



## Freedom of Choice

Hamilton County  
Employee Guide to Employee Benefits Enrollment

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**Effective 1.1.2012**



Revised: 11/10/2011

This enrollment guide contains only the highlights of the different insurance plans available to County employees. Each plan is governed by an official plan document. In case of any conflict between this Enrollment Guide and an official plan document, the official plan document will be the final authority.



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## What's New for 2012?

### Medical Plan Changes

- There are no changes in the coverage levels of the Coverage First 1000, Coverage First 2500, and NPOS 500 plan. This means no changes in office visit co-payments, co-insurance amounts, for example.
- The HMO will no longer be offered.
- There is a new Medical Plan option available, a Medical Expense Reimbursement Plan. (MERP). The MERP is available to employees who have alternate coverage available and they enroll in that alternate coverage. The MERP plan will then reimburse employees for their eligible expenses incurred under the Alternate Coverage. If the alternate coverage available to employees is a high-deductible health plan with a HSA, the employee is NOT eligible to participate in the MERP. The alternate coverage cannot be a County plan. Eligible expenses under the plan include:
  - Premiums (i.e., payroll contributions) paid
  - Co-Payments incurred (including those for prescription drugs)
  - Co-Insurance incurred (including those for prescription drugs)
  - Deductibles incurred
- Prescription Drug Coverage: There are no changes in the co-payments for prescription drug coverage. However, as is typical each plan year, there are prescription drugs that change from one tier to another tier.

### Supplemental Life Insurance Changes - The Hartford

- There are no changes in the Supplemental Life Insurance program, however an employee may see a higher premium due to the employee and/or the employee's spouse changing age band(s) in the 2012 plan year.

### Long Term Disability

- There are no changes in the Long-Term Disability program, however an employee may see a higher premium due to the employee and/or the employee's spouse changing age band(s) and/or salary in the 2012 plan year.



### When can I make changes in my enrollment?

**1. During Open Enrollment.** Or,

**2. During the Plan Year when you experience a Qualifying Event.** You must notify your department payroll officer within **31 days** of the Qualifying Event in order for the change to take place. All requests for changes during the plan year must be approved by the Human Resources Department.

Changes made during a plan year, as a result of a qualifying event are only to the coverage level (single, double, family) and not to the plan.

When changing your elections during the plan year, the *changes you make must be consistent with the change in status*. For example, you can go from double to family coverage if you experience the birth of a child. But, you could not drop your coverage if you experience the birth of a child.

### What is a Qualifying Event?

Because there are tax advantages associated with insurance coverage, you can only change your elections for insurance when you experience a qualifying event, as defined by the IRS. These qualifying events includes things like:

- Legal Marital Status Change
  - Marriage,
  - Divorce,
  - Legal Separation,
  - Annulment
  - Death of a spouse
- Change in Number of Eligible Dependent Children
  - Birth or adoption of a child
  - Child is no longer considered an eligible dependent due to age/student status.
  - Death of a child
- A change in your or your spouse's employment that affects benefits
  - You or your spouse lose his/her coverage in another medical plan
  - Your work hours change so you are no longer eligible for benefits
  - Spouse costs for medical insurance increase significantly
- A court ordered benefit change

### Adding Dependents? VERIFICATIONS NEEDED!

In order to **add** a dependent to your coverage who was not covered at the end of 2011, proper documentation will be required. You must submit a Dependent Verification Form to your Department Payroll Officer.



## Medical Insurance



### WHO is eligible for medical coverage?

- Any Permanent Full-Time Employee, or one who is regularly scheduled 30 or more hours per week. Plus, any of the employees covered dependents, including:
  - Spouse
  - Children under age 26 who are not eligible for any health benefit plan through his/her employer.
  - Dependents who are mentally or physically disabled and incapable of self-support, even if they are older than age 25. Dependents must be declared disabled before age 18 in order to qualify for this extended coverage.
  - Unmarried adult children ages 26 and 27 who are a resident of the state of Ohio or a full-time student at an accredited public or private institution of higher education, not eligible for any health benefit plan through his/her employer, and not eligible for Medicaid or Medicare.



### WHEN is my coverage effective?

- New hires are eligible for coverage the first of the month following 90 days of service. Please see the Policy Manual Section 5.2H for more details.
- For existing County employees, the changes made during the open enrollment process will be effective 1/1/2012.



### WHEN can I make changes?

- During the Open Enrollment period.
- During the Plan Year, when a qualifying event occurs. You must notify your department representative within 31 days of the qualifying event. For more details contact your department payroll officer.
- You may be required to submit supporting documentation, in order to add/delete dependents from coverage. For a list of necessary supporting documentation, please reference the Dependent Verification Form.



### WHICH plan is right for me?

- **You are the only one that can decide which medical plan is right for you! Employees are encouraged to take a close look at your plan choice to see if this is the year to make a change!**

Log on to [www.humana.com](http://www.humana.com) for help making your decision!!!

**HUMANA.**  
Guidance when you need it most



### WHAT are my medical coverage options?

Hamilton County has four different medical plan options available for eligible employees. The information below is a brief summary of the four plans. For details regarding the medical coverage available under each plan, please see the following pages and the Humana SmartSuite Guide.

<p><b>Humana POS 500</b></p>	<ul style="list-style-type: none"> <li>• Members pay a lower share of cost when seeking services from network providers.</li> <li>• Members have the ability to seek services from non-network provider, at a higher share of cost.</li> <li>• The member pays towards a \$500 deductible/individual (\$1000 for family).</li> <li>• Members are not required to identify a Primary Care Physician.</li> </ul>
<p><b>Humana CoverageFirst 1000</b></p>	<ul style="list-style-type: none"> <li>• The plan pays the first \$500 of eligible expenses from network providers for each member, other than co-payments and preventative care.</li> <li>• Once a member has used the \$500 Benefit Allowance, the member pays towards the \$1000 deductible/individual (\$2000 for family).</li> <li>• After the \$1000 deductible is met, the member is responsible for coinsurance and co-payments, until the annual out-of-pocket maximum is met.</li> </ul>
<p><b>Humana CoverageFirst 2500</b></p>	<ul style="list-style-type: none"> <li>• The plan pays the first \$500 of eligible expenses from network providers for each member, other than co-payments and preventative care.</li> <li>• Once a member has used the \$500 Benefit Allowance, the member pays towards the \$2500 deductible/individual (\$5000 for family).</li> <li>• After the \$2500 deductible is met, employee is responsible for coinsurance and co-payments, until the annual out-of-pocket maximum is met.</li> </ul>
<p><b>Medical Expense Reimbursement Plan</b></p>	<ul style="list-style-type: none"> <li>• Employees are eligible to enroll if they are enrolled in Alternate Coverage, so long as the alternate coverage is not a High Deductible Health Plan with a HSA.</li> <li>• The plan reimburses employees who are enrolled in Alternate Coverage for their premiums/payroll contributions up to applicable maximums. (See next page for current maximums.)</li> <li>• The plan also reimburses employees for the health care expenses they incur while enrolled in alternate coverage, so long as the expense would have otherwise been covered by the Hamilton County medical plan. This includes expenses incurred for co-payments, co-insurance, and deductibles.</li> </ul>



## Medical Insurance: plans at a glance

Medical Benefit		Humana CoverageFirst 2500
<b>Benefit Allowance per covered member</b>	Network	\$500
	Non-Network	Not Applicable
<b>Annual Deductible</b> co-payments not applied towards meeting annual deductible	Network	\$2,500 Individual \$5,000 Family
	Non-Network	\$7,500 Individual \$15,000 Family
<b>Physician Services - Primary Care Physician</b>	Network	\$25
	Non-Network	70% after deductible
<b>Physician Services - Specialist Physician</b>	Network	\$40
	Non-Network	70% after deductible
<b>Facility Services - Inpatient</b>	Network	100% after deductible
	Non-Network	70% after deductible
<b>Facility Services - Outpatient</b>	Network	100% after deductible
	Non-Network	70% after deductible
<b>Facility Services - Hospital Emergency Services</b>	Network	\$200 copayment
	Non-Network	\$200 copayment
<b>Urgent Care</b>	Network	\$40 copayment
	Non-Network	70% after deductible
<b>Other Medical Services -</b> <ul style="list-style-type: none"> <li>• Skilled Nursing Facility - 60 days per calendar year (HMO-100 days per calendar year)</li> <li>• Home Health Care - unlimited</li> <li>• Therapy (physical, cognitive, speech, hearing) - 60 combined total visits per calendar year</li> <li>• Durable Medical Equipment - unlimited</li> </ul>	Network	100% after deductible
	Non-Network	70% after deductible
<b>Chiropractic Services</b> <ul style="list-style-type: none"> <li>• 25 visits per calendar year</li> </ul>	Network	\$40 Specialist Co-Payment
	Non-Network	70% after deductible
<b>Behavioral Health Services</b> <ul style="list-style-type: none"> <li>• Mental health and substance abuse</li> <li>• Inpatient services</li> <li>• Outpatient sessions</li> </ul>	Network	Inpatient: 100% after deductible Outpatient: \$25 Co-Pay
	Non-Network	70% after deductible
<b>Annual Out of Pocket Maximum</b>	Network	\$2,000 Individual \$4,000 Family
	Non-Network	\$6,000 Individual \$12,000 Family
<b>Lifetime Maximum Benefit</b>	Network	Unlimited
	Non-Network	Unlimited
<b>Eye Exams</b> One exam per 24 month period	Network	\$40
	Non-Network	70% after deductible
<b>Prescription Drugs</b>	The Humana Medical Plans offer the same	



## Medical Insurance: plans at a glance



Humana CoverageFirst 1000	Humana National POS 500
\$500	Not Applicable
Not Applicable	Not Applicable
\$1,000 Individual \$2,000 Family	\$500 Individual \$1000 Family
\$3,000 Individual \$6,000 Family	\$1,500 Individual \$3,000 Family
\$20	\$30
50% after deductible	60% after deductible
\$35	\$45
50% after deductible	60% after deductible
80% after deductible	90% after deductible
50% after deductible	60% after deductible
80% after deductible	90% after deductible
50% after deductible	60% after deductible
\$200 copayment	\$200 copayment
\$200 copayment	\$200 copayment
\$35 Specialist Co-Payment	\$75 copayment
50% after deductible	60% after deductible
80% after deductible	90% after deductible
50% after deductible	60% after deductible
\$35 Specialist Co-Payment	\$45 Specialist Co-Payment
50% after deductible	60% after deductible
Inpatient: 80% after deductible Outpatient: \$20 Co-Pay	Inpatient: 90% after deductible Outpatient: \$30 Co-Pay
50% after deductible	Inpatient: 60% after deductible Outpatient: 60% after deductible
\$2,000 Individual \$4,000 Family	\$2,000 Individual \$4,000 Family
\$6,000 Individual \$12,000 Family	\$6,000 Individual \$12,000 Family
Unlimited	Unlimited
Unlimited	Unlimited
\$35	\$45
50% after deductible	60% after deductible
prescription drug coverage. See page 12 for details.	

### NEW! Medical Expense Reimbursement Plan (MERP)

Enrolled employees are eligible for reimbursement of medical expenses incurred under their Alternate Coverage.

#### Premiums

Enrolled participants are eligible for reimbursement for premiums paid for Alternate Coverage that exceeds the current payroll contribution for the Coverage First 2500 plan, up to the maximums below:

- **Single:** \$150 / month
- **Double:** \$200 / month
- **Family:** \$400 / month

#### Spousal Surcharge

Enrolled participants are eligible for reimbursement for premiums paid as a spousal surcharge for Alternate Coverage that exceeds the current Hamilton County Spousal Surcharge.

#### Health Care Expenses

Enrolled participants are eligible for reimbursement for the following Expenses incurred while enrolled in the MERP:

- Deductibles
- Co-Payments (incl. Rx)
- Co-Insurance (incl. Rx)
- Other expenses that are otherwise excluded from coverage under the terms of the Alternate Coverage.

**The Expenses listed above are only eligible for reimbursement, to the extent they would have otherwise been covered by the Hamilton County plan.**



## Prescription Drug Benefits

### Prescription Drug Co-Pays

The three Humana medical plans offer the same prescription drug coverage, as described below. For details on which medications are included in each level, you can refer to the Humana website, [www.humana.com](http://www.humana.com).

	30-day Supply	Mail Order Cost
Level 1:	\$15	\$30 for 3 month supply
Level 2:	\$30	\$60 for 3 month supply
Level 3:	\$50	\$100 for 3 month supply
Level 4:	25% up to \$250 per Rx (\$2500 Out of Pocket Max)	25% up to \$500 for 3 month supply (\$2500 Out of Pocket Max)

### 90-day Retail Option

- For certain maintenance prescription medications, you can receive a maximum 90-day supply per prescription. Filling this prescription at a retail location will cost 3x the regular 30-day supply co-pay. (Note: certain self-administered injectables and specialty drugs are limited to a 30-day supply.)
- Have your doctor write your prescription for the maximum allowable days (usually 90-days).
- Take your prescription to a participating retail pharmacy. *Note: Some retail outlets may not dispense on a 90-day basis.*

### Mail-Order Option: Humana *RightSourceRx*

- For certain maintenance prescription medications, you can receive a maximum 90-day supply per prescription or refill in an effort to help reduce your prescription drug costs. (Note: certain self-administered injectables and specialty drugs are limited to a 30-day supply.)
- Have your doctor write your prescription for the maximum allowable days (usually 90-day)
- Check the Humana drug formulary to see which level (1,2,3, or 4) applies to your prescription.
- Fill out the *RightSourceRx* Registration form ([www.humana.com/rightsource](http://www.humana.com/rightsource))
- Mail the registration form and appropriate payment to *RightSourceRx*.
- **REFILLS ARE EASY:** You can easily refill your prescriptions in three ways.
  1. Via the web. [www.humana.com](http://www.humana.com).
  2. Via mail. Use the reorder form that comes with each delivery.
  3. Via telephone: Call 1-800-379-0092 and have your Rx number ready



### What is the Spousal Surcharge?

Employees who choose to cover his/her spouse on a Hamilton County medical plan, and the spouse has coverage available through his/her employer but chooses not to enroll in that coverage, then the employee will be subject to an additional payroll deduction/surcharge.

### When must I pay the surcharge?

If you choose to enroll your spouse on a Hamilton County medical plan, and your spouse is eligible for employer-sponsored medical insurance and he/she elected not to enroll in his/her medical coverage.

### Under what circumstances do I avoid paying the surcharge?

Employees do not have to pay the spousal surcharge if any one of the following apply:

- You have elected to waive your medical coverage through Hamilton County or you have enrolled in the MERP plan through Hamilton County.
- You do not have a spouse or have chosen not to cover your spouse on the Hamilton County medical plan
- You have elected medical coverage through Hamilton County and your spouse is also an employee of Hamilton County
- You have elected medical coverage and have chosen to enroll your spouse on a Hamilton County medical plan and a) your spouse is not eligible for an employer-sponsored medical insurance OR b) your spouse works part-time and is regularly scheduled to work less than 20 hours per week. (For example: My spouse is un-employed or self-employed, or my spouse works part-time with no medical insurance benefits).
- You have elected medical coverage and have chosen to enroll your spouse on a Hamilton County medical plan and your spouse is ALSO enrolled in another medical plan and is considered as PRIMARY on that plan.

### What if my spouse becomes eligible for employer-sponsored health insurance mid-year? Or, what if my spouse loses eligibility for employer sponsored health insurance mid-year?

If your Spouse loses or obtains medical coverage through his/her employer, you have 31 days to notify Hamilton County of the change. Please contact your department representative for information on making these changes. Family status changes must also be made within 31 days of when the change occurred. Failure to notify your department representative will prohibit you from making any changes until the next annual open enrollment period.



### Eye Hardware

Hamilton County offers a discount on your eye hardware (glasses, frames, etc) through the EyeMed Vision Plan. All employees are eligible for the discount, even if the employee is not enrolled in the medical plan.



## Dental Insurance



### WHO is eligible for dental coverage?

- Any Permanent Full-Time Employee who is regularly scheduled to work 30 or more hours per week. Plus, any of the employees covered dependents:
  - Spouse
  - Unmarried dependents under age 19
  - Unmarried dependents from age 19 until age 25, if they are full-time students and not working full-time.
  - Dependents who are mentally or physically disabled and incapable of self-support, even if they are older than age 25. Dependents must be declared disabled before age 18 in order to qualify for this extended coverage.



### WHEN is my coverage effective?

- All new hires are eligible for coverage the first of the month following 90 days of service. Please see the Policy Manual Section 5.2H for specifics.
- For existing County employees, the changes made during the open enrollment process will be effective 1/1/2012.



### WHEN can I make changes?

- During the Open Enrollment period.
- During the Plan Year, when a qualifying event occurs. You must notify your department payroll officer of the change in status within 31 days of the qualifying event (marriage, birth of a child, etc.). For more details contact your department payroll officer.
- You will be required to submit supporting documentation, in order to add/delete dependents from coverage. For a list of applicable supporting documentation, please reference the Dependent Verification Form.



### WHICH plan is right for me?

- **You are the only one that can decide which plan is right for you!**



### WHAT are my dental coverage options?

Hamilton County has two dental plan options available for eligible employees. Both plans are offered by Dental Care Plus. For details regarding the dental coverage available under each plan, please see below and the applicable website.

**The main differences between the two plan options are: Orthodontia, Major Services, and the Annual Maximum per member.** The network of provider dentists is identical across the two plans.

	DCP - Premium	DCP - Basic
<b>Website</b>	www.dentalcareplus.com	www.dentalcareplus.com
<b>Description</b>	<ul style="list-style-type: none"> <li>Offers access to 2200+ dentists. (96% locally)</li> <li>Services must be obtained from a network dentist.</li> <li><b>Includes orthodontia coverage.</b></li> </ul>	<ul style="list-style-type: none"> <li>Offers access to 2200+ dentists (96% locally)</li> <li>Services must be obtained from a network dentist.</li> <li><b>No orthodontia coverage.</b></li> </ul>
<b>Deductible</b>	None.	None.
<b>Preventative Services</b> Examples: teeth cleaning, routine exams, x-rays, juvenile fluoride treatments	Plan pays 100% of allowed charges.	Plan pays 100% of allowed charges.
<b>Basic Services</b> Examples: most oral surgery, fillings, simple root canals, simple extractions	Plan pays 80% of allowed charges.	Plan pays 80% of allowed charges.
<b>Major Services</b> Examples: crowns, dentures, bridges, inlays, and onlays.	Plan pays <b>60%</b> of allowed charges.	Plan pays <b>50%</b> of allowed charges.
<b>Orthodontia</b> For the employee and/or eligible dependent children under age 19.	<b>Plan pays 50% of allowed charges</b>	<b>Not Covered.</b>
<b>Max Ortho Benefit</b>	\$1500 Lifetime Max per eligible member	Not Applicable.
<b>Max Plan Benefit</b>	<b>\$1500</b> per year per member (excluding orthodontia)	<b>\$1000</b> per year per member



### Is my dentist in the Dental Care Plus Network?

- You can find out by going to: [www.dentalcareplus.com](http://www.dentalcareplus.com)
- Click on "Find a Dentist"
- Click on "Dentist Search"
- Click on the blue "Dental Care Plus" logo.
- Enter your search criteria!

**The Dental Care  
PLUS GROUP**  
The plus is service.



## Long-Term Disability



### WHAT is long-term disability (LTD) insurance?

The LTD insurance is designed to replace a percentage of your income if you were to become disabled, even on a temporary basis. Hamilton County offers the choice of two coverage levels:

- 40% up to a maximum \$2400 monthly benefit, or
- 50% up to a maximum \$3000 monthly benefit.

This benefit amount is offset by any other disability income that you may receive from other sources such as Workers' Compensation, Social Security, government programs such as Ohio PERS (Ohio Public Employees Retirement System), and any other program to which Hamilton County contributes. However, no matter how much you receive in benefits from those other sources, your LTD plan benefit would always be at least \$150 per month or 10% of your gross Monthly Benefit, whichever is greater.

#### **When would I get benefits?**

Benefits begin after a period of absence of 90 or more calendar days. This income continues for up to two years as long as you are disabled from performing your own occupation, or until you reach Social Security Normal Retirement Age if you are totally and permanently disabled. For details regarding what is considered the Normal Retirement Age, see [www.socialsecurity.gov](http://www.socialsecurity.gov). For more information you can also view the Certificate of Coverage.

Additionally, if you receive disability benefits for 6 months or more, and you die while receiving benefits the plan will pay an additional 3 months of benefit payments to your eligible survivor.



### WHO is eligible for long-term disability insurance

- Any Permanent Full-Time Employee who is regularly scheduled to work 30 or more hours per week.



### WHEN is my coverage effective?

- All new hires are eligible for coverage the first of the month following 90 days of service. Please see the Policy Manual Section 5.2H for specifics.
- For existing County employees, the changes made during the open enrollment process will be effective 1/1/2012.



### WHEN can I make changes?

- During the Open Enrollment period.

Note: A pre-existing condition for which you received treatment during the six-month period immediately prior to the effective date of your coverage will be excluded for the first 24 months of coverage or of the increased amount of your benefit amount.

- During the Plan Year, when a qualifying event occurs. Notify your department payroll officer of the change in status within 31 days of the qualifying event (marriage, birth of a child, etc. See page 5 for more details.

Note: If you have a qualifying event during the plan year, you can enroll in the plan or change benefit level. For example, if you declined coverage previously, then had a child during the plan year, you could enroll in LTD coverage or increase your benefit level.

## Long-Term Disability Insurance



### What about pre-existing conditions?

Disabilities, which are the result of a condition for which you sought care, treatment, or medical advice during the 6 months prior to your coverage effective date, are not covered unless the disability occurs after you have been insured for 24 months.

If you have met the requirement to complete the pre-existing condition restriction, and have continued LTD coverage without lapse, you will not have to complete the requirement again with any other insurance company Hamilton County contracts with for this benefit. However, if you increase your coverage from the 40% plan to the 50% plan, there will be a new pre-existing condition waiting period in order to receive the additional 10% benefit.

### Comparing LTD with OPERS Disability Benefits

When considering whether to enroll in the LTD plan, you may want to compare the LTD benefits with the disability benefits you may be entitled to through your contribution to the Ohio Public Employees Retirement System (OPERS). To help, here are a few facts:

	Long-Term Disability	OPERS Disability Benefits
When am I eligible for benefits?	1st of the month following 90 days of service	After 5 years of OPERS service.
When would I get benefits?	After 90 days of disability.	At the time of disability, so long as you have 5 years of OPERS service. Subject to OPERS approval.
Are temporary disabilities covered?	Yes.	No. Coverage only if you are not expected to return to work in your lifetime.
What is the benefit amount?	40% of 50% of your pay, reduced by other income sources (SSA, Workers' Comp, etc.) for as long as the disability continues for up to two years	Based on salary at time of disability and projected service through age 60 (up to 75% of pay) or age 70 (up to 60% of pay). Refer to <a href="http://www.opers.org">www.opers.org</a> for more details.
Where can I get more details?	Please refer to the Certificate of Coverage.	<a href="http://www.opers.org">www.opers.org</a>



## FSA: Healthcare Spending Account



### WHAT do I need to know about a healthcare spending account?

A Healthcare spending account allows you to set aside money each pay period to reimburse yourself for certain health care related expenses that you expect to incur during the plan year. Funds that are put into this account are not subject to state and federal income tax. Because of this tax savings, funds that you do not request reimbursement for before the close of the plan year (or your termination in the plan) are forfeited. (Use it or lose it!)

Over the counter medications are no longer considered an eligible expense unless you have a prescription for the over-the-counter medication.

You can submit claims for your eligible dependents until the first of the year in which they turn 27. For example, if your eligible dependent is turning 27 in November 2012, then you are not able to submit any FSA claims for them in 2012.



### How much can I contribute?

Minimum: \$260 annually  
Maximum: \$4000 annually



### WHEN is my election effective?

- All new hires are eligible for participation on the first of the month following 90 days of service. Please see the Policy Manual Section 5.2H for specifics.
- For existing County employees, the changes made during the open enrollment process will be effective 1/1/2012.

### WHEN can I make changes?

- During the Open Enrollment period.
- During the Plan Year, when a qualifying event occurs. See page 5 for more details.

You can enroll in the plan or change your contribution level according to the minimums and maximums defined above. The change must be consistent with the qualifying event. For example, if you had declined coverage previously, but experience the birth of a child during the plan year, you could enroll in the flexible spending account or you could increase your contribution amount.

It is important to note that if you terminate your election in the flexible spending account, you are not eligible for reimbursement for claims that are incurred after the end of the month in which you terminate your election.



### WHO is eligible to participate in the Flexible Spending Accounts?

Any Full or Part Time County employee.



**More facts about the Healthcare Spending Account:**

<p><b>WHAT TYPES OF EXPENSES ARE COVERED?</b></p>	<ul style="list-style-type: none"> <li>Any co-pays and deductibles not fully paid by your medical insurance.</li> <li>Hearing aids and batteries.</li> <li>Elective eye surgery, glasses, contact lenses, saline solution, other vision care.</li> <li>Annual physicals, immunizations and vaccines</li> </ul> <p><i>Note: over the counter medications are no longer considered an eligible expense without a prescription, per national healthcare reform.</i></p> <p><b>However, you are still able to submit claims for over-the-counter items that are <u>not considered a drug or a medicine</u>, such as bandages, blood pressure monitors, contact lens solution, etc.</b></p>
<p>What types of expenses are NOT covered?</p>	<ul style="list-style-type: none"> <li>Expenses claimed as a deduction on income tax returns</li> <li>Health care insurance premiums</li> <li>Expenses reimbursed under another program, like Medicare or the MERP.</li> <li>Expenses for funerals or burials</li> <li>Expenses for Maternity clothes, diaper services, or house help.</li> <li>Expenses for toiletries/cosmetics</li> <li><b>Expenses for over the counter medications, without a Rx.</b></li> </ul>
<p>When must I incur the expenses?</p>	<p>Between your coverage effective date and the end of the plan year (12/31/2012), or your termination in the plan, whichever comes first. However, there is a built in grace period. So long as you are still enrolled in the plan, you have until March 15, 2013 to incur expenses.</p>
<p>When can I request reimbursement?</p>	<p>You must submit request for reimbursement by March 31, 2013. Any funds not requested for reimbursement are forfeited. Use it or lose it! You can request reimbursement for a health care expense as soon as you incur the expense, up to the total amount you (will) contribute for the year. It is important to note that if you terminate your election in the flexible spending account, you are not eligible for reimbursement for claims that are incurred after the end of the month in which you terminate your election.</p>
<p>How do I request reimbursement?</p>	<p>Reimbursements are processed through our vendor, Chard-Snyder. You will need to complete a Chard-Snyder Request for reimbursement. They have paper reimbursements and electronic processing. Please refer to <a href="http://chard-snyder.com">chard-snyder.com</a> for more details.</p>
<p>How do I get Reimbursed?</p>	<p>Chard-Snyder processes the reimbursements and will either mail a check or have the funds direct deposited into an account of your choosing.</p>
<p>What happens if I have money left at year-end?</p>	<p>Funds are forfeited if reimbursement is not requested by March 31st, 2013. Therefore it is extremely important to carefully consider what your actual expenses will be for the plan year, and only have that amount deposited into the account(s).</p>
<p>What happens if my employment ends?</p>	<p>You may continue to submit claims for expenses incurred before the end of the month in which your employment terminated or otherwise become ineligible for participation in the plan. (If you die during the plan year, then your dependents may be reimbursed for eligible expenses incurred before your death.)</p>

	<p><b>Where can I get more information?</b>  <a href="http://www.chard-snyder.com">www.chard-snyder.com</a>  <a href="mailto:askpenny@chard-snyder.com">askpenny@chard-snyder.com</a>                      513-459-9997</p>
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## FSA: Dependent Care Spending Account



### WHAT do I need to know about the dependent care account?

Dependent Care Spending Accounts allow you to set aside money each pay period to reimburse yourself for certain dependent care related expenses. Funds in these accounts are not subject to state and federal income tax. Because of this tax savings, funds that you do not request reimbursement for before the close of the plan year are forfeited. (Use it or lose it!) *This plan is **NOT** for health care related expenses for your dependents, rather it is for the cost of care for your dependent(s) while you work or search for work (daycare, etc.)*



### HOW much can I contribute?

**Minimum: \$260 annually**

**Maximum: \$5000 annually\*** (\*The max amount depends on your tax filing status.)

- Single or Head of Household: \$5,000
- Married filing separately: \$2,500
- Married or Married Filing Jointly: (Between you and your spouse you can contribute a combined total of \$5000.) The lesser of
  - \$5,000
  - Your income
  - Your spouse's income



### WHEN is my election effective?

- All new hires are eligible for participation on the first of the month following 90 days of service. Please see the Policy Manual Section 5.2H for specifics.
- For existing County employees, the changes made during the open enrollment process will be effective 1/1/2012.



### WHEN can I make changes?

- During the Open Enrollment period.
- During the Plan Year, when a qualifying event occurs. See page 5 for more details.

You can enroll in the plan or change your contribution level according to the minimums and maximums as defined above. The change must be consistent with the qualifying event. For example, if you had declined coverage previously, but experience the birth of a child during the plan year, you could enroll in the flexible spending account or you could increase your contribution amount. It is important to note that if you terminate your election in the flexible spending account, you are not eligible for reimbursement for claims that are incurred after the end of the month in which you terminate your election.



### WHO is eligible to participate in the Flexible Spending Accounts?

Any full or part time County employee who has an eligible dependent, and one of the following applies:

- Your spouse works
- Your spouse attends school fulltime for at least 5 months during the year while you are at work.
- Your spouse is disabled and cannot care for him/herself.
- You are single, divorced, or legally separated and have custody of the dependent(s) most of the time, even if the other parent claims the dependent on his/her taxes.

For purposes of this rule: a dependent is any person under age 13 whom you claim as a tax exemption, or another dependent who is unable to care for him/herself and spends 8 or more hrs in your home each day.



**More facts about Dependent Care Spending Accounts**

<p><b>WHAT</b> expenses are covered?</p>	<p>Cost for care for your dependent while you work or search for work :</p> <ul style="list-style-type: none"> <li>• In or out of your home</li> <li>• In a day care center</li> <li>• By a housekeeper as part of his/her job.</li> </ul> <p><u>This account is NOT used to pay health care expenses for a dependent.</u></p>
<p>What types of expenses are NOT covered?</p>	<ul style="list-style-type: none"> <li>• Costs for care provided by your spouse.</li> <li>• Care provided by your child under age 19.</li> <li>• Care provided by anyone you claim as a tax exemption.</li> <li>• Costs for kindergarten</li> </ul>
<p>When must I incur the expenses?</p>	<p>Between your coverage effective date and the end of the plan year (12/31/2012), or your termination in the plan, whichever comes first.</p>
<p>When can I request reimbursement?</p>	<p>You must submit request for reimbursement by March 31, 2013. Any funds not requested for reimbursement are forfeited. Use it or lose it!</p> <p>You can only request reimbursement for funds that are available in your account at the time of the request.</p> <p>It is important to note that if you terminate your election in the account, you are not eligible for reimbursement for claims that are incurred after the end of the month in which you terminate your election.</p>
<p>How do I request reimbursement?</p>	<p>Reimbursements are processed through our vendor, Chard-Snyder. You will need to complete a Chard-Snyder Request for reimbursement. They have paper reimbursements and electronic processing. Please refer to <a href="http://chard-snyder.com">chard-snyder.com</a> for more details.</p>
<p>How do I get Reimbursed?</p>	<p>Chard-Snyder processes the reimbursements and will either mail a check or have the funds direct deposited into an account of your choosing. Please refer to <a href="http://Chard-snyder.com">Chard-snyder.com</a> (and click on Forms).</p>
<p>What happens if I have money left at year-end?</p>	<p>Funds are forfeited if reimbursement is not requested by March 31st, 2013. Therefore it is extremely important to carefully consider what your actual expenses will be for the plan year, and only have that amount deposited into the account(s).</p>
<p>What happens if my employment ends or I terminate my election in the plan?</p>	<p>You may continue to submit claims for expenses incurred before the end of the month in which your employment terminated or otherwise become ineligible for participation in the plan. (If you die during the plan year, then your dependents may be reimbursed for eligible expenses incurred before your death.) You are not eligible to be reimbursed for expenses incurred after your termination in the plan.</p>



**Where can I get more information?**  
[www.chard-snyder.com](http://www.chard-snyder.com)  
[askpenny@chard-snyder.com](mailto:askpenny@chard-snyder.com)  
 513-459-9997



## Life Insurance: Basic Life



### WHAT is Basic Life Insurance?

- Hamilton County provides life insurance at no cost to eligible employees in the amount of your annual salary (up to policy maximum of \$300,000). This insurance is provided through Dearborn National.

*Note: This coverage decreases to 65% of an employee's salary on an employee's 65th birthday, and to 50% on an employee's 70th birthday.*



### WHO has Basic Life Insurance?

- Any Permanent Full-Time Employee who is regularly scheduled to work 30 or more hours per week.



### WHEN is my coverage effective?

- All new hires are eligible for coverage the first of the month following 90 days of service. Please see the Policy Manual Section 5.2H for specifics.



### How do I designate a Beneficiary?

- Employees designate beneficiaries using the paycor online enrollment. **Employees are required to indicate the benefit percentage to primary and/or contingent beneficiaries in the system.**
- Employees are permitted to change a beneficiary designation at any time during the year.

## Life Insurance: Supplemental Life



### WHAT is Supplemental Life Insurance?

Hamilton County provides eligible county employees the ability to purchase additional life insurance coverage through The Hartford.



### WHO is Eligible for Supplemental Life Insurance?

- Any Permanent Full-Time Employee who is regularly scheduled to work 30 or more hours per week. *If the employee purchases coverage, he/she may also purchase coverage for his/her spouse and/or eligible dependents.*



### WHEN is coverage effective?

- All new hires are eligible for participation on the first of the month following 90 days of service.
- For existing County employees, the changes made during the open enrollment process will be effective 1/1/2012.



### WHEN can I make changes?

- During the Open Enrollment period.
- During the Plan Year, when a qualifying event occurs. Notify your department payroll officer of the change in status within 31 days of the qualifying event (marriage, birth of a child, etc.). See your dept representative for more information and enrollment forms.



### WHAT are my supplemental life insurance coverage options?

	Employee	Employee's Spouse	Employee's Dependent Child(ren)
<b>Coverage Increments</b>	\$10,000	\$5,000	\$2,000
<b>Maximum Coverage Amount</b>	The lesser of \$500,000 or 5 times your annual salary	50% of employee's supplemental life insurance coverage, up to \$250,000	50% of employee's supplemental life insurance coverage, up to \$10,000
<b>Guaranteed Issue Amount -New Hires</b>	\$100,000	\$25,000	\$10,000
<b>Guaranteed Issue Amount - Current Employees</b>	2 Increments, if employee's coverage does not exceed \$100,000	2 Increments, if spouse's coverage does not exceed \$25,000	\$10,000

- If you wish to enroll in amounts over the guaranteed issue amounts, you will need to provide evidence of good health by submitting a Personal Health Application.





## SmartCommuter: transportation reimbursement



### WHAT is SmartCommuter?



SmartCommuter allows Hamilton County employees to pay for eligible parking, mass transit, and van pooling expenses through a pre-tax deduction. You decide how much to contribute (up to the plan limits) and whether you will be reimbursed for parking and/or mass transit expenses. Your contributions will be deducted from your paycheck on a pre-tax basis twice each month (24 times per year). Then, you can request reimbursement for these expenses once you have incurred them.



### WHO is eligible to participate in SmartCommuter?

All Hamilton County employees and elected officials are eligible to participate.



### How do I enroll?

Complete an Enrollment form (Go to on [www.chard-snyder.com](http://www.chard-snyder.com), click on SmartCommuter).



### WHEN can I make changes?

- You can enroll at any time during the year.
- Once enrolled you can modify your deduction amounts up to four times per year.

## More facts about SmartCommuter

How much can I contribute?	Mass Transit Monthly Maximum: <b>\$230</b> Parking Monthly Maximum: <b>\$230</b>
What expenses are covered?	<ul style="list-style-type: none"> <li>• Parking at or near work (excluding residence)</li> <li>• Mass transit passes and tokens</li> <li>• Commuter van pooling fares</li> </ul>
When must I incur the expenses?	Between your coverage effective date and the end of the plan year, 1/1/2012 to 12/31/2012 or termination in the program, whichever occurs first.
When can I request reimbursement?	<b>You must request reimbursement for eligible expenses within 180 days (or six months) of incurring the expense, and within 90 days of the conclusion of the plan year (March 31, 2013).</b>
How do I request reimbursement?	Reimbursements are processed through our vendor, Chard-Snyder. You will need to complete a Chard-Snyder Request for reimbursement. They have paper reimbursements and electronic processing. Please refer to <a href="http://chard-snyder.com">chard-snyder.com</a> , and click on SmartCommuter.
How do I get reimbursed?	Chard-Snyder processes the reimbursements and will mail a check or direct deposit the funds into an account of your choosing. Please refer to <a href="http://Chard-Snyder.com">Chard-Snyder.com</a> and click on SmartCommuter.
What happens if I have money left at year-end?	Funds will be carried over to the next year. (If you were enrolled in the plan in 2011 your year-end balance will continue to be available for reimbursement in 2012.)
What types of expenses are <u>NOT</u> covered?	<ul style="list-style-type: none"> <li>• Taxicab fares, car pooling, tolls, vehicle operation expenses</li> <li>• Expenses incurred prior to enrollment in plan</li> <li>• Expenses incurred after termination of employment or after termination of participation in plan</li> </ul>

## EAP: Employee Assistance Program



### WHAT is the EAP?

- An employee assistance program (EAP) is designed to help employees and their families address problems that can compromise personal satisfaction and, sometimes, job performance.
- From time to time, everyone encounters problems and obstacles which can seem insurmountable. The EAP is available to help when you experience difficult periods in your relationships with others, pressures associated with work, family turmoil surrounding a troubled child or teen, the excessive use of alcohol or prescription or illegal drugs, or even legal problems.
- Counselors are available who are carefully selected for their practical, active approach to counseling, so that your problems can be quickly and effectively resolved.
- **It's confidential, it's convenient, and it's easy to use.**



### WHO is Eligible to consult with the EAP?

All Hamilton County employees and elected officials are eligible to participate. You don't need to do anything, except call the number below when you need to utilize the services.



### What is included?

**The Employee Assistance Program will provide up to  
10 FREE Sessions  
with an EAP Counselor.**

EAP counseling staff are licensed to provide a wide range of assessment and problem solving skills. You and/or household family members can discuss your particular situation confidentially with a professional, whether it involves marital problems, work-related problems, substance abuse issues, family or financial concerns, or even stress management. Within legal limits, no one will be given any information about your session without your prior written consent.

If you require counseling beyond 10 sessions, your EAP professional will work with your medical insurance company to facilitate a transition to that program.

### For More Information:

<http://www.hamiltoncountyohio.gov/hr/Benefits/EAPHome.asp>

Or

Contact LIFE OPTIONS directly:

**1-877-704-2695**

**[www.achievesolutions.net/LifeOptions](http://www.achievesolutions.net/LifeOptions)**



## IMPORTANT NOTICE ABOUT CONTINUING YOUR BENEFITS

This notice about group health insurance continuation coverage applies individually to the following plan participants: **Enrolled employees and their covered dependents**. It is important that all covered individuals take the time to read this notice carefully and to be familiar with its contents. If there is a covered dependent whose legal residence is different from the employee's, you must provide written notification to the payroll/personnel/health care representative of the employee's department so that a separate notice can be sent to him or her as well.

Under federal law, Hamilton County is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan would otherwise end because of certain qualifying events. **You are not losing your group health insurance at this time!** This notice is intended to inform all plan participants, in a summary fashion of potential future options and obligations under the continuation coverage provisions of COBRA law. Should an actual qualifying event occur in the future, your department or agency will send you additional information and the appropriate election notice at that time. **Please take special note, however, of your notification obligations, which are highlighted in the next section!**

**Qualifying Events For Covered Employee** - If you are the covered employee, you may have the right to elect health plan continuation coverage **if** you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

**Qualifying Events For Covered Spouse** - If you are the covered spouse of an employee, you may have the right to elect health plan continuation coverage for yourself **if** you lose group health coverage under a plan offered by Hamilton County because of any of the following reasons:

1. A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with Hamilton County;
2. The death of your spouse;
3. Divorce or, if applicable, legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

**Qualifying Events For Covered Dependent Children** - If you are the covered dependent child of an employee, you may have the right to elect continuation coverage for yourself **if** you lose group health coverage under a plan offered by Hamilton County because of any of the following reasons:

1. A termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with Hamilton County;
2. The death of the employee of Hamilton County;
3. Parents' divorce or, if applicable, a legal separation;
4. The employee of Hamilton County becomes entitled to Medicare; or
5. You cease to be a "dependent child" under the terms of the health plan.

**Election Period And Coverage** - Once the payroll/personnel/health care representative of the employee's department learns a qualifying event has occurred; they will notify covered individuals (also known as qualified beneficiaries) of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 days to elect continuation coverage. The 60-day election window is measured from the later of the date health plan coverage is lost due to the event or from the date of notification. This is the maximum period allowed to elect continuation coverage as the plan does not provide an extension of the election period beyond what is required by law. If a qualified beneficiary does not elect continuation coverage within this election period, rights to continue health insurance will end and he or she ceases to be a qualified beneficiary.

If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the health insurance. Hamilton County is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, the change and/or modification will be made to a qualified beneficiary's coverage as well.

**Length Of Continuation Coverage - 18 Months.** If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, each qualified beneficiary will have the opportunity to continue coverage for 18 months from the loss of coverage date.

Social Security Disability - The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines that a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation coverage. In the case of a newborn or adopted child that is added to a covered employee's COBRA coverage, the first 60 days of continuation coverage for the newborn or adopted child is measured from the date of the birth or the date of the adoption. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and to provide a copy of the determination to the Hamilton County Human Resources Department within 60 days after the date of the determination and before the original 18 months of continuation coverage expire.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, the applicable premium rate is 150% of the premium rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at the 102% level. It is also the qualified beneficiary's responsibility to notify the Hamilton County Human Resources Department within 30 days if a final determination has been made that he or she is no longer disabled.

Secondary Events - Another extension of the 18-month or the above mentioned 29-month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second event takes place that causes another loss of coverage (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event occurs, the original 18 months or 29 months of continuation coverage can be extended to 36 months from the date of the original loss of coverage date for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify the Hamilton County Human Resources Department in writing within 60 days of the second event and within the original 18-month or 29-month continuation timeline. In no event will continuation coverage last beyond 36 months from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not considered a second event.

**Length Of Continuation Coverage - 36 Months.** If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under a plan offered by Hamilton County, each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.



## IMPORTANT NOTICE ABOUT CONTINUING YOUR BENEFITS

**Eligibility, Premiums, and Potential Conversion Rights** - A qualified beneficiary does not have to show insurability to elect continuation coverage, however, he or she must have been covered by the plan on the day before the event to be eligible for continuation coverage. An exception to this rule is if while on continuation coverage a baby is born to or adopted by the covered *employee* qualified beneficiary. If this occurs, the newborn or adopted child can be added to the plan and he or she will gain the rights of all other qualified beneficiaries. The continuation coverage timeline for the newborn or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in your insurance member handbook/certificate of coverage and must be followed. The plan administrator reserves the right to verify continuation of eligibility status and to terminate continuation coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts. A qualified beneficiary will have to pay all of the applicable premium for continuation coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months as a result of a Social Security disability, Hamilton County can charge up to 150% of the applicable premium during the extended coverage period. Qualified beneficiaries will be allowed to pay on a monthly basis. In addition there will be a maximum grace period of thirty (30) days for the regularly scheduled monthly premiums. At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary must be allowed to enroll in an individual conversion health plan provided under a plan offered by Hamilton County if an individual conversion plan is available at that time.

**Cancellation Of Continuation Coverage** - The law declares that continuation coverage will end prior to the maximum continuation period for any of the following reasons:

1. Hamilton County ceases to provide any group health plan to any of its employees;
2. Any required premium for continuation coverage is not paid in a timely manner;
3. A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
4. A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
5. A qualified beneficiary extended continuation coverage to 29 months as a result of a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A qualified beneficiary notifies the Hamilton County Auditor's Office or the Hamilton County Human Resources Department that he or she wishes to cancel continuation coverage; or
7. For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

**Notification Of Address Change** - To insure that all covered individuals receive information properly and efficiently, it is important that qualified beneficiaries notify the Hamilton County Human Resources Department in writing of all address changes as soon as possible. Failure to do so will result in delayed notifications or a loss of continuation coverage options.

**Any Questions?** - Remember, this notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for continuation, you will be notified of all your rights at that time. If any covered individual does not understand any part of this summary notice or has questions regarding the information or qualified beneficiary obligations, please contact the Human Resources Department at (513)946-4700.



#### **IMPORTANT EMPLOYEE, SPOUSE, and DEPENDENT NOTIFICATIONS REQUIRED**

Under the law, the employee, spouse, or other family member has the responsibility to make written notification to Hamilton County of a divorce, legal separation, or a child losing dependent status under the County's group health plan. This notification must be made within 60 calendar days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event.

Notification must be made by completing, in writing, the appropriate change forms to delete the affected dependent(s) from the current insurance contract. Change forms should be submitted to the payroll/personnel/health care representative of the employee's department within 60 calendar days from the event date or from the date on which coverage would be lost under the terms of the insurance contract because of the event.

If this notification is not completed according to the above procedures and within the required 60-day notification period, rights to continuation will be forfeited. Carefully read the dependent eligibility rules contained in your insurance member handbook/certificate of coverage so you are familiar with them when a dependent ceases to be a dependent under the terms of the plan. The employee's department or agency will notify the Hamilton County Human Resources Department of the employee's termination of employment, reduction in hours, death, or Medicare entitlement.



## PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan — whether received in writing, in an electronic medium, or as an oral communication. **This notice describes the privacy practices of the Flexible Spending Account (FSA) component of the Hamilton County Flexible Benefits Plan (“the Plan”).**

**Your privacy rights under the other components of the Plan, such as medical and dental, will be explained in Privacy Notices provided by the insurance companies that provide those plans (e.g., Humana, Dental Care Plus)**

### **The Plan’s duties with respect to health information about you**

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan’s legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It’s important to note that these rules apply to the Plan, not Hamilton County as an employer. Different policies may apply to other Hamilton County programs or to data unrelated to the health plan.

### **How the Plan may use or disclosure your health information**

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment activities, and Health Care Operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share health information about you with physicians who are treating you.*
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as “behind the scenes” plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*
- **Health care operations** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs.*

The amount of health information used or disclosed will be limited to the “Minimum Necessary” for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

### **How the Plan may share your health information with Hamilton County**

The Plan, or its insurers, may disclose your health information without your written authorization to Hamilton County for plan administration purposes. Hamilton County may need your



health information to administer benefits under the Plan. Hamilton County agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The Benefits/HR Department are the Hamilton County employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Hamilton County, as allowed under the HIPAA rules:

- The Plan, or its Insurers, may disclose "summary health information" to Hamilton County if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information have been removed.
- The Plan, or its Insurers, may disclose to Hamilton County information on whether an individual is participating in the Plan, or has enrolled or dis-enrolled in an insurance option offered by the Plan.

In addition, you should know that Hamilton County cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Hamilton County from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

**Other allowable uses or disclosures of your health information**

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities listed on the next page.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

**Your individual rights**

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

**Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse**

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.



## PRIVACY NOTICE cont'd

Workers' Compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent service threat to health or safety	Disclosures made in good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonable able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believe may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public Health Activities	Disclosures authorized by law to person who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement official required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private party review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing action) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine Plan's compliance with the HIPAA privacy rule



The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

**Right to receive confidential communications of your health information**

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement that disclosure of all or part of the information could endanger you.

**Right to inspect and copy your health information**

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

**Right to amend your health information that is inaccurate or incomplete**

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.



## PRIVACY NOTICE cont'd

### Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2004 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

### Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

	Restricted Disclosures	Confidential Disclosures	Access to or Copies of Your Health Information	Amendment of Your Health Information	Accounting of Disclosures
Humana (Medical)			866-861-2762		
Dental Care Plus			800-367-9466		



## IMPORTANT NOTICE About Your Rx Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Humana 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:

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.

Humana has determined that the prescription drug coverage offered by Hamilton County 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 prescription drug plan.

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### **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 November 15<sup>th</sup> through December 31<sup>st</sup>.

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 Humana coverage will not be affected. The Humana coverage will pay as primary and Medicare D coverage pays secondary.

Note that you may not drop just prescription drug coverage under the Humana coverage. This is because prescription drug coverage is part of the entire medical plan.

If you decide you want to drop your Humana coverage through Hamilton County, be aware that you may only drop or add coverage at the plan's next annual enrollment period.



## IMPORTANT NOTICE About Your Rx Coverage and Medicare cont'd

### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information [or call Humana at (800) 555-2546]. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Humana changes. You also may request a copy of this notice.

### **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](http://www.medicare.gov)

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	11/10/2011
Name of Entity/Sender:	Hamilton County
Contact--Position/Office:	Human Resources Department
Address:	138 East Court St., Rm 707 Cincinnati, OH 45202
Phone Number:	(513-946-4700





## Freedom of Choice: 2012