continue for that coverage period without any break. You will receive periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates explained above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan(s) only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the plan(s).

Your first payment and all periodic payments for continuation coverage should be sent to the address on the invoice or coupon sent by the provider. If you have any questions regarding COBRA payments, or where to send the payment, you may contact DCH Human Resources at 205-750-5035.

For more information

This notice does not fully describe continuation coverage or other rights under the plan(s). More information about continuation coverage and your rights under the plan(s) is available in your summary plan description or from the Plan Administrator.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep your plan informed of address changes
In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator contact information
DCH Human Resources
809 University Blvd. East
Tuscaloosa AL 35401

Phone & Fax Numbers: 1-205-333-4772 (phone)
1-205-750-5541 (fax)

Life Insurance – United of Omaha – Group G000AQZQ

DCH provides you with basic term life insurance and accidental death and dismemberment insurance at no cost to you. The amount of coverage is based on your job at DCH.

In addition, you have the opportunity to buy additional life insurance for yourself. You pay the full cost of any Option 1 or dependent term life insurance you elect through salary deductions with after-tax dollars. The cost of optional life insurance is listed on the Total Rewards Benefits Package Enrollment Form.

Accidental Death & Dismemberment (AD&D) Plan

You automatically receive basic AD&D insurance in the same amount as your basic term life insurance. DCH pays the full cost of this coverage for you. In addition, if you purchase Option 1 term life insurance coverage for yourself, you will automatically receive AD&D insurance in the same amount.

AD&D insurance pays benefits under two circumstances: accidental death or dismemberment. The life insurance carrier determines benefits payable to you if you suffer the loss of eyes, hands, arms or feet. Payment is based on a percentage of the total benefit to which your beneficiary would be entitled in the event of your accidental death. Benefits will be paid to your beneficiary at your death if you die as a result of an accident.

There is no conversion option for AD&D insurance.

Option 1: Term Life Insurance for Employees

Option 1 allows you to purchase additional term life insurance of one, two, three or four times your basic amount. This term life insurance is available to you while you are employed by DCH. If you leave DCH's employment or change to a non-benefited position, this group coverage ends at the end of the month in which your employment terminates or you change to a non-benefited position unless you convert to an individual term or whole-life policy. DCH will provide information regarding continuing your coverage when you are no longer eligible for group coverage.

If you enroll within 30 days of your benefits eligibility date, you may elect up to four times the basic benefit. If you miss this opportunity to receive the maximum supplemental coverage and you decide to enroll or increase coverage during our annual open enrollment in the fall, you must answer health questions and may be denied additional coverage.

Optional Term Life Insurance for Dependents

In addition to term life insurance for yourself, DCH offers you the choice to purchase term life insurance for your eligible dependents. If you elect this option, you will receive coverage in the following amounts:

- $15,000 for your spouse.
- $5,000 for each dependent child under age 26.

Your dependents' coverage will not be effective if they are confined either at home or in a hospital at the time of your election. Coverage becomes effective on the date they are no longer confined. Benefits under dependent life insurance will be paid to you if your dependent dies.

If you decide to enroll dependents during the annual open enrollment in the fall, your spouse will be subject to underwriting and may be denied coverage. Your dependent children are not subject to underwriting. If your spouse or dependent child works for DCH in a benefited position, you cannot insure them under dependent term life. If both you and your spouse work for DCH in a benefited position, you cannot both insure your children.

If you leave DCH's employment or change to a non-benefited position, you or your covered dependents may convert this insurance to a term or whole life policy. Information will be provided to you when you are no longer eligible for group coverage.

Long-Term Disability (LTD) Plan – United of Omaha – Group G000AQZQ

We offer basic and optional long-term disability insurance to help replace a portion of your income if you become disabled. DCH provides basic LTD insurance at no cost to you. You pay the full cost of any optional LTD coverage.

Basic LTD for Employees

When you're eligible, DCH provides you with basic long-term disability insurance at no cost to you. Your basic LTD coverage would replace up to 40% of your base earnings up to a maximum monthly benefit of $7,000. Base earnings are defined as your hourly rate of pay multiplied by the hours associated with your FTE (full time equivalent). Base earnings do not include overtime pay or shift differential.

Optional LTD for Employees

You have the choice to purchase additional LTD coverage—to buy up your LTD benefit. This additional coverage would increase your LTD benefit to 60% of base earnings up to a total maximum monthly benefit of $10,500. The formula to calculate the cost of LTD insurance is shown on the Total Rewards Benefits Package Enrollment Form.

Enrolling in LTD

- If you are not actively at work because of injury or illness, your effective date of coverage will be delayed until the day you return to active employment.
- If you wait to enroll at a future annual open enrollment, you must submit to medical underwriting and you may be denied coverage.
- If you leave DCH's employment, LTD coverage ends at the end of the month in which your employment ends. There is no option to convert this coverage.

When LTD Benefits Are Paid

- If the LTD carrier approves your claim, the LTD plan pays benefits if you are unable to perform the duties of your job because of a disability, as defined by the plan.
- If you become disabled, there is a 90-day waiting period before your LTD benefits begin.
- For the first 24 months, disability is defined as your inability to perform each of the duties of your own occupation. After 24 months of disability, it is defined as your inability to perform the duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience.
- Generally, benefits will be paid as long as you are disabled, as defined by the plan, until you reach your 65th birthday.
- Benefits from the LTD plan will be reduced by any amount you are entitled to receive from:
    - Social Security retirement and disability benefits (full family benefits).
    - Any group or franchise plan.
    - The DCH Healthcare Authority Defined Benefit Pension Plan or The Fayette Medical Center Pension Plan.
    - Workers' Compensation or any similar law.
    - Any local, state or federal government disability retirement law.
    - Any earnings from full or partial employment.
    - Any amount paid from Paid Time Off (PTO), Personal Illness Bank (PIB) or Banked Sick Time.

  In other words, the plan guarantees you up to 40% or 60% (depending on whether you choose optional LTD coverage) of your base earnings in combination with other disability benefits received.

- Benefits under this plan will not be payable because of a disability resulting from a condition that existed before you became covered under the plan, until the earlier of the date:
    - You have not received treatment for the condition for three consecutive months, or
    - You have been covered by the plan for at least 12 months.
- If you become disabled and draw a disability benefit, the portion of the benefit that is paid for by DCH will be subject to federal, state and FICA taxes. The portion of the benefit that is paid for by you is not subject to taxes because you will pay your premium after-tax.

Short-Term Disability (STD) Plan – United of Omaha – G000AQZQ

You have the option to purchase short-term disability coverage that will replace 60% of your base earnings up to a maximum benefit of $2,000 per week if you are disabled due to an illness or injury that is not work-related. Base earnings are defined as your hourly rate of pay multiplied by the hours associated with your FTE (full time equivalent). Base earnings do not include overtime pay or shift differential.

You pay the full cost of any STD coverage through salary deductions with after-tax dollars. The formula to calculate the cost of STD insurance is shown on the Total Rewards Benefits Package Enrollment Form.

Enrolling in STD

- If you are not actively at work because of injury or illness, your effective date of coverage will be delayed until the day you return to active employment.
- If you wait to enroll at a future annual open enrollment, you must submit to medical underwriting and you may be denied coverage.
- There is no pre-existing condition waiting period for this coverage.

If you leave DCH's employment, STD coverage ends at the end of the month in which your employment ends. There is no option to convert this coverage to an individual policy after leaving employment.

When STD Benefits Are Paid

- If the STD carrier approves your claim when you are unable to perform the duties of your job because of an illness or injury.
- The elimination period before the STD benefit begins is seven days or the date your PTO/PIB ends, whichever is greater.
- Benefits begin the day after the elimination period is complete.
- The elimination period is included as part of the Maximum Period of Payment of 90 days.
- If you continue to be disabled for more than 90 days, you may be eligible for benefits from the long-term disability plan.
- If you become disabled and draw a STD disability benefit, the benefit is not subject to federal, state and FICA taxes because you will pay the premium after-tax.

Cancer Insurance – AFLAC

An additional part of your insurance protection is the financial support of your Personal Cancer Indemnity Plan. The Personal Cancer Indemnity plan provides cash reimbursement directly to you for cancer treatment. Because the payment is made to you, you can choose how you spend the money.

Accident Only Insurance – AFLAC

The financial impact of an accident is often surprising. With Accident Advantage Insurance, AFLAC pays cash benefits for covered accidental injuries directly to you. So you can use the cash for anything you want.

Pet Insurance - Nationwide

Nationwide Pet Insurance provides coverage for veterinary expenses related to accidents and illnesses. Policies are available for dogs, cats, birds, reptiles and other exotic pets. Optional wellness coverage is also available for dogs and cats, providing the reimbursement for the preventive care necessary to keep them healthy year after year. Enrollment is web-based and open year-round.

Tax-Free Spending Accounts – Health Equity

The tax-free spending accounts let you reimburse yourself for eligible health care and dependent care expenses—and save on taxes. DCH partners with Health Equity for the processing and reimbursement of DCH spending accounts.

Plan Features

- A tax-free spending account debit card that allows you to pay for many eligible medical expenses at the point of sale. That means in many cases you won't have to fill out claim forms and wait for reimbursement.
- On-line access to your account balance and claims history 24 hours a day, seven days a week.
- Daily processing of paper claims—with the choice of direct deposit or a check mailed to your home.
- Some qualifying events may allow you to increase or decrease your contributions within 30 days, as defined by the IRS.
- If you leave DCH's employment, you may continue contributing to the medical spending account through Dec. 31 of the year in which you leave, but only on an after-tax basis. You do so by electing COBRA and paying the required contribution to your medical spending account. If you do not elect COBRA coverage, you may continue to submit requests for reimbursement of only those eligible expenses that were incurred before your termination date.
- If you leave DCH's employment, you won't be able to add to your dependent care account, but you can continue to submit reimbursement requests up to April 15 of the year following your date of termination for expenses incurred during the calendar year of your termination, but only up to the amount you contributed before your date of termination.
- Since the tax-free spending accounts are governed by IRS rules, you may want to check with your tax advisor to make sure your situation, including the type of expenses you want to have reimbursed, meet IRS requirements.

How Tax-free Spending Accounts Can Save You Money

Since you set aside money for eligible expenses before taxes are taken out, your taxable income is lower. See below for an example.

Example:

Assumptions: $20,800 annual salary, 18 percent tax rate (federal, state and Social Security taxes for a married employee who files jointly), $2,000 in eligible expenses

	With Tax-free Spending Account	Without Tax-free Spending Account
Annual pay	$20,800.00	$20,800.00
Less tax-free spending account deduction	- 2,000.00	- 0
Taxable pay noted on W-2	$18,800.00	$20,800.00
Less federal, state and Social Security taxes	- 3,384.00	- 3,744.00
Income left after taxes are deducted	$15,416.00	$17,056.00
Less eligible out-of-pocket expenses	- 0	- 2,000.00
Total income left:	**$15,416.00**	**$15,056.00**

Total saved by using tax-free spending accounts: $360.00

Estimating Your Expenses—Plan Carefully

- Tax-free spending accounts are "use it or lose it" accounts under IRS guidelines. Because of the tax advantages they offer, any unused money in your account cannot be returned to you at the end of the plan year and will be forfeited.
- To avoid losing any money, you should try to determine what your eligible expenses will be before you decide how much to contribute.
- While both the medical spending and dependent care accounts are tax-free accounts, they are completely separate accounts. You cannot transfer money between your medical spending account and the dependent care spending account.
- For the dependent care account—use your expenses from the previous year to help estimate your dependent care costs. Keep in mind that you may not have any expenses during vacations or holidays.
- For the medical spending account—look at your unreimbursed health care expenses for the past several years to get an idea of your annual out-of-pocket expenses. You also can plan for certain predictable expenses, such as dental care or vision care not covered by the plans.
- You might want to put less money in each account than you expect to spend—just to be on the safe side.

Using Your Accounts and Being Reimbursed

- When you enroll in a tax-free spending account, you will receive a debit card from Health Equity, our tax-free spending account vendor, which you may use to pay for eligible expenses such as prescriptions, medical, dental or vision deductibles and co-pays or dependent care expenses.
- If your provider doesn't accept debit cards you may submit a paper reimbursement form to Health Equity.
- Be sure to save all your receipts—the IRS requires documentation of all reimbursement expenses and Health Equity may ask you to submit documentation for expenses paid with your debit card.
- For the medical spending account, you will be reimbursed for the total amount of your eligible health care expense, up to the maximum amount you will contribute to this account during the year, even if your reimbursement request is for a higher amount than your current account balance.
- For the dependent care spending account, you will be reimbursed for the amount up to your current account balance. Expenses over your account balance will be paid as money is deducted from your paycheck and put into your account.

- You have until April 15, to file for reimbursement of expenses that you had during the previous calendar year. Only expenses incurred during the plan year can be reimbursed out of money set aside for that year. In addition, if you stop your contributions to a medical spending account due to termination or change in family status, only expenses incurred before the date your contributions ended can be reimbursed.
- You can access account information 24 hours a day at HealthEquity.com or by going through the Blue Cross Blue Shield website. Simply log on to set-up your secure account and view your account balance, status of claims, etc.
- You may also contact Health Equity at 1-877-288-0719.

Medical Flexible Spending Account – Health Equity

(Minimum annual contribution $200; maximum 2023 annual contribution $2,850)
There are 26 pay periods in 2023

As part of the DCH benefits package, you may use pre-tax deductions to set aside cash for many health, dental and vision care expenses not covered by your insurance plans. Money set aside in a medical FSA will reduce your taxable income, providing you and your family more value for your dollar.

Money from this account is best used for regular, predictable health expenses. Setting up a Medical FSA can provide tax advantages that your tax advisor can confirm and explain to you in more detail.

Some common eligible expenses that can be paid from the Medical FSA include:

- Prescription drug co-pays
- Over-the-counter medications submitted with a copy of the doctor's written prescription
- Deductibles
- Office visit co-pays
- Hearing care
- Orthodontia

Expenses that are **not** eligible include:

- Premiums paid for coverage under any other health insurance, dental or vision plan, including your spouse's health insurance.
- Elective cosmetic or dental surgery
- Over-the-counter medication that are purchased to treat or alleviate illness or injury unless prescribed by your physician
- Nursing care for a healthy infant.

How does the Medical Spending Account Work?

You decide if you would like to enroll in the Medical FSA and how much to contribute for the upcoming year. The amount you elect will be broken down into equal amounts. These funds are deducted from your pay before taxes are withheld and deposited into your account.

Once you enroll, you will receive a welcome letter and debit card from Health Equity with information about your account.

You may receive reimbursements from your Medical FSA for the entire annual election amount regardless of how much you have actually had payroll deducted. In effect, you can receive reimbursement advances on what you will contribute through payroll deductions later in the year.

Medical Spending Account Grace Period - 2023

The grace period provision provides for a delay to the "use it or lose it" rule under traditional FSA plans. **The grace period allows for money remaining in the Medical FSA at the end of a plan year to carry over to cover eligible expenses incurred through the 15th day of the third month after the plan ends.** Keep in mind, this does not eliminate the "use it or lose it" rule completely. Any unsued amounts from the prior plan year that are not used to reimburse expenses by the end of the grace period, and submitted according to the timely filing period explained below, remain subject to the "use it or lose it" rule and must be forfeited.

How Does This Affect a Medical Spending Account?

Because the DCH benefit plan year runs from Jan. 1 through Dec. 31, under a traditional FSA plan with a rollover provision, any money remaining in your Medical Spending Account at the end of the plan year on December 31 would be lost. Under the grace period provision, you have a grace period from Jan.1 through March 15 of the new plan year to incur eligible expenses.

You will be reimbursed for these expenses from money remaining in your Medical FSA from the immediately preceding plan year ending on Dec. 31. All Medical FSA reimbursements issued during the grace period will be processed as "first dollar in, first dollar out."

What is Meant By "First Dollar In, First Dollar Out?

In an effort to help you prevent the potential loss of any remaining prior year funds, requests for reimbursement received during the grace period are processed against your Medical FSA in the order that they are received, regardless of the plan year. The first expense received will go against any prior year balance remaining. For example, if after the 2023 plan year, you have $200 remaining in your Medical FSA, the first request for funds during the grace period in 2024 will be processed against the $200 funds from the 2023 plan year. This is regardless of the method the request is submitted or received (i.e. the submitted request, Preferred Flex card transaction or automatically applied medical claim.)

Medical Spending Account Rollover – 2022

The 2022 medical spending account carried a provision that allowed for a delay to the "use it or lose it" rule under traditional FSA plans. The rollover provision allowed you to rollover a maximum of $570.00 from plan year 2022 to plan year 2023. Keep in mind, this does not eliminate the "use it or lose it" rule completely. Any unused amounts from the year 2022 in excess of $570.00 that are not used by the end of the plan year 2023 will be forfeited. Funds that roll over from plan year 2022 to plan year 2023 become available for use in 2023 on or after May 1, 2023.

Timely Filing Period

You have until the end of the timely filing period to submit a Request for Reimbursement against your account. The timely period ends 105 days after the close of the plan year (April 15). At the end of the timely filing period, any unused funds up to the maximum of $570.00 will rollover to your current year FSA.

For example, if you have funds remaining in your 2022 Medical FSA on Dec. 31, 2022, you have until March 15, 2023 to incur additional eligible expenses. The additional eligible expenses must be submitted to Health Equity by March 15, 2023, or any remaining 2022 funds will be forfeited.

If you need additional information on this type of situation, please contact Health Equity Customer Service at 1-877-288-0719, and they can explain your options and any actions required on your part.

FSA Debit Card

The flex card provides instant access to the pre-tax funds available in your Medical FSA. The Preferred Flex Spending Card may be used at authorized merchants and healthcare providers that accept MasterCard™ for eligible products or services, which are reimbursable under your Medical FSA. Rather than paying out-of-pocket and waiting for reimbursement, you will be able to utilize the card to pay for qualified expenses. The flex card will pay the provider or merchant directly from your Medical FSA utilizing the MasterCard™ Network.

When using the flex card at self-service merchant terminals, select the "credit" option. **DO NOT** select "debit" since **NO PIN** is associated with this card.

It is important to note, however, that even if you use your Preferred Flex Spending Account at authorized merchants and healthcare providers, Health Equity may on occasion ask for additional information pertaining to your purchase. For that reason, be sure you keep a file of reimbursement receipts for documentation if requested by Health Equity.

* ***The Preferred Flex Spending Card is not currently offered for use with the Dependent Care Spending Account.***

***Other reimbursement options:** You may also submit a claim for reimbursement to Health Equity at any time by submitting a Flex Spending claim form and receipt of payment. The flex card is intended for, and restricted to, use for eligible services and/or purchases associated with a Medical Care Spending Account, as governed by the Internal Revenue Service in conjunction with flexible spending accounts and all federal and state laws relative to those accounts.

Dependent Care Flexible Spending Account – Health Equity
(Minimum 2023 annual contribution is $500; Maximum 2023 annual contribution is $5,000 or $2,500 for married taxpayers filing separate returns)
There are 26 pay periods in 2023
As part of the DCH benefits program, you may use payroll deductions to create a pre-tax account to help pay for your dependent care expenses. You can set up a Dependent Care Flexible Spending account during open enrollment (or within 30 days of your benefits eligibility date).

Money set aside in your Dependent Care FSA will reduce your taxable income, providing you and your family more value for your dollar.

This account reimburses you for expenses associated with the care of your children or other dependents while you (and your spouse) work or attend school full-time.

While a Dependent Care FSA can save you money by using pre-tax dollars, it requires careful planning. Keep in mind that money deducted from your pay and deposited in your Dependent Care Account must be used for the appropriate expenses during the year while you have an active account. **Money left in an account does not carry over to the next year, and it is not refundable to you at the end of the year. In other words, if you don't use it, you'll lose it.**

Eligible expenses that can be paid from the Dependent Care Account include:

- Licensed nursery school and day care facilities for children
- Child care in or outside your home
- Day care for an elderly or disabled dependent

Expenses that are **not** eligible include:

- Expenses for educational purposes (for example, kindergarten)
- Overnight camps

- Child support payments
- Food, clothing and entertainment
- Cleaning and cooking services provided by the caregiver

Eligible Dependents

- Children under age 13 who are included on your federal income tax return.
- Anyone who is physically or mentally unable to take care of themselves and who normally spends at least eight hours a day in your home, such as a disabled parent, child, brother or sister.

How does the Dependent Care Spending Account Work?

You decide if you would like to enroll in the Dependent Care FSA and how much to contribute for the upcoming year. The amount you elect will be broken down into equal amounts. These funds are deducted from your pay before taxes are withheld and deposited in your account.

Once you enroll, you will receive a welcome letter from Health Equity with information about your account.

The money you pay out-of-pocket for dependent care services is reimbursed to you from your account. You will need to file a Request for Reimbursement form in order to be reimbursed. Health Equity will process reimbursements daily. Direct deposit to your bank account is available.

Reimbursements from the Dependent Care FSA cannot exceed the amount deposited in your account at the time your reimbursement is processed.

Money left in an account does not carry over to the next year, and it is not refundable to you at the end of the year. In other words, if you don't use it, you'll lose it!

What about the Current Child Care Tax Credit?

The advantage of the Dependent Care FSA is that it allows you to pay the eligible expenses with pre-tax dollars. There are other tax considerations that you must weigh when making decisions about this account, such as the Child Care Tax Credit.

The IRS allows you to take a credit on your federal income taxes for your work-related dependent day care expenses if you file an itemized return. Depending on your income and tax filing status, this Child Care Tax Credit may offer more, or less, tax savings than the Dependent Care FSA.

You can use both the tax credit and the Dependent Care FSA (not for the same expenses), but any tax credit you take reduces the amount you can contribute to, and claim from, the account. Consult a tax advisor before deciding which option is best for you.

Timely Filing Period

You have until the end of the timely filing period to submit a Request for Reimbursement against your account for claims incurred by December 31. The timely filing period ends 105 days after the close of the plan year (April 15).

If you need additional information on this type of situation, please contact Health Equity Customer Service Department at 1-877-288-0719 and they can explain your options and any actions required on your part.

Your Two-Part Retirement Program – Transamerica Retirement Solutions

DCH offers a Two-Part Retirement Program—the DCH Healthcare Authority Pension Plan (Tuscaloosa County Holdings) or the Fayette Medical Center Pension Plan and the DCH and Fayette Supplemental Retirement Plans—to help you prepare for the future. The program focuses not only on the benefits you can expect to receive from DCH, but also on the other two sources of retirement income—Social Security and personal savings. Remember, no single component is designed to meet all your retirement needs. It takes all three.

The DCH Healthcare Authority (Tuscaloosa County Holdings) and Fayette Medical Center Pension Plans

You don't have to do anything to join the DCH Healthcare Authority (Tuscaloosa County Holdings) or Fayette Medical Center Pension Plans. You automatically become a plan participant when you are first eligible—generally, after you are age 21 and you have worked 1,000 hours in one year.

- Benefits from the DCH or Fayette Medical Center Pension Plans are provided to eligible employees at no cost to you.
- You may earn a retirement benefit after five years of vesting service.
- When you die, your spouse or beneficiary may receive a benefit from the plan.
- To find out more about the DCH Healthcare Authority Pension Plan (Tuscaloosa County Holdings) see the Summary Plan Description located on The Loop.

The DCH and Fayette Supplemental Retirement Plans

Retirement benefits from the pension plan and Social Security most likely will not be enough for real financial security through your retirement years. That's why DCH provides you with the opportunity to save through the DCH Health System or Fayette Supplemental Retirement Plans.

Through these plans, you can save with Transamerica Retirement Solutions, our Supplemental Retirement Plan vendor.

Plan Highlights

- Your savings are deducted from your paycheck before taxes are taken out. This means you lower your taxable income and the amount of income taxes you have to pay each year.
- Your savings—along with the DCH matching contribution you may receive when you're eligible—grow tax-deferred until you withdraw them.
- In addition, you may have access to your money before retirement through loans and hardship withdrawals.

Joining the Supplemental Retirement Plan

- Unlike the pension plan in which participation is automatic, to participate in the Supplemental Retirement Plan, you must enroll.
- You can start saving in the plan on the first day you are a DCH employee.
- After you reach age 21 and you have two years of service in which you have worked 1,000 consecutive hours in each year, you are eligible for the DCH discretionary matching contribution.
- You must save through the plan, work at least 1,000 consecutive hours in that year, and be employed on Dec. 31 to be eligible for the match.
- You can change the amount of your contributions or stop saving at any time, effective the next payroll period.
- If you stop making contributions, you can start saving again any time. (You must wait six months to start contributing again if you receive a hardship withdrawal.)
- The IRS limits the amount you can contribute each year to this type of plan. As part of the enrollment process, your maximum annual contribution will be calculated.
- You may save in either whole percentages (1%, 2%, 3%, etc.) or a flat dollar amount. If you elect a percentage of pay contribution, the actual dollar amount you save will vary, as your pay varies.

- Your savings are deducted from your pay through automatic payroll deductions. From there, it is entrusted by the hospital to Transamerica and to the investment fund(s) you specify when you enroll.
- For purposes of the TSA Plan, your pay is defined as your gross pay during the plan year according to the guidelines of the TSA Plan document.
- The maximum amount of your pay that can be considered for plan purposes is limited by IRS regulations. You will be notified if these limits apply to you.

The DCH Discretionary Matching Contribution

Each year, DCH will decide whether it will make a matching contribution for the year end and, if it does, how much that discretionary contribution will be.

DCH will place the matching contribution with Transamerica. If you are eligible, and the discretionary match is made, the matching contributions will be made no later than such date as may be required by law to be treated as a contribution for such year. No guarantee can be made that matching contributions will be made under the Plan in any year.

Remember, you can start saving in the Supplemental Retirement Plan as soon as you come to work at DCH—the DCH match doesn't begin until you are eligible. You must save through the plan to receive the discretionary match.

Loans and Hardship Withdrawals

- Transamerica will work with you to determine the presence of a "hardship" and the need for a withdrawal, based on the rules outlined in the plan document and by government regulations.
- Only the portion of your account made up of your contributions—called your elective contributions—and any interest earnings on those contributions, are available for a loan.
- Only your elective contributions, excluding any investment earnings, are available for hardship withdrawals.
- The DCH match, and any investment earnings on the match, is not available for loans or hardship withdrawals.

Receiving Plan Benefits

You can receive your entire account balance—your savings, the DCH match and any investment earnings on them—at retirement, termination of employment, death or disability.

Tax Considerations

- The contributions you make to the DCH Supplemental Retirement Plan are subtracted from your pay before federal income taxes are withheld. Lowering your taxable income means you pay less federal income tax now. Your Social Security taxes are not affected.
- As long as the money stays in your account, it remains tax-free.
- Loans are also non-taxable, since you have an obligation to repay them.
- Taxes are payable when you withdraw the money, whether it's through a hardship withdrawal while you're an active DCH employee, or a regular withdrawal after you stop working for DCH.
- In addition, because the government wants you to leave the money in your account until retirement, the IRS imposes an extra 10% excise tax if you receive the money before you reach age $59^{1/2}$.

DCH Health System
BlueCard® PPO
Effective January 1, 2023

BENEFIT	DCH NETWORK (USING DCH FACILITIES OR CHILDREN'S HOSPITAL IN BIRMINGHAM)	PPO NETWORK (ANY OTHER BCBS PPO PROVIDER OTHER THAN DCH OR CHILDREN'S HOSPITAL)	OUT-OF-NETWORK (NOT USING DCH OR BCBS PPO FACILITY/PROVIDER)
GENERAL PROVISIONS (Includes Mental Health Disorders and Substance Abuse)			
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.			
Major Medical Calendar Year Deductible	$200 per person; 3 per family to a maximum of $600		
Annual Out-of-Pocket Maximum	$6,850 per person; $13,700 per family Deductibles, copays and coinsurance for in-network services and out-of-network mental health and substance abuse emergency services apply to the in-network out-of-pocket maximum, including prescription drugs.		No limit on out-of-pocket expenses.
INPATIENT HOSPITAL FACILITY BENEFITS (Includes Mental Health Disorders and Substance Abuse)			
Deductible and Copays Length of stay based on Blue Cross guidelines	$200 per admission copay	$1,000 deductible per admission; $100 copay per day, days 2 through 11 for all services excluding mental health disorders and substance abuse. If admitted due to medical emergency or accidental injury subject to $100 admission copay. $100 copay per admission for mental health disorders and substance abuse services. **No benefit within 11 county service area.***	No benefit unless medical emergency/accidental injury. If admitted due to medical emergency or accidental injury covered at 100% subject to $100 admission copay
Coverage (including maternity)	100% allowed amount	80% allowed amount after deductible and daily copays for all services excluding mental health disorders and substance abuse. If admitted due to medical emergency or accidental injury covered at 100% subject to $100 admission deductible. 100% allowed amount for mental health disorders and substance abuse services. **No benefit within 11 county service area.***	No benefit unless medical emergency/accidental injury. If admitted due to medical emergency or accidental injury covered at 100% subject to $100 admission copay
Preadmission Certification	Required for all admissions except maternity admissions and as required by Federal law; emergency admissions require notification within 48 hours. If not obtained, no benefits are available.		
Individual Case Management	Coordinates care in the event of a catastrophic or lengthy illness or injury. For more information, call 1-800-821-7231.		
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.		
Baby Yourself®	A maternity program. For more information, call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.**		

BENEFIT	DCH NETWORK (USING DCH FACILITIES OR CHILDREN'S HOSPITAL IN BIRMINGHAM)	PPO NETWORK (ANY OTHER BCBS PPO PROVIDER OTHER THAN DCH OR CHILDREN'S HOSPITAL)	OUT-OF-NETWORK (NOT USING DCH OR BCBS PPO FACILITY/PROVIDER)
OUTPATIENT HOSPITAL FACILITY SERVICES (Includes Mental Health Disorders and Substance Abuse)			
Precertification is required for some outpatient hospital benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.			
Emergency Room Services for Accidental Injuries	100% allowed amount after $30 copay **Note:** 100% coverage does not include DME	100% allowed amount after $30 copay. If admitted through ER, copay waived. **Note:** 100% coverage does not include DME	100% allowed amount after $30 copay. If admitted through ER, copay waived. **Note:** 100% coverage does not include DME
Emergency Room Services for Medical Emergencies	100% allowed amount after $30 copay **Note:** 100% coverage does not include DME	100% allowed amount, after $30 copay. If admitted through ER, copay waived. **Note:** 100% coverage does not include DME	100% allowed amount, after $30 copay. If admitted through ER, copay waived. Mental health disorders and substance abuse covered at 100% allowed amount after $30 copay. If admitted through ER, copay waived; applies to in-network out-of-pocket **Note:** 100% coverage does not include DME
Facility Charges When Having Outpatient Surgery	100% allowed amount after $200 copay **North River Surgical Center:** 100% allowed amount after $250 copay	80% allowed amount after $1,000 copay. **No benefit within 11 county service area.***	No benefit
Facility Charges for Diagnostic X-ray, Lab and Pathology	100% allowed amount	80% allowed amount**. No benefit within 11 county service area except when rendered by DCH providers, excluding wellness services.*** **Note:** MRIs, CT Scans, PET Scans, mammograms, colonoscopies and Dexa Scans must be performed at a DCH facility within the 11 county service area	No benefit
Facility Charges for Diagnostic Colonoscopy	100% allowed amount **North River Surgical Center:** Covered at 100% of the allowed amount after $250 facility copay	100% allowed amount	No benefit
Facility Charges for Diagnostic MRI, CT Scan, PET Scan and Dexa-Scan	100% allowed amount after $200 per day copay. **No benefit within the 11 county service area* except at a DCH facility.**	100% allowed amount after $500 per day copay. **No benefit within the 11 county service area* except at a DCH facility.**	No benefit
Facility Charges for Hemodialysis	100% allowed amount	80% allowed amount. **No benefit within 11 county service area.***	No benefit
Facility Charges for IV Therapy	100% allowed amount	100% allowed amount	No benefit
Facility Charges for Chemotherapy and Radiation Therapy	100% allowed amount	100% allowed amount if outside DCH 11 county service area. **No benefit within the 11 county service area* except at a DCH facility.**	No benefit

BENEFIT	DCH NETWORK (USING DCH FACILITIES OR CHILDREN'S HOSPITAL IN BIRMINGHAM)	PPO NETWORK (ANY OTHER BCBS PPO PROVIDER OTHER THAN DCH OR CHILDREN'S HOSPITAL)	OUT-OF-NETWORK (NOT USING DCH OR BCBS PPO FACILITY/PROVIDER)
Urgent Care Facilities	100% allowed amount after a $50 copay (excluding mental health and substance abuse) 100% allowed amount for mental health and substance abuse.	100% allowed amount after a $50 copay (excluding mental health and substance abuse) 100% allowed amount for mental health disorders and substance abuse.	No benefit
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	100% allowed amount after $45 copay	100% allowed amount after $45 copay	No benefit
PHYSICIAN SERVICES (Includes Mental Health Disorders and Substance Abuse)			
Precertification is required for some physician benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.			
Office Visits and Outpatient Consultations rendered by a PCP (Family Practitioner, General Practitioner, Pediatrician and Internist)	100% allowed amount after a $30 copay Wellness visit - no copay required	100% allowed amount after a $30 copay Wellness visit - no copay required	No benefit
Office Visits and Outpatient Consultations rendered by a Specialist	100% allowed amount after a $45 copay Wellness visit - no copay required	100% allowed amount after a $45 copay Wellness visit - no copay required	No benefit
Physician Services for Surgery and Anesthesia in the Physician's Office	100% allowed amount after the applicable office visit copay	100% allowed amount after the applicable office visit copay	No benefit
Physician Services for Surgery and Anesthesia not in the Physician's Office	100% allowed amount	80% allowed amount	No benefit
Physician Inpatient Visits in Hospital	100% allowed amount	80% allowed amount (excluding mental health and substance abuse) 100% allowed amount for mental health and substance abuse	No benefit
Physician Services for Newborn Well Child Exam in the Hospital	100% allowed amount	100% allowed amount	No benefit
Physician Services for X-rays and Lab Exams	100% allowed amount	80% allowed amount; 100% of allowed amount within11 county service area.*	No benefit
Physician Charges for Cancer Treatment – Office Visit	100% allowed amount after a $35 copay	Within 11 county service area* – $500 annual deductible applies then 100% allowed amount after $35 copay. Outside 11 county service area*, 100% allowed amount after $35 copay	No benefit

Physician Services for Temporomandibular Joint Disorders	100% allowed amount; Phase II services limited to a $2,000 lifetime maximum	100% allowed amount, Phase II services limited to a $2,000 lifetime maximum	No benefit
Physician Services in the Emergency Room for Medical Emergency	100% allowed amount	100% allowed amount	100% allowed amount
Physician Services in the Emergency Room for Accidental Injury	100% allowed amount	100% allowed amount	100% allowed amount
Physician Services for prenatal, delivery and postnatal care	100% allowed amount	80% allowed amount after $1,000 deductible.	No benefit
Physician Services for Routine Office Visit for Well Child Physical Examinations	100% allowed amount. Nine visits the first two years of the child's life and one visit annually thereafter	100% allowed amount. Nine visits the first two years of the child's life and one visit annually thereafter	No benefit
Physician Services for Routine Office Visit for Physical Examination	100% allowed amount. One visit annually for ages 2 and over	100% allowed amount. One visit annually for ages 2 and over	No benefit
Physician Services for Annual Routine OB/GYN visit	100% allowed amount	100% allowed amount	No benefit
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	100% allowed amount	100% allowed amount after a $30 copay	No benefit
TELEHEALTH SERVICES			
Benefits are provided for Telehealth Services subject to applicable cost-sharing for In-network and Out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.			
ROUTINE IMAGING AND LAB WORK **Imaging services (excluding MRIs, CT scans, PET scans and Dexa Scans) can be done in a physician's office or a DCH facility. MRIs, CT scans, PET Scans, Dexa Scans, mammograms and colonoscopies must be performed at a DCH facility within the 11 county service area. Lab work drawn in a physician's office within the 11 county service area must be processed in the physician's office or sent to a DCH Lab for processing to be covered.***			
Routine Immunizations and Preventive Services	Covered at 100% allowed amount with no deductible or copay. See **AlabamaBlue.com/PreventiveServices and AlabamaBlue.com/StandardACAPreventiveDrugList** for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy.	Covered at 100% allowed amount with no deductible or copay. See **AlabamaBlue.com/PreventiveServices and AlabamaBlue.com/StandardACAPreventiveDrugList** for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy.	No benefit

BENEFIT	DCH NETWORK (USING DCH FACILITIES OR CHILDREN'S HOSPITAL IN BIRMINGHAM)	PPO NETWORK (ANY OTHER BCBS PPO PROVIDER OTHER THAN DCH OR CHILDREN'S HOSPITAL)	OUT-OF-NETWORK (NOT USING DCH OR BCBS PPO FACILITY/PROVIDER)
Other Routine Screenings & Lab	100% allowed amount Urinalysis and Complete Blood Count (CBC) covered when visit is covered TB skin testing covered with preventive office visit when necessary Cholesterol testing – annually Dexa-Scan – based on Blue Cross guidelines Colonoscopy – based on Blue Cross guidelines Hemocult stool check - annually, ages 50 and over Sigmoidoscopy - every 3 years, ages 50 and over **North River Surgical Center:** Covered at 100% allowed amount after $250 facility copay for colonoscopies.	100% allowed amount Urinalysis covered when visit is covered. Cholesterol Test, once every year TB skin test covered with preventive office visit when necessary Complete Blood Count – covered when visit is covered Hemocult Stool check – annually beginning at age 50 **No coverage within the 11 county service area unless lab work is processed in the physician's office or at a DCH lab.** Sigmoidoscopy – Every three years beginning at age 50 **Colonoscopy and Dexa Scan– Based on BCBS guidelines and no benefits within the 11 county service area unless performed at a DCH facility.** **Note: MRIs, CT Scans, PET Scans, mammograms, colonoscopies and Dexa Scans must be performed at a DCH facility within the 11 county service area**	No benefit
OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)			
Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.			
Ambulance Services	80% allowed amount after $200 major medical deductible **Note:** Ambulance charges for transport of a patient between DCH Health System facilities covered at 100% allowed amount with no deductible or copay.		
Air Ambulance Transport	Not applicable	100% allowed amount. Based on medical necessity and subject to medical review.	100% billed amount. Based on medical necessity and subject to medical review.
Air Medical Transport	Air medical transportation to a network hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624		
Participating Chiropractic Services	80% allowed amount after $200 major medical deductible; maximum of 20 visits a year	80% allowed amount after $200 major medical deductible; maximum of 20 visits a year	No benefit
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per calendar year	80% allowed amount after $200 major medical deductible **No benefit within 11 county service area* except at DCH facility or University of Alabama Speech and Hearing for dependents to age 26.**	80% allowed amount after $200 major medical deductible **No benefit within 11 county service area* except at University of Alabama Speech and Hearing for dependents to age 26.**	No benefit

Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per calendar year	80% allowed amount after $200 major medical deductible **No benefit within 11 county service area* except at DCH facility or University of Alabama Speech and Hearing for dependents to age 26.**	80% allowed amount after $200 major medical deductible **No benefit within 11 county service area* except at University of Alabama Speech and Hearing for dependents to age 26.**	No benefit
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18	100% allowed amount	100% allowed amount after a $30 copay	No benefit
Durable Medical Equipment, Prosthetic Devices	80% allowed amount after $200 major medical deductible	80% allowed amount after $200 major medical deductible	No benefit
Diabetic Supplies	80% allowed amount after $200 major medical deductible. Insulin covered under pharmacy copay	80% allowed amount after $200 major medical deductible. Insulin covered under pharmacy copay	No benefit
Home Health **Covers up to 60 visits per calendar year**	100% allowed amount Must use DCH or LHC Home Health. Note: IV home infusion therapy covered at 100% allowed amount when provided by any PPO provider.	If residing outside Fayette or Tuscaloosa counties, 100% allowed amount with a Blue Cross provider. No benefit in Tuscaloosa or Fayette counties except with DCH or LHC Home Health. Note: IV home infusion therapy covered at 100% allowed amount when provided by any PPO provider.	No benefit
Home Infusion	100% of the allowed amount	100% of the allowed amount	No benefit
Hospice	100% allowed amount through Hospice of West Alabama	80% allowed amount, no deductible	No benefit
Allergy Testing	80% allowed amount after $200 major medical deductible	80% allowed amount after $200 major medical deductible	No benefit

Allergy Treatment	100% allowed amount	80% allowed amount, 100% of allowed amount within 11 county service area.*	No benefit
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per calendar year	100% allowed amount	100% allowed amount after a $30 copay	No benefit
Prescription Drugs	Covered by OptumRx		

Please note: In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. Providers/Specialists may be listed in a PPO directory or on the provider finder website (**AlabamaBlue.com**), but not covered as PPO benefits by this group health plan. Please check your benefit matrix or benefit booklet to determine coverage. To maximize your benefits, always use in- network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website (**AlabamaBlue.com**) or call 1-800-810-BLUE (2583).

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

*** DCH 11 COUNTY SERVICE AREA: Bibb, Fayette, Greene, Hale, Lamar, Marengo, Marion, Perry, Pickens, Sumter, Tuscaloosa**

*** DCH NETWORK: Regional Medical Center, Northport Medical Center, Fayette Medical Center, Pickens Medical Center, Children's Hospital in Birmingham, AL**

*** DCH MENTAL HEALTH PROVIDERS: Dr. Srilata Anne, Dr. Mohammad Mohabbat, Dr. Gary Newsom, Dr. Kamal Raisani, Dr. Sanjay Singh**

*** DCH Encore Locations: 1050 Ruby Tyler Parkway, Tuscaloosa, AL; 92 McFarland Blvd., Northport, AL; 6561 Hwy. 69 S., Tuscaloosa, AL; 12500 Wildcat Dr., Northport, AL; 2901 Northridge Road, Tuscaloosa, AL**

Statement of Nondiscrimination

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711)