

SOLID WASTE DISPOSAL AUTHORITY
ESTD
2023
BALDWIN COUNTY, AL

2026-2027

EMPLOYEE BENEFITS GUIDE

TABLE OF CONTENTS

03 INTRODUCTION

04 ELIGIBILITY & ENROLLMENT

05 MEDICAL INSURANCE

06 PRESCRIPTION DRUG PLAN | MEDICAL RATES

07 DENTAL INSURANCE

08 DENTAL RATES / MDLIVE (VIRTUAL CARE)

09 VISION INSURANCE

10 AMBULANCE COVERAGE

11 EMPLOYEE ASSISTANCE PROGRAM (EAP)

12 FLEXIBLE SPENDING ACCOUNT (FSA)

13 BASIC LIFE INSURANCE AND AD&D

13 ADDITIONAL LIFE AND AD&D

14 SHORT-TERM DISABILITY

15 LONG-TERM DISABILITY

16 ACCIDENT INSURANCE | HOSPITAL INDEMNITY

17 CRITICAL ILLNESS INSURANCE

18 EMPLOYEE RETIREMENT (ERS/RSA)

19 HOLIDAYS | ANNUAL LEAVE | PAID TIME OFF

20 PET INSURANCE

21 CONTACT INFORMATION

22 ANNUAL NOTICES



The Solid Waste Disposal Authority of Baldwin County is committed to providing employees with a competitive and comprehensive benefits package. Our program offers a broad range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist you in providing for the health, well–being and financial security of you and your covered dependents. Helping you understand the benefits available to you is important to us and that is why we have created this Employee Benefits Guide.

Overview

This guide provides a general overview of your benefit choices to help you select coverage that is right for you. Of course, with choice, comes responsibility and planning, so please take time to read about and understand the benefits plan, and enroll on time. Included in this guide are summary explanations of the benefits and costs, as well as contact information for each provider.

It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you. This guide is not intended to cover all provisions of all plans but rather is a quick reference to help answer most of your questions. You can obtain full policy documents from Human Resources for complete plan details. We hope this guide will give you a clear explanation of your benefits and help you be better prepared for the enrollment process.

ELIGIBILITY & ENROLLMENT

WELCOME TO YOUR NEW EMPLOYEE BENEFITS



WHO IS ELIGIBLE

All full-time associates working at least 30 hours per week are eligible for the full range of benefits provided by The Solid Waste Disposal Authority of Baldwin County. You may also enroll your eligible dependents.

*Active part-time employees may be eligible for some of the benefits listed in this guide. Contact the HR Department to inquire.



EFFECTIVE DATE OF COVERAGE

Most of the benefits described herein begin on the first day of the month following the full-time employee's hire date.

BENEFIT PLAN YEAR October 1, 2026 through September 30, 2027 (Note: The deductible period for health coverage is on a Calendar Year basis, from January 1 through December 31 of each year.)



WHEN TO ENROLL Benefit eligible associates initially have the two following opportunities to enroll in the associate benefits program:

- **NEW HIRE ENROLLMENT** New hires have 30 days from their date of hire to enroll in benefit coverages. Most plans become effective the first of the month following the employee's hire date. Associates not enrolling during this period must wait until the next open enrollment to elect coverage (Evidence of Insurability forms may be required for certain coverages).
- **ANNUAL ENROLLMENT** Employees can change their benefit elections during our Annual Enrollment Period. Evidence of Insurability (EOI) forms may be required for certain coverages. Any elections made during this period are effective on October 1, 2026 (or the date EOI is approved).

WHEN YOU CAN MAKE CHANGES

Due to IRS regulations, once you have made your elections for this plan year, you cannot change your benefits until the next Annual Enrollment Period. The only exception is if you have a qualified life event change. Election changes must be consistent with your status change. If you experience one of the following qualified events, you will have the option of changing your benefits.

Qualifying Events:

- Marriage, legal separation, or divorce
- Birth or adoption of child
- Change in employment status (including spouse)
- Change in a dependent's benefits eligibility status (e.g., a dependent child exceeding the maximum age for coverage)
- A significant change in the cost or coverage of your spouse's benefits
- Loss of a dependent (death)

If you have a life event change, you must submit notification to Human Resources within 30 days of the qualifying event. Please contact Nicole Skelton, nicole.skelton@baldwincountyswda.org. Depending on the type of change, you may need to provide documentation proof (for example, a marriage license or birth certificate). If you do not submit notification within 30 days, you will have to wait until the next Annual Enrollment period to make benefit changes.

WHEN COVERAGE ENDS

All coverage ends at the end of the month following the termination date.

MEDICAL INSURANCE

CIGNA HEALTHCARE

The Solid Waste Disposal Authority of Baldwin County provides all eligible employees the opportunity to enroll in the group's Cigna Healthcare medical plan. Health insurance is designed to provide you and your eligible dependents with financial protection against the high costs associated with health care and prescription drugs for any potential illnesses or injuries. The Open Access Plan allows you to choose from a large list of participating providers for all of your health care needs. You may access a list of providers for covered services by visiting the Cigna website at www.mycigna.com.

BENEFITS	OPEN ACCESS PLAN	
	IN-NETWORK	OUT-OF-NETWORK
Deductible *Individual* *Family*	$500 $1,500	$1.000 $3,000
Out-of-Pocket Maximum *Individual* *Family*	$6,250 $12,500	$90,000 $90,000
Inpatient Hospital Facility	$300 copay	20% Coinsurance
Emergency Room Care	$200 copay	
Physician Office Visits *Preventive Care* *Office Visits—PCP* *Office Visits– Specialist* *Urgent Care* *Virtual Care - via MDLIVE*	Covered 100% (not subject to ded) $30 copay $50 copay $30 copay Covered 100%	Not Covered 20% Coinsurance 20% Coinsurance 20% Coinsurance Not Covered
Outpatient Surgery	$100 copay	20% coinsurance
Mental Health, Behavioral Health, or Substance Abuse Services	Inpatient: $300 copay/admission Outpatient: $50 copay/office visit; MDLive & all other outpatient services covered 100% (not subject to deductible)	20% coinsurance
Diagnostic Testing *X-Rays, Blood work, etc.* *Imaging (CT, Pet scans, MRIs)*	Covered 100% (not subject to ded) Covered 100% after deductible	20% coinsurance
Other Covered Services *Ambulance Services* *Home Health / Hospice* *Durable Medical Equipment* *Rehabilitation / Habilitation*	Covered 100% after deductible Covered 100% after deductible Covered 100% after deductible $30 - $50 copay (PCP vs Specialist)	Same as in-network 20% coinsurance 20% coinsurance 20% coinsurance

PRESCRIPTION DRUG PLAN

CIGNA HEALTHCARE

The Prescription Drug plan is included with your Cigna Healthcare medical plan. You can locate all participating pharmacies in your area at www.mycigna.com.

PRESCRIPTION TIER	OAP—STANDARD TIER 4 IN-NETWORK ONLY COVERAGE FOR RX
Retail Prescriptions	**Covered at the following copays for a 30-day supply for each prescription.**
Tier 1 (Generic) Drugs	$15 copay
Tier 2 (Preferred Brand) Drugs	$40 copay
Tier 3 (Non-Preferred Brand) Drugs	$60 copay
Tier 4 (Specialty) Drugs	$100 copay
Cigna Diabetes Prevention Program in collaboration with Omada	

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee. Visit omadahealth.com/omadaforcigna to see if you're eligible.



2026-2027 MEDICAL INSURANCE RATES

CIGNA HEALTHCARE

Medical Tier Elected		Total Monthly Premium	SWDA Contribution	Employee Contribution	Employee Per Pay Deduction
Active Employees	Single	$674.54	$620.57	$53.97	$26.99
	EE + Spouse	$1,430.03	$1,144.03	$286.00	$143.00
	EE + Child(ren)	$1,153.46	$922.77	$230.69	$115.35
	Family	$2,023.63	$1,618.90	$404.73	$202.37

DENTAL INSURANCE

CIGNA HEALTHCARE

The Solid Waste Disposal Authority of Baldwin County provides dental programs through Cigna Healthcare. Employees have the option to select between two plan design options.
With the Cigna Healthcare dental plans, you may choose any dentist to provide your oral care; however, if you choose a preferred provider, claims may be paid directly to your dentist at a lower cost to the participant. You may access a list of providers for covered services by visiting the Cigna website at www.mycigna.com. Identification cards will be provided to all enrolled participants.

SUMMARY OF BENEFITS	Option 1 With Orthodontics	Option 2 No Orthodontics
CALENDAR YEAR DEDUCTIBLE		
Individual Deductible	$50	$50
Family Deductible	$150	$150
CALENDAR YEAR MAXIMUM		
Plan Maximum	$2,000	$1,000
CLASS 1 EXPENSES: PREVENTATIVE AND DIAGNOSTIC CARE		
• Oral Exams (2 per calendar year) • Cleanings (2 per calendar year) • X-Rays (Bitewing: 2 per calendar year; Full mouth: 1 every 3 years; Panorex: 1 every 3 years) • Fluoride Application (1x calendar year for children under 19) • Sealants • Space Maintainers	Covered at 100% Not subject to deductible	
CLASS 2 EXPENSES: BASIC RESTORATIVE CARE		
• Emergency treatment for pain • Fillings • Oral Surgery • Anesthetics • Minor & Major Peiodontics • Root Canal Therapy / Endodontics • Relines, Rebases, and Adjustments • Repairs for Bridges, Crowns, Inlays, and Dentures • Brush Biopsy	Covered at 80% Subject to deductible	
CLASS 3 EXPENSES: MAJOR RESTORATIVE CARE		
• Crowns, Inlays, Onlays • Stainless Steel / Resin Crowns • Dentures • Bridges	Covered at 50% Subject to deductible	
CLASS 4 EXPENSES: ORTHODONTIA		
• Coverage for Children and Adults • No Separate Deductible for Orthodontia	Covered at 50% $1,000 Lifetime Maximum	Not Covered



DENTAL INSURANCE EMPLOYEE CONTRIBUTIONS—PER PAY PERIOD		
COVERAGE TIER	OPTION 1 - WITH ORTHO	OPTION 2 - NO ORTHO
Single	$12.67	$12.04
Employee + Spouse	$25.34	$24.23
Employee + Child(ren)	$29.51	$26.97
Family	$47.02	$37.78

MDLIVE

CIGNA VIRTUAL CARE

Life is demanding. It's hard to find time to take care of yourself and your family members as it is, never mind when one of you isn't feeling well. That's why your health plan through Cigna includes access to virtual medical and behavioral care. Whether it's late at night and your doctor or therapist isn't available, or you just don't have the time or energy to leave the house, you can:

- Access care from anywhere via video or phone
- Get minor medical virtual care 24/7/365—even on weekends and holidays
- Schedule a behavioral/mental health virtual care appointment online in minutes
- Connect with quality board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.
- Have a prescription sent directly to your local pharmacy, if appropriate.

Connect with virtual care your way

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand on myCigna.com
- Schedule an appointment with an MDLIVE provider or licensed therapist on myCigna.com
- Call MDLIVE 24/7 at 888-726-3171.



VISION INSURANCE

CIGNA HEALTHCARE

The Solid Waste Disposal Authority of Baldwin County offers voluntary vision coverage through Cigna, who uses the EyeMed Network. You get the most from your vision benefits and pay less out-of-pocket when you visit an in-network eyecare provider. Log into myCigna.com to find an in-network Vision provider or the EyeMed Directory. See overview of benefits and rates below:

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ROUTINE VISION SERVICES (1 PER 12 MONTHS)		
Exam Retinal Imaging	$10 Copay Up to $39 Copay Max	$45 Allowance Not Covered
MATERIALS (1 PER 12 MONTHS)		
Single Vision / Bifocal / Trifocal / Lenticular Lenses	$0 Copay for all	Allowance up to: $32 / $55 / $65 / $80
FRAMES (1 PER 12 MONTHS)		
Retail (20% discount on amount over allowance) Costco	$150 Allowance $100 Allowance	$83 Allowance
CONTACT LENSES (1 PER 12 MONTHS)		
Fitting & Evaluation Conventional (15% discount on amount over allowance) Disposable	Up to $40 Copay Max $150 Allowance $150 Allowance	Not Covered $120 Allowance $120 Allowance
LENS ENHANCEMENTS		
Oversize Lenses Ultraviolet Coating Polycarbonate for Children / Adults Progressive Standard / Premium Scratch Resistant or Standard Ultraviolet Coating Anti-Reflective Coating Plastic Dye Tints Photochromatic Lenses Premium Anti-Reflective Coating	Covered 100% $15 Covered 100% / $40 $65 / $85-$110 $15 $45 $15 $75 Tier 1: $57 / Tier 2: $68 / Tier 3: 20% off Retail	Not Covered

VISION INSURANCE EMPLOYEE CONTRIBUTIONS		
COVERAGE TIER	MONTHLY	PER PAY PERIOD
Single	$7.76	$3.88
Employee + Spouse	$15.44	$7.72
Employee + Child(ren)	$13.09	$6.55
Family	$21.13	$10.57

AIRMEDCARE AMBULANCE COVERAGE



The Solid Waste Disposal Authority of Baldwin County has partnered with AirMedCare to offer all full-time eligible employees membership in the AirMedCare Network program—at NO additional cost to you!

ABOUT AIRMEDCARE NETWORK

If you or a household member experience a life or limb-threatening emergency, our alliance of air ambulances can provide medical transport— dramatically reducing travel time to an emergency treatment facility. AirMedCare Network is America's largest air medical membership network, providing financial coverage for emergency air medical transport. As an AMCN member, you're covered by over 320 locations across 38 states, including Alaska & Hawaii.

MEDSTAR EMS GROUND MEMBERSHIP PROVIDES EVEN MORE COVERAGE

A Medstar membership protects you from having to pay out-of-pocket expenses for emergency Medstar ground transports that aren't covered by your insurance or benefits provider, providing financial peace of mind to focus on your recovery. Medstar EMS is the exclusive ground ambulance provider in Baldwin County, Alabama. Medstar EMS memberships are honored for all emergency transports completed by Medstar EMS in Baldwin County.

MEMBERSHIP PROVIDES FINANCIAL PEACE OF MIND

Even with medical insurance, medical transport can result in significant out-of-pocket expenses. However, an AMCN air and Medstar ground membership ensures **no out-of-pocket expenses for medically necessary transport only by an AMCN / Medstar provider.**

Our household plan provides membership benefits for any person who resides under one residential roof. Full-time undergraduate college students can be covered under their parents' membership if their primary residence is still with the parents.

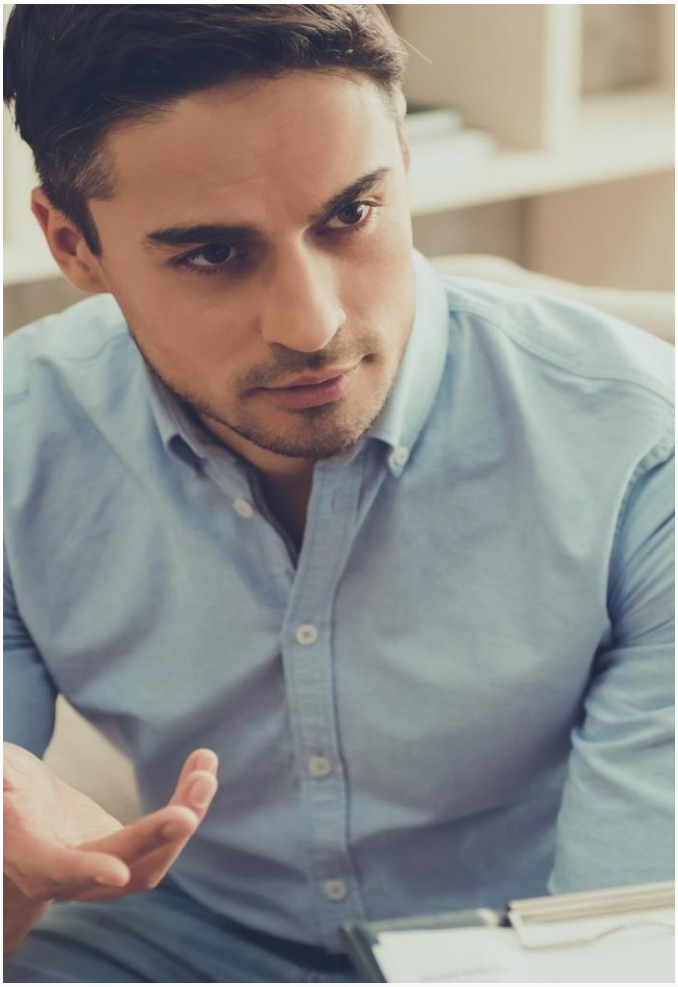
For Questions, Please Contact:
William Gilmore AT 251-504-4179 OR William.Gilmore@gmr.net
PROVIDE TRACK CODE: 14942 AND PLAN CODES: 20106 / 21007

AirMedCare NETWORK
A Global Medical Response Solution
AIR EVAC LIFETEAM | GUARDIAN FLIGHT | MED-TRANS | REACH

EMPLOYEE ASSISTANCE PROGRAM (EAP)

BEHAVIORAL HEALTH SYSTEMS

Living a healthy, satisfying lifestyle includes your physical health and emotional well-being. However, life can be a challenge as you juggle the demands of work, home, and other obligations. We have partnered with Behavioral Health System to provide EAP services to help you achieve balance in your life.



ALL SERVICES ARE 100% COVERED

An Employee Assistance Program (EAP) is a professional service providing assessment, short-term counseling and referral to appropriate treatment providers or programs when needed. It is a company benefit, provided by your employer AT NO COST TO YOU! The BHS National Network is comprised of psychologists and Master's-Level Counselors.

People use the EAP for a variety of reasons. If you are preoccupied with a problem, having ongoing signs of stress, experiencing a major life transition, or simply need an objective point of view - your EAP coverage can assist you with a multitude of difficulties, no matter the situation. Your use of the EAP is completely confidential. In addition to referral for assessment, counseling or medication management, your BHS Care Coordinator can assist you in determining the appropriateness and availability of community resources, such as support groups, that may be beneficial.

SERVICES

- **Counseling Services:** *All employees and dependents may receive up to 5 visits/consults per year.*
- **24/7 Access:** *Call BHS at 800-245-1150 any day, any time to speak with a live Care Coordinators.*
- **Assessment and Referral Services:** *Face-to-face or telephonic assessments with outside referral available as needed.*
- **Legal Consultation**: *Receive free, confidential access to experienced attorneys, mediators & legal document specialists. If additional services are needed, you will receive a 25% discount off the professional's hourly rate.*
- **Financial Consultation:** *Receive free consultation with accountants and certified financial professionals for credit issues, debt/ budgeting assistance, tax/estate planning & more! 25% discount on additional services.*
- **Eldercare Assistance:** *Support, guidance & planning for aging loved ones is available.*
- **Online Services:** *Please visit www.behavioralhealthsystems.com to navigate services offered, locate providers in your area, take surveys, and much more. The BHS online portal has access to thousands of articles and interactive modules involving work/life topics such as emotional well-being, family life, health, financial, legal, personal growth, etc. Some popular items include downloadable will kits, financial calculators, etc.*



FLEXIBLE SPENDING ACCOUNTS (FSAs)

FLORES HR

The Solid Waste Disposal Authority of Baldwin County offers Flexible Spending Account (FSA) benefits that allow you to save money on your eligible health care and/or dependent care expenses every year by using pre-tax dollars, thus lowering your taxable income.

HOW IT WORKS

Upon enrollment, you choose the dollar amount you want to contribute based on your estimated upcoming Plan Year expenses, up to $3,400. Your contributions will be deducted on a pre-tax basis, in equal amounts from 24 paychecks, throughout the Plan Year.

Reimbursements and the Debit Card – As you incur eligible expenses, you may submit a request for reimbursement through Flores's website, text message, mobile app, fax, or mail. For additional convenience, you will be issued a Debit Card to directly access your flexible spending account funds when paying for eligible expenses at the point of purchase. This eliminates the need for requesting a reimbursement.
Keep in mind that some purchases will always require additional substantiation as most Doctor's offices, Hospitals,
Dental Providers, and some Drug Stores do not utilize the Inventory Information Approval System (IIAS). **Make sure you keep your receipts for verification purposes.**

FSA Eligible Expenses – Flexible Spending Account funds may only be used for eligible expenses under your healthcare FSA and/or dependent care FSA. Complete lists of eligible and non-eligible expenses can be found by visiting www.irs.gov.

Dependent Care FSA— The Dependent Care FSA enables you to pay for out-of-pocket qualified daycare expenses that allow you and your spouse to work or attend school full time. Two parent households can only utilize Dependent Care Reimbursement flexible spending accounts if both parents work outside of the home.

Qualified Dependent Care arrangements include:

- Dependent (Day) Care centers
- Educational Institutions for pre-school children
- An "Individual" who provides care inside or outside your home (with appropriate licensing and Tax ID number)
- After School Care

You may contribute up to $7,500 to your Dependent Care FSA if you are married filing a joint tax-return or you are head of the household. You and your spouse may each contribute up to $3,750 if you are married and filing separate tax-returns.

The IRS requires that you substantiate:

- Dates of Service
- Dollar amount incurred
- Day-care provider name
- Day-care provider signature

Note: Day-care expenses must be incurred (not just paid) in order to receive reimbursement.
(Example: day care expenses that you paid in January, for February services, should be submitted in February.)

BASIC LIFE / AD&D COVERAGE

METLIFE

The Solid Waste Disposal Authority of Baldwin County provides you with Basic Life/AD&D insurance and is paid 100% by the employer. This coverage is designed to help protect your family or other beneficiary from a loss of income in the event of your death. Benefits are also paid to you if you suffer a loss of a member (hand, foot or eye) due to an injury as a result of a covered accident.
The basic life insurance coverage is equal to $30,000. You are also provided with basic Accidental Death and Dismemberment (AD&D) insurance in the amount equal to your basic life coverage. Benefits will reduce as follows: 35% at Age 65, 60% at Age 70, 80% at Age 75. Benefits terminate upon retirement.

VOLUNTARY LIFE / AD&D COVERAGE AND RATES

METLIFE

In addition to your employer paid life insurance, eligible employees (full-time, active employees working at least 30 hours/week) are allowed to purchase additional Term Life and Accidental Death & Dismemberment (AD&D) insurance for yourself and your eligible dependents on a voluntary basis (100% employee paid) through MetLife. See overview of voluntary life benefit options below:

Employee Benefit	May elect benefit amount in $10,000 increments up to $500,000 or 10x your Annual Salary. Amounts over $250,000 (unless approved prior to 10/1/20) will require an EOI (Evidence of Insurability) Form.
Spouse Benefit	If employee is enrolled, spouses are eligible to elect a benefit amount in $5,000 increments up to $250,000; The elected amount cannot exceed the employee's vol life benefit. Amounts over $50,000 require EOI.
Child Benefit	If employee is enrolled, you may elect coverage for eligible children. Children 15 days to 6 months have a $1,000 benefit. Children 6 months to 26 years can elect a benefit amount of $1,000, $2,000, $4,000, $5,000 or $10,000.

Both you and your spouse's monthly rates for Voluntary Life/AD&D insurance are based on your age. All children have a flat rate regardless of age & number of eligible children covered. Premiums are paid through payroll deductions on an after-tax basis. Your cost automatically adjusts each year in October to reflect the age-banded rates listed below.

Monthly Rates per $1,000 Benefit									
Age	<34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +
Employee	$0.067	$0.100	$0.137	$0.209	$0.332	$0.618	$0.740	$1.423	$2.361
Spouse	$0.067	$0.100	$0.137	$0.209	$0.332	$0.618	$0.740	$1.423	$2.361
Child Life **Child AD&D**	$0.182 $0.051			**Employee & Spouse AD&D**			$0.021		

Step 1	**EXP:** Age 35 with $80,000 coverage. Find your age bracket in the rate table above.
Step 2	Multiply the number of thousands of voluntary life coverage that you wish to elect, multiplied by the applicable age-banded rate to determine monthly premium. *Note: rates are based per $1,000 of coverage **Vol Life: 80 x $0.10 = $8.00/ month** **AD&D: 80 x .021 = $1.68/ month** **Total = $9.68/month**
Step 3	Multiply the total monthly premium by 12 months, then divide it by 24 pay periods to determine your cost per payroll deduction: **Ex: $9.68 x 12 = $116.16 ÷ 24 = $4.84 per pay period**

SHORT-TERM DISABILITY

METLIFE

Voluntary short-term disability (STD) insurance provides income protection for employees who are unable to work due to personal illness or injury. Employees participating in the plan may receive disability earnings from MetLife due to an eligible illness or injury. This is a voluntary benefit and therefore 100% employee-paid, if elected. Please see an overview of the STD benefits & rates below:

Overview of STD Coverage	
Benefit	The benefit amount is 60% of pre-disability weekly earnings up to $500 per week.
Elimination Period	Benefit payments begin on the 31st day after an employee has been determined disabled due to an illness or injury.
Maximum Benefit Period	If applicable, benefits may continue up to a maximum of 22 weeks, at which time LTD may kick in if disability continues.
Definition of Disability	Due to an eligible illness or injury, you are unable to earn more than 80% of pre-disability earnings at your own occupation for an employer.
Limitations	3/12 Pre-existing Condition Limitation
Temporary Recovery	If you return to work after completing the elimination period, then become disabled again due to the same or related condition within 5 day or less, you will not be subject to completing a new elimination period.
Additional Benefits	Rehabilitation Program (10%), Return-to-Work, Family Care ($100), Moving Expense Reimbursement, Organ Donor Benefit (10%)

Monthly Rates per $10									
Age	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Rate	$0.307	$0.292	$0.277	$0.285	$0.322	$0.367	$0.457	$0.555	$0.630

Example: Age 35 Electing STD	
Step 1	Annual Salary / 52 X 60% = Weekly Benefit **($40,000 / 52) X .60 = $462**
Step 2	Find your age and rate in the chart above
Step 3	Multiply your rate by your weekly premium and divide by 10 to determine monthly premium. **($0.277 X $462) / 10 = $12.80 per month**
Step 4	Multiply your premium by 12 and then divide it by the number of pay periods (24) to determine the cost per pay period. **($12.80 X 12) / 24 = $6.40 per pay period**



LONG-TERM DISABILITY

METLIFE

Long-term disability (LTD) benefits provide you with a percentage of your income if you become disabled due to a covered accident or illness for an extended period of time. **We provide LTD coverage for all eligible employees at no cost to you!**

The LTD coverage pays a benefit to replace a portion of the earnings you lose as a result of your disability. If your disability is permanent, this benefit may continue until you reach normal retirement age. Benefits will be coordinated with any Social Security benefit you may receive. Please see an overview of the LTD benefits below. To receive a copy of full policy documents, please contact the HR Department.

Overview of LTD Coverage	
Benefit	The benefit amount is 50% of pre-disability earnings up to $5,000 per month.
Elimination Period	Benefit payments begin on the 181st day after an employee has been determined disabled due to an illness or injury OR the day following the end of the STD benefit period, whichever is greater.
Definition of Disability	Due to an eligible sickness or accidental injury: • First 24 months: You are unable to earn more than 80% of your pre-disability earnings at your OWN occupation for any employer. • After 24 months: You are unable to earn more than 60% of pre-disability earnings from ANY occupation for which you are reasonably qualified for based upon your training, prior education & experience.
Maximum Benefit Period	To Social Security Normal Retirement Age (SSNRA) with benefit duration scale (see plan booklet for details).
Temporary Recovery	If you return to work BEFORE completing the elimination period, then become disabled again due to the same or related condition within 60 days, you are not subject to completing a new elimination period. If you return to work AFTER completing the elimination period and you become disabled again due to the same or related condition within 180 days, you are not subject to a new elimination period.
Limitations	3/12 Pre-existing Condition Limitation 24-month limitation for: • Mental/Nervous Disorders • Chronic Fatigue Syndrome • Musculoskeletal or Soft Tissue Disorders • Fibromyalgia • Alcohol, Drug Substance Abuse & Addictions
Other Provisions	Waiver of Premium, Survivor Benefit, Rehabilitation Incentive, Return-to Work Incentive, Family Care Benefit, Moving Expense Benefit, and much more. See full policy for details.

ACCIDENT COVERAGE

METLIFE

The Solid Waste Disposal Authority of Baldwin County offers Accident Insurance coverage through MetLife. Accident insurance pays a benefit amount depending on the type of accident or injury you have and the type of treatment you need. These amounts are paid in addition to your medical plan and aim to help with any out-of-pocket expenses.

Benefit	Employee	Spouse	Child
Accidental Death	$50,000	$25,000	$10,000
Dismemberment Losses	$1,000 to $40,000		
Coma	$10,000		
Dislocations	$200 to $10,000		
Fractures	$200 to $10,000		
Lacerations	$75 to $700		
Burns	$100 to $15,000		
Health Screening Benefit	$50		

	Monthly Rates	Per Pay Rates
Employee Only	$11.15	$5.58
Employee + Spouse	$12.95	$10.98
Employee + Child(ren)	$25.55	$12.78
Employee + Family	$30.64	$15.32

HOSPITAL INDEMNITY

METLIFE

The Solid Waste Disposal Authority of Baldwin County offers Hospital Indemnity Insurance which provides a cash benefit for covered hospital stays, regardless of the actual medical expenses. It helps with out-of-pocket costs associated with hospitalization, such as deductibles, copays, and other expenses like childcare or transportation.

Coverage Overview	
Hospital Admission	$1,500
ICU Admission	$1,000
Confinement per day	$200
ICU Confinement per day	$200
Confinement for Newborn Nursery	$200
Health Screening Benefit	$50

	Monthly Rates	Per Pay Rates
Employee Only	$22.27	$11.14
Employee + Spouse	$51.46	$25.73
Employee + Child(ren)	$39.04	$19.52
Employee + Family	$68.24	$34.12



CRITICAL ILLNESS

METLIFE

The Solid Waste Disposal Authority of Baldwin County offers Critical Illness coverage through MetLife. If you are diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. Please refer to your full benefit summary for additional details on covered conditions.

Coverage Overview	
Employee Benefit	$10,000 or $20,000
Spouse Benefit	50% of Employee Benefit
Child(ren) Benefit	50% of Employee Benefit
Heart Attack, Stroke, Major Organ Failure, End Stage Kidney Disease, etc.	100% of Benefit Amount
Invasive Cancer	100% of Benefit Amount
Wellness Benefit	$50

Monthly Rates per $1,000 Benefit												
Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Employee	$0.53	$0.59	$0.66	$0.84	$1.08	$1.42	$1.85	$2.48	$3.19	$3.99	$5.19	$7.13
Spouse	$0.73	$0.78	$0.86	$1.03	$1.27	$1.60	$2.07	$2.73	$3.49	$4.32	$5.54	$7.49
Child	$0.69											

Multiply the per $1,000 rates shown above by the benefit amount divided by $1,000 (e.g., 15 for $15,000 of coverage) and round to two decimals to calculate rates for the quoted benefit amounts.

Coverage Example: 42-Year-Old Employee Choosing $10,000 Benefit Amount

($1.08 x $10,000) / $1,000 = $10.80 monthly or $5.40 each pay period

EMPLOYEE RETIREMENT (ERS/RSA)

The Employee's Retirement System is a defined benefit plan qualified under section 401(a) of the Internal Revenue Code. Since its inception in 1945, the plan has provided disability and service retirement benefits to members and survivor benefits to qualified beneficiaries. A defined benefit plan provides the employee with a specific benefit at a retirement by calculating the retirement benefit based on a formula. Benefits are payable monthly for the lifetime of the member, possibly continuing for the lifetime of his or her beneficiary. *The Code of Alabama 1975, section 16 -25* contains the actual language governing the plan.

Through your employment with The Solid Waste Disposal Authority of Baldwin County, participation in the ERS is mandatory if a person is employed in a position eligible for coverage in a non-temporary capacity on at least a one-half time basis earning at least the deferral minimum wage. **All employees will contribute 7.5% each pay period . The Authority contributes each pay period based on a defined rate established by RSA each fiscal year.**

*Tier 2 members are employees hired on or after January 1, 2013.

Service Retirement

Service retirement benefits are available to members who cease ERS covered employment and meet minimum service and age requirements:

- Has at least 10 years of service credit and has attained the age of 60 **or** after accumulating 25 years of service credit at any age.

Calculating Your Retirement

Average Final Salary x Years and Months of Service x Benefit Factor /12 = Maximum Monthly Benefit

Ex: Average Final Salary: $35,000 and Service Credit: 27 years and 6 months
$35,000*27.5*.020125/12=$1,614.19 per month

RSA 1-877-517-0020

https://www.rsa-al.gov/ers/

Mailing Address:

P.O. Box 302150

Montgomery, AL 36130-2150

Street Address:

201 South Union Street

Montgomery, AL 36104

DEFERRED COMPENSATION PLANS

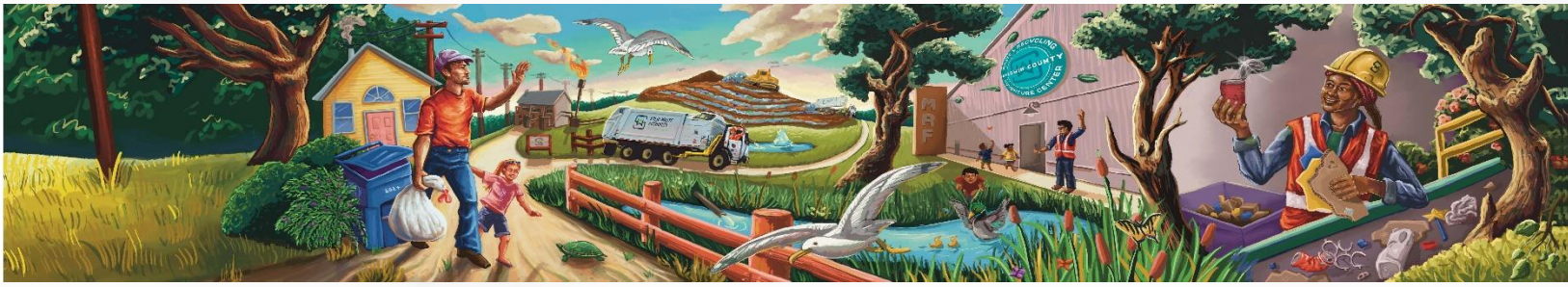
RSA-1 AND NATIONWIDE

The Solid Waste Disposal Authority of Baldwin County offers two deferred compensation plans, sometimes referred to as a 457 plan. These benefits are provided through RSA-1 and Nationwide.

Under a Deferred Compensation Plan, employees may elect to defer receipt of a portion of his or her salary until a later determined date, usually at retirement or other termination of service. Because receipt of the income is deferred, the deferred income is NOT included in your federal or state gross taxable income.

The deferred income is paid into RSA-1/Nationwide account and invested for your benefit. Investment earnings are accumulated in the fund and like the deferred income, are not subject to federal or state income taxation until distributed to the employee. Deferred income and the investment earnings are held in the participant's account for the exclusive benefit of the plan participants and their beneficiaries.

RSA-1 now offers a Roth account. The advantage of the Roth account is the potential to make tax-free withdrawals in retirement. You can elect to make designated Roth contributions of money from your paycheck that has already been taxed. Therefore, you are paying taxes upfront rather than later. That's the power and flexibility of an RSA-1 Roth account.



HOLIDAYS / ANNUAL LEAVE / SICK LEAVE

2027 HOLIDAY SCHEDULE

HOLIDAY	OBSERVED
New Year's Day	Friday, January 1
Martin Luther King Jr. Day	Monday, January 18
President's Day	Monday, February 15
Mardi Gras (Fat Tuesday)	Tuesday, February 9
Good Friday	Friday, March 26
Memorial Day	Monday, May 31
Juneteenth	Friday , June 18
Independence Day	Monday, July 5
Labor Day	Monday, September 6
Veteran's Day	Thursday, November 11
Thanksgiving Holiday	Thursday/Friday, November 25 & 26
Christmas Holiday	Thursday/Friday , December 23 & 24

ANNUAL LEAVE AND PTO

Employees shall accrue paid annual leave on a calendar year with employees accruing leave twenty-six pay periods. Employees may carry over up to two years of annual leave. Any excess at year-end will be paid out if the employee has taken at least 40 hours of consecutive annual leave during the year. When an employee resigns or is terminated, the employee is entitled to payment for any unused annual leave that has been accrued. Employees terminated before successfully completing their probationary period will not be eligible for payout of any annual leave accrued. Part-Time employees shall accrue paid time off at a rate of 0.0319 per hours worked for a maximum of 48 hours per calendar year.

YEARS OF CONSECUTIVE SERVICE	HOURS
0-4 calendar years	96 hours
5-9 calendar years	120 hours
10-14 calendar years	168 hours
Over 15 calendar years	192 hours

SICK LEAVE

All current full-time Appointed, Classified and Probationary employees shall earn paid sick leave at the rate of eight hours of leave per month based on a 26-pay period accrual. The accrual will be credited at 3.69231 hours each pay period for a total of 96 hours per year. There is no maximum number of accrued sick leave days. Upon separation from employment, an employee will not be paid for their accrued sick leave with the exception of retirement as outlined in the Employee Handbook, Section V, P.

PET INSURANCE

SPOT PET INSURANCE

- Exclusive Discounts on Pet Care with Customizable Coverage Options
- No Networks: Visit any licensed vet in the US
- Eligibility: All Employees; part-time and full-time
- Vet Tele-Health: 24/7 access to a pet health helpline at no additional cost
- Benefits Concierge: Dedicated employee benefits customer service center
- Pre-existing conditions: Not covered



Enroll here **https://spotpet.link/baldwincountyswda** or Call **888-343-2340**

What's Covered?

Where top-rated coverage meets affordability, Spot's Accident & Illness policies help cover:

Vet Exam Fees
For allergies, stomach issues, etc.

Surgery
At licensed vets or hospitals

Specialized Treatment
Including acupuncture, and more

Cuts, Bite Wounds, Insect Stings

Dental Illnesses
Including extractions, gingivitis, and more

Breed-Specific, Congenital & Genetic Conditions
- Allergies
- Hip dysplasia
- Cataracts
- Degenerative myelopathy
- Intervertebral disc disease (IVDD)

Diagnostics
Blood tests, x-rays, MRI's & CT scans

Prescription Medications & Food*
Including special diets and supplements

Swallowed Objects & Toxic Ingestions

Broken Bones & Other Injuries

Cancer
Including lymphoma, melanoma, and more

Chronic Conditions
- Arthritis
- Diabetes
- Kidney disease
- Inflammatory bowel disease (IBD)
- Seizures

Sample Rates- Summerdale, AL

Everybody's pet is unique. Employees have the freedom to design their own plans. Employees provide the pet's **species, breed, age, and ZIP code** and can customize their price by choosing their **annual limit, reimbursement rate, annual deductible, and optional wellness add-ons**.

The sample plans shown to the right have the following coverage plan:

- Annual Limit: **$5,000**
- Reimbursement Rate: **80%**
- Annual Deductible: **$500**

Accident Only

1 Year Old	
Dog	
Medium Mix	$10.40
Labrador Retriever	$10.40
Chihuahua	$10.40
Dachshund	$10.40
Cat	
Domestic Shorthair	$8.25

Accident & Illness

1 Year Old	
Dog	
Medium Mix	$20.92
Labrador Retriever	$29.30
Chihuahua	$12.75
Dachshund	$30.96
Cat	
Domestic Shorthair	$9.99

CONTACT INFORMATION

CONTACT INFORMATION			
BENEFIT	**PROVIDER**	**PHONE**	**WEBSITE/EMAIL**
Medical & Prescription Drug	Cigna Healthcare	1.800.244.6224	www.mycigna.com
Ambulance Services	AirMedCare	1.843.708.6192	wes.mcadenl@gmr.net
EAP	Behavioral Health Systems	1.800.245.1150	www.behavioralhealthsystems.com
Flexible Spending Account	Flores HR	1.800.532.3327	www.flores247.com
Dental	Cigna Healthcare	1.800.244.6224	www.mycigna.com
Vision	Cigna Healthcare	1.800.2446224	www.mycigna.com
Basic Life Insurance	MetLife	1.800.438.6388	www.metlife.com/mybenefits
Additional Life Insurance	MetLife	1.800.438.6388	www.metlife.com/mybenefits
Short-Term Disability	MetLife	1.800.438.6388	www.metlife.com/mybenefits
Long-Term Disability	MetLife	1.800.438.6388	www.metlife.com/mybenefits
Critical Illness, Accident, Hospital Indemnity	MetLife	1.800.438.6388	www.metlife.com/mybenefits
Retirement Program	Retirement Systems of Alabama	1.877.517.0020	www.rsa-al.gov
Pet Insurance	Spot Pet Insurance	1.888.343.2340	https://spotpet.link/baldwincountyswda



The Solid Waste Disposal Authority of Baldwin County

15093 Landfill Dr., Summerdale, AL, 36580
Nicole Skelton, Plan Administrator, (251) 972-8548

Effective Date: October 1, 2026

Employee & Eligible Beneficiaries,

As an employee of The Solid Waste Disposal Authority of Baldwin County and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. If you have any questions please contact Nicole Skelton, Human Resources Director, The Solid Waste Disposal Authority of Baldwin County at: (251) 972-8548

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

IMPORTANT INFORMATION

MEDICARE PART D NOTICE

Medical Plan: Cigna Healthcare

About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug

plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. We have determined the prescription drug coverage offered by Cigna Healthcare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore **considered Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

Visit http://www.cms.hhs.gov/CreditableCoverage/ which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your

premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...
Contact the person listed in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.Medicare.gov or call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 800-MEDICARE (800-633-4227). TTY users should call (877) 486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call (800) 772-1213 (TTY 1-800-325-0778).

Remember to keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

NOTIFICATIONS

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents

(including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

Notice of Privacy Practices – Business Associates

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT A PARTICIPANT MAY BE USED AND DISCLOSED AND HOW A PARTICIPANT CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice describes the legal obligations of The Solid Waste Disposal Authority of Baldwin County (the "Business Associate") and its legal responsibilities regarding protected health information held by the Business Associate of participants of health plans ("Covered Entities) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"). This Notice has been drafted in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule.

When we refer to participants in this Notice, we are referring to the participants of these Covered Entities.

Among other things, this Notice describes how this protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law on behalf of participants of these Covered Entities.

We are required to provide this Notice of Privacy Practices (the "Notice") to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from participants or created or received by a health care provider, a health care clearinghouse, a health plan, or the employer on behalf of its group health plan that relates to the participant's:

- Past, present or future physical or mental health or condition;
- Provision of health care; or
- Past, present or future payment for the provision of health care.

Contact Person

If you have any questions about this Notice or about our privacy practices, please contact Nicole Skelton, Human Resources Director, (251) 972-8548.

Effective Date

This Notice is effective July 30, 2026.

Our Responsibilities

We are required by law to:

- Maintain the privacy of participant protected health information;
- Inform participants if a breach occurs that may have compromised the privacy or security of the participant's information;
- Provide participants with certain rights with respect to their protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to a participant's protected health information;
- Follow the terms of the Notice that is currently in effect; and
- Not use or share a participant's information other than as described here unless the participant tells us in writing that we can. If a participant tells us we can share information, the participant may change his/her mind at any time and advise us in writing of such change.

We reserve the right to change the terms of this Notice and to make new provisions regarding a participant's protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide a participant with a copy of our revised Notice of Privacy Practices by electronic distribution.

How We May Use and Disclose Participants' Protected Health Information

Under the law, we may use or disclose participant protected health information under certain circumstances without the participant's permission. The following categories describe the different ways that we may use and disclose a participant's protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We may use or disclose a participant's protected health information to facilitate medical treatment or services by providers. We may disclose medical information about a participant to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of a participant. For example, we might disclose information about a participant's prior prescriptions to a pharmacist to determine if prior prescriptions contra indicate a pending prescription.

For Payment

We may use or disclose a participant's protected health information to determine a participant's eligibility for benefits, to facilitate payment for the treatment and services a participant receives from health care providers, to determine benefit responsibility under the covered entity, or to coordinate covered entity's coverage. For example, we may tell a participant's health care provider about a participant's medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share a participant's protected health information with a utilization review or pre-certification service provider. Likewise, we may share a

participant's protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose a participant's protected health information for other covered entity operations. These uses and disclosures are necessary to run the covered entity. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general administrative activities. If use or disclosure of protected health information is made for underwriting purposes, any such protected health information that is genetic information of an individual is prohibited from being used or disclosed.

To Other Parties

We may contract with other individuals or entities to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, these individuals will receive, create, maintain, use and/or disclose a participant's protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding a participant's protected health information. For example, we may disclose a participant's protected health information to a third party to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the third party enters into an agreement with us.

As Required by Law

We will disclose a participant's protected health information when required to do so by federal, state or local law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law. For example, we may disclose a participant's protected health information when required by national security laws or public health disclosure laws.

To Prevent a Serious Threat to Health and Safety.

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering a Covered Entity, we may disclose protected health information to certain employees of an employer. However, those employees will use or disclose that information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless the participant whose PHI is in question has authorized further disclosures. A participant's protected health information cannot be used for employment purposes without a participant's specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose a participant's protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If a participant is an organ donor, we may release a participant's protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If a participant is a member of the armed forces, we may release a participant's protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release a participant's protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose a participant's protected health information for public health actions. These actions generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if a participant agrees, or when required or authorized by law.

Health Oversight Activities

We may disclose a participant's protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If a participant is involved in a lawsuit or a dispute, we may disclose a participant's protected health information in response to a court or administrative order. We may also disclose a participant's protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell a participant about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose a participant's protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- About a death that we believe may be the result of criminal conduct;
- About criminal conduct; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release a participant's protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If a participant is an inmate of a correctional institution or is under the custody of a law enforcement official, we may disclose a participant's protected health information to the correctional institution or law enforcement official, if necessary (1), for the institution to provide a participant with health care; (2), to protect a participant's health and safety or the health and safety of others; or (3), for the safety and security of the correctional institution.

Research

We may disclose a participant's protected health information to researchers when:

- The individual identifiers have been removed; or
- When an institutional review board or privacy board (1) has reviewed the research proposal; and (2) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of a participant's protected health information we are required to make.

Government Audits

We are required to disclose a participant's protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to a Participant

When a participant requests, we are required to disclose to a participant the portion of that participant's protected health information that contains medical records, billing records, and any other records used to make decisions regarding a participant's health care benefits. We are also required, when requested, to provide a participant with an accounting of most disclosures of a participant's protected health information where the disclosure was for reasons other than for payment, treatment or health care operations, and where the protected health information not disclosed pursuant to a participant's individual authorization. Such requests must be made through the Covered Entity.

Participant Choices

For certain health information, participants can tell us their choices about what we share. If a participant has a clear preference for how we share his/her information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, participants have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for a participant's care
- Share information in a disaster relief situation

If a participant is not able to tell us his/her preference, for example if he/she is unconscious, we may go ahead and share the participant's information if we believe it is in his/her best interest. We may also share a participant's information when needed to lessen a serious and imminent threat to health or safety.

Personal Representatives

We will disclose a participant's protected health information to individuals authorized by a participant, or to an individual designated as a participant's personal representative, attorney-in-fact, etc., so long as a participant provides us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- A participant has been, or may be, subjected to domestic violence, abuse or neglect by such person;
- Treating such person as a participant's personal representative could endanger a participant; or
- In the exercise of professional judgment, it is not in a participant's best interest to treat the person as a participant's personal representative.

Fundraising and Marketing

Prior to disclosing a participant's protected health information in the case of fundraising efforts, the participant will be notified prior to receiving such fundraising communications. Such communication will provide the participant with the option of opting-out of receiving such communications. Additionally, uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI will require authorization.

Authorizations

Other uses or disclosures of a participant's protected health information not described above will only be made with a participant's written authorization. Where appropriate, most uses and disclosures of psychotherapy notes will require a participant's authorization.

A participant may revoke written authorization at any time, so long as the revocation is in writing. Once we receive a participant's written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving a participant's written revocation.

A Participant's Rights

A Participant has the following rights with respect to his or her protected health information:

Right to Access

A participant has the right to inspect and copy certain protected health information that may be used to make decisions about a participant's health care benefits. To inspect and copy a participant's protected health information, a participant must submit a participant's request in writing to the Covered Entity. If a participant requests a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with a participant's request.

Additionally, a participant has the right to request electronic copies of certain protected health information in a designated record set. We will provide such information in the electronic form and format requested

by the participant, provided it is readily producible. If the requested form and format are not readily producible, we will provide the information in a readable electronic form and format that is mutually agreed upon with the requesting participant. If a participant requests a copy of the electronic information, we may charge a reasonable fee for the labor costs and supplies involved in creating the information.

We may deny a participant's request to inspect and copy in certain very limited circumstances. If a participant is denied access to his or her medical information, a participant may request that the denial be reviewed by submitting a written request to the Covered Entity.

Right to Amend

If a participant feels that the protected health information, we have about that participant is incorrect or incomplete, a participant may ask the Covered Entity to amend the information. A participant has the right to request an amendment for as long as the information is kept by or for the Covered Entity.

To request an amendment, a participant's request must be made in writing and submitted to the Covered Entity. In addition, a participant must provide a reason that supports a participant's request.

We may deny a participant's request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny a participant's request if a participant asks us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that a participant would be permitted to inspect and copy; or
- Is already accurate and complete.

If we deny a participant's request, we will notify the participant in writing within 60 days with an explanation as to why the request was denied. The participant then has the right to file a statement of disagreement with us and any future disclosures of the disputed information will include the participant's statement.

Right to an Accounting of Disclosures

A participant has the right to request an "accounting" of certain disclosures of his or her protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to a participant; (3) disclosures made pursuant to a participant's authorization; (4) disclosures made to friends or family in a participant's presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, a participant must submit the participant's request in writing to the Covered Entity. A participant's request must state a time period of not longer than six years prior to the date the participant asks for the accounting.

A participant's request should indicate in what form the participant wants the list (for example, paper or electronic). The first list a participant requests within a 12-month period will be provided free of charge. For additional lists, we may charge a participant for the costs of providing the list. We will notify a participant of the cost involved and a participant may choose to withdraw or modify a participant's request at that time before any costs are incurred.

Right to Request Restrictions

A participant has the right to request a restriction or limitation on a participant's protected health information that we use or disclose for treatment, payment or health care operations. A participant also has the right to request a limit on a participant's protected health information that we disclose to someone who is involved in a participant's care or the payment for a participant's care, like a family member or friend. For example, a participant could ask that we not use or disclose information about a surgery that a participant had.

If a participant requests a restriction, it is the participant's responsibility to notify any other entity that may be impacted by the requested restriction.

We are not required to agree to a participant's request. However, if we do agree to the request, we will honor the restriction until a participant revokes it or we notify the participant.

To request restrictions, a participant must make a participant's request in writing to the Covered Entity. In a participant's request, the participant must tell us (1) what information a participant wants to limit; (2) whether a participant wants to limit our use, disclosure, or both; and (3) to whom a participant wants the limits to apply—for example, disclosures to a participant's spouse.

Right to Request Confidential Communications

A participant has the right to request that we communicate with a participant about medical matters in a certain way or at a certain location. For example, a participant can ask that we only contact the participant at work or by mail.

To request confidential communications, a participant must make the participant's request in writing to the Covered Entity. We will not ask a participant the reason for the participant's request. A participant's request must specify how or where the participant's wishes to be contacted. We will accommodate all reasonable requests if the participant clearly provides information that the disclosure of all or part of a participant's protected information could endanger a participant.

Right to Receive Notification of a Breach

A participant has the right to receive notification of any breach of your protected health information. Such notice will be provided to participants within sixty (60) days of the breach being identified.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if the participant has agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, contact Nicole Skelton, Human Resources Director, Nicole.Skelton@baldwincountyswda.org, (251) 972-8548.

Right to Choose Someone to Act for the Participant.

Participants have the right to appoint a personal representative to act on their behalf with respect to their protected health information, such as if a participant has given someone medical power of attorney or if someone is a participant's legal guardian.

To appoint a personal representative to act on a participant's behalf, the participant must make a request in writing to Nicole Skelton, Human Resources Director, Nicole.Skelton@baldwincountyswda.org, (251) 972-8548. The request must specify who the individual is that the participant is appointing as personal representative, that individual's contact information, and in which matters the personal representative may act on the participant's behalf.

Complaints

If a participant believes that his or her privacy rights have been violated, he or she may file a complaint with covered entity or with the Office for Civil Rights. To file a complaint with the covered entity, contact: Nicole Skelton, Human Resources Director, Nicole.Skelton@baldwincountyswda.org, (251) 972-8548.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with the covered entity

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus

carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

COBRA NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company plan. This notice explains COBRA continuation

coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., $2,550 of coverage); (2) the total reimbursable claims

submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

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

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts 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 entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children

receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059 the federal phone number for information and complaints.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

Part of the health care law that took effect in 2014 provides other coverage options to purchase 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 The Solid Waste Disposal Authority of Baldwin County.

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 tax credit that lowers your monthly premium.

The Open Enrollment period each year is usually between the beginning of November to mid-December; this can vary by state. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event).

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 may not be eligible for a tax credit through the Marketplace depending on the below factors and your household income. You may want 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 9.96% for the 2026 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.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, you may lose the employer contribution (if any) to the employer-offered coverage. Additionally, the employer contribution, as well as your employee contribution to employer-offered coverage, are 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 your employer.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. Residents of the following states must use the state-run health exchange, and more information about the state-specific sites can be found at https://www.healthcare.gov/marketplace-in-your-state/

CA, CO, CT, DC, GA, ID, KY, MA, MD, ME, MN, NJ, NM, NV, NY, PA, RI, VA, VT, WA

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

1. Employer Name: The Solid Waste Disposal Authority of Baldwin County
2. Employer Identification Number (EIN): 93-1408508
3. Employer Address: 15093 Landfill Dr.
4. Employer phone number: (251) 972-8548
5. City: Summerdale
6. State: AL
7. ZIP code: 36580
8. Who can we contact about employee health coverage at this job: Nicole Skelton
9. Phone number for contact: (251) 972-8548
10. Email address: Nicole.Skelton@baldwincountyswda.org

Here is some basic information about health coverage offered by this employer:

• As your employer, we offer a health plan to: Eligible Employees.

Eligible employees are: Regular full-time employees who work an average of 30 or more hours per week).

• With respect to dependents: We do offer coverage to all eligible dependents.

Eligible dependents are: Legal spouse and dependent children of eligible employee.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.*Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. if you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	ILLINOIS – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672

MISSOURI – Medicaid	MONTANA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programsservices/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-formedicaid-health-insurance-premium-payment-programhipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-andeligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)



2026-2027 EMPLOYEE BENEFITS GUIDE