- **OPEN ENROLLMENT** begins **Friday, Oct. 15** and ends **Saturday, Oct. 30** at 11:59 p.m. CDT.

- **ACTION IS REQUIRED** if you want to participate in a healthcare flexible spending account (HCFSA), dependent care flexible spending account (DCFSA) or a health savings account (HSA) for the 2022 plan year. Your current election will not rollover. If you want to participate in these benefits, you must elect a contribution amount. If you fail to elect a new contribution amount, you must wait until the next open enrollment period to elect coverage unless a qualifying life event occurs.

- **NO ACTION IS REQUIRED** if you do not want to make any changes to health, dental or vision coverages. You will keep current benefit coverages effective Jan. 1, 2022 without taking any action.

- **UA employees will continue to have a CHOICE** in medical plans between the Preferred Provider Organization (PPO) plan or the High Deductible Health Plan (HDHP) option. The HDHP has proven to be a popular choice – 22% of employees selected the HDHP during last year's Open Enrollment.

How to enroll or make changes to your benefits:

Open Enrollment is a virtual process within the BenefitFocus platform, available 24/7 from Oct. 15-30, 2021. To enroll or make changes to your coverage, log in to myBama and click the BenefitFocus icon. If you do not know your myBama username and/or password, contact the IT Service Desk at (205) 348-5555 or email itsd@ua.edu.

Dependent documentation is required to add a new dependent spouse or child. The type of documentation required can be found on the HR website at hr.ua.edu/benefits/benefits-eligibility. You will not be required to submit documentation for dependents that have previously been verified and enrolled in coverage.

PayFlex – New Vendor for HCFSA, DCFSA and HSA

Effective Jan. 1, 2022, UA will transition to a new vendor, PayFlex, to serve as third-party administrator for all HCFSAs, DCFSAs and HSAs. PayFlex, an affiliate of Aetna Life Insurance Company, currently manages UA's COBRA Continuation Coverage benefit and administers all tax-favored accounts for the University of Alabama at Birmingham and the University of Alabama in Huntsville.

All plan participants will receive a new debit card in the mail from PayFlex in December. It's important to make sure your local mailing address is up to date in myBama.

Contributions for plan year 2022 will be deposited into your PayFlex account beginning in January. The current administrator, Total Administrative Services Corp. (TASC) will continue to manage the run-out period. This means any unreimbursed claims incurred in 2021 should be submitted by **March 31, 2022**. It's strongly recommended to file any reimbursement requests with TASC ***before the end of 2021*** to minimize the potential for account balance discrepancies during the transition to PayFlex.

Substantiation required for FSA expenses

The Internal Revenue Service (IRS) requires PayFlex to verify that all FSA debit card transactions are for eligible medical or childcare expenses, a process also known as substantiation. When using your debit card to access funds from your FSA, PayFlex has established certain systems and rules to automatically verify the funds were used for an eligible expense. However, sometimes PayFlex can't prove that the funds were used for eligible expenses. When this occurs, you will receive a "Request for Documentation" notice on the PayFlex member website, by email or mail based on your account settings.

The best type of documentation to provide for substantiation is the Explanation of Benefits (EOB) from an insurance company showing the "final" amount owed. PayFlex will also accept an itemized receipt including: 1) provider or merchant name, 2) patient name, 3) date of service, 4) type of service or item description and 5) final amount owed. It's strongly recommended to keep all receipts, invoices, EOBs, etc. PayFlex Mobile allows members to simply take a picture of a document and upload it through the app. PayFlex Mobile also features an Eligible Expense Scanner for barcodes and a list of common eligible items.

If your transaction is identified as not eligible for reimbursement then your FSA may be subject to correction procedures, including suspending the use of your debit card until the required documentation is received by PayFlex OR the exact amount is paid back to your account.

Changes to Benefit Payroll Deductions

Medical, dental and vision premiums are currently collected one month in advance. For example, premiums collected for medical insurance on your November check(s) will pay for coverage in December. Effective Jan. 1, 2022, these premiums will be collected in the current month for January coverage. As a result, **all benefit-eligible employees who pay medical, dental or vision premiums via payroll deduction in November (which pays for December coverage) will have no medical, dental or vision deductions on their December check(s)**. The current month change also impacts coverage in the event of termination of employment. Effective Jan. 1, all medical, dental and vision coverage(s) will end effective the last day of the month of termination.

In addition, the payroll deduction schedules for biweekly, non-exempt employees will change. Currently, there are 26 pay periods per year with medical premiums collected each pay period (i.e., 26 per year), dental premiums collected on the first paycheck each month (i.e., 12 per year), and vision premiums collected on the second paycheck each month (i.e., 12 per year), etc. The following example highlights current premium deductions for single, employee only coverage:

BW Check	Pay Date	Medical	Dental	Vision	Total Premium
1st Check	June 4	$53.54	$28.38	$0	**$81.92**
2nd Check	June 18	$53.54	$0	$5.74	**$59.28**
1st Check	July 2	$53.54	$28.38	$0	**$81.92**
2nd Check	July 16	$53.54	$0	$5.74	**$59.28**
3rd Check	July 30	$53.54	$0	$0	**$53.54**

Effective Jan. 1, 2022, all benefit premiums will be deducted over 24 pay periods. This will standardize payroll deduction amounts for all benefits, making it easier for employees to understand and budget for recurring expenses as shown in the following example:

BW Check	Pay Date	Medical	Dental	Vision	Total Premium
1st Check	June 4	$58	$14.19	$2.87	**$75.06**
2nd Check	June 18	$58	$14.19	$2.87	**$75.06**
1st Check	July 2	$58	$14.19	$2.87	**$75.06**
2nd Check	July 16	$58	$14.19	$2.87	**$75.06**
3rd Check	July 30	$0	$0	$0	**$0**

Benefits Highlights

LifeLock Identity Theft Protection: LifeLock with Norton Benefit Premier helps provide employees peace of mind with comprehensive protection for their identity, connected devices and online privacy. Monthly rates are $8.89 for Employee Only and $15.89 for Family. Additional information is available at hr.ua.edu/benefits/lifelock. If you have existing coverage with LifeLock, it's important to cancel this duplicate coverage before enrolling in UA's plan. You are permitted to use Norton 360 antivirus software on personal computers only, not UA computers.

TELADOC: Teladoc is a telemedicine company that uses telephone and videoconferencing technology to provide 24/7, on-demand remote medical care for acute, nonemergency illnesses like the flu. Each Teladoc visit costs $55 compared to a typical office visit of $75-100. After the first-dollar deductible is met, members on the PPO will pay a $20 copay and members on the HDHP will pay 20% coinsurance ($11 per visit).

No Increase in Premiums

	PPO Medical (Monthly)		HDHP Medical (Monthly)	
Tiers	2021	2022	2021	2022
Employee Only	$116	$116	$57	$57
Family without a Spouse	$406	$406	$198	$198
Family with a Spouse	$478	$478	$234	$234

	Dental (Monthly)		Vision (Monthly)	
Tiers	2021	2022	2021	2022
Employee Only	$28.38	$28.38	$5.74	$5.74
Employee + 1	$55.60	$55.60	$10.59	$10.59
Family	$80.58	$80.58	$18.52	$18.52

High Deductible Health Plan & Health Savings Account

UA offers a qualified HDHP with HSA which features lower premiums and a higher deductible when compared to the PPO. Employees will pay less in monthly premiums to maintain coverage, but more out-of-pocket when seeking medical care. After an employee or family satisfies the higher deductible, they will pay a 20% coinsurance based on the allowed or eligible charges.

An HSA is a tax-advantaged savings account available only to individuals enrolled in the UA HDHP. HSAs are like individual savings accounts at your bank, but the funds can only be used to pay for qualified medical, dental or vision expenses.

The following are key HSA benefits for employees:

Triple Tax Savings: Tax-free payroll contributions from the employee and UA; tax-free earnings, if invested; and tax-free distributions when used for qualified medical, dental or vision expenses.

Retirement Savings Tool: Once you have a $1,000 minimum balance, HSA's offer IRA-like investments including annuities and mutual funds. After age 55, you can contribute an additional $1,000 per year. At age 65, you can no longer contribute to your HSA if you are enrolled in Medicare, however, you may continue to use your HSA funds to pay for Medicare premiums or long-term care and more.

Employee Ownership: You own the money in your HSA account, even if you leave UA or switch to the PPO in the future. You can increase, decrease or stop contributions at any time. You also control how and when your money is spent.

Benefit Plan Comparison (In-Network Covered Services)	HDHP with HSA	PPO with HCFSA
First-Dollar Deductible	$1,400 employee $2,800 family	$400 per person
UA Contributions (Seed Money)	$400 employee $800 family	*Not applicable to HCFSA*
Employee Annual Contribution Limit	$3,250 employee $6,500 family	$2,750
Out-of-Pocket Maximum	$3,500 employee $7,000 family	$5,000 per person $14,300 per family
Employee Pays (after deductible)	20% coinsurance	Flat copayment
In-Network Providers and Covered Services	Preferred providers, in-network facilities and covered services are the same for both plans.	
Preventive Care	Routine screenings and preventive care covered at 100% for both plans (no deductible). For list of services, visit www.AlabamaBlue.com/preventiveservices	

Pharmacy Changes

Effective Jan. 1, 2022, Blue Cross will transition home delivery/mail order drug services to MedsYourWay through Amazon Pharmacy. Additionally, specialty drugs will only be provided by Express Scripts' specialty pharmacy named Accredo. AllianceRx Walgreens Prime (ARxWP) and CVS Caremark will no longer be covered pharmacies in the specialty network. Additional information about the home delivery/mail order and specialty drug changes will be sent from Blue Cross to all impacted members' home mailing address.

Premium Assistance Program Continues

UA provides premium assistance to benefit eligible active employees by giving a medical premium discount based on (1) family size and (2) total combined household income (1.5x the Federal Poverty Level). The amount of the discount is $57 per month, equal to the Employee Only premium under the HDHP.

To apply for this discount, active employees must submit the Premium Assistance Application and furnish acceptable proof of total annual household income based on their most recently filed Federal Income Tax Return, W-2s and 1099s. To apply for Premium Assistance, visit hr.ua.edu/benefits/premium-assistance.

Application Deadlines: Current employees must submit documentation annually during Open Enrollment. New Employees have 30 days from the date of hire to enroll in the premium assistance program.

Wellness and Work-Life:

Wellness and Work-Life provides support and encouragement for UA employees to prioritize their wellbeing. Attend your annual free WellBAMA health screening to discuss your current health status and explore positive lifestyle choices that can impact your health. You'll receive a $50 gift card for completing your health screening. Earn additional WellBAMA Rewards money by participating in other wellness programs. Go to wellness.ua.edu for additional information.

Explore your enrollment options during an information session via Zoom:

Topic	Date/Time	Registration Required
General Open Enrollment Info Session	Wed., Sep. 29, 10-11 a.m.	**Click here to register**
HDHP- Specific Info Session	Mon., Oct. 4, 10-11 a.m.	**Click here to register**
General Open Enrollment Info Session	Tues., Oct. 12, 2-3 p.m.	**Click here to register**

NOTICE TO ENROLLEES IN A SELF-FUNDED NONFEDERAL GOVERNMENTAL GROUP HEALTH PLAN

Group health plans sponsored by state and local governmental employers must generally comply with federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The University of Alabama has elected to exempt The University of Alabama group health plans from the following requirement:

Protections against having benefits for mental health and substance use disorders will be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the 2022 plan year beginning Jan. 1 and ending Dec. 31, 2022. The election may be renewed for subsequent plan years.

The exemption will not impact any current mental health and substance use disorder benefits. The exemption only applies to the Applied Behavior Analysis (ABA) therapy benefit for children ages 0-18 with an autism spectrum disorder diagnosis. The University of Alabama must be exempt from this Title XXVII requirement in order to offer ABA therapy with age-banded annual financial maximums.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 may 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 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 <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- 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.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may call the Customer Service number on the back of your insurance ID card for more information.