



Employee Benefits Guide

Hamilton County
Employee Guide to Employee Benefits Enrollment

Effective 1.1.2016



Revised: 09/16/2015

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.



Employee Benefits Guide

TABLE OF CONTENTS

Making Enrollment Changes	3
What is a Qualifying Event?	3
Adding Dependents	3
Medical Insurance	4-7
Prescription Drug Coverage	8
Vision Insurance	9
ClearCost Health: Healthcare Shopping Tool	9
Dental Insurance	10-11
Long-Term Disability (LTD) Insurance	12-13
FSA: Healthcare Spending Accounts	14-15
FSA: Dependent Care Spending Account	16-17
Life Insurance: Basic and Supplemental	18-19
\$martCommuter Transportation Reimbursement Program	20
Employee Assistance Program	21
Voluntary Benefits: Accident and Critical Illness	22-23
Required Notices: COBRA HIPAA Medicare Marketplace Exchg	24-35

Making Changes To Your Elections



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
 - 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!

DURING Open Enrollment:

In order to **add** a dependent to your coverage who was not covered at the end of 2015, you must submit the Open Enrollment Verification Form to your Department Payroll Officer by the deadline listed on the form. The Form can be obtained from your department representative, or by logging into Paycor and looking in the Documents and Links section.

During the Plan Year with Qualifying Event:

You must submit the Qualifying Event Form. The Form can be obtained from your department representative, or by logging into Paycor and looking in the Documents section.

Add Dependents during your Initial Enrollment upon Hire:

You must submit the New Hire Enrollment Form. The Form can be obtained from your department representative, or by logging into Paycor and looking in the Documents section.



Medical Insurance



WHO is eligible for **medical** insurance coverage?

- Any Permanent Full-Time Employee, or one who is regularly scheduled an average of 30 or more hours per week. If eligible, the employee can cover eligible dependents:
 - Spouse
 - Children under age 26.
 - Dependents who are mentally or physically disabled and incapable of self-support, even if they are older than age 25.

***Note: Temporary and Seasonal employees *may* be eligible for medical coverage. See the PPM Section 5.2 for details.**



WHEN is my coverage effective?

- New hires are eligible for coverage the first of the month following 60 days of service. Please see the Policy Manual Section 5.2 for more details.
- For existing County employees changes made during the open enrollment process will be effective 1/1/2016.



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 Qualifying Event Form.



WHICH plan is right for me?

- **You are the only one that can decide which medical insurance 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!**



Medical Insurance Coverage Options?

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

<http://www.hamiltoncountyohio.gov/hr/Benefits/HealthDentalInsur/SmartSuiteGuide.pdf>

<p>Humana POS 500 (National POS Co- payment 90/60 Plan)</p>	<ul style="list-style-type: none"> • Members pay a lower share of cost when seeking services from network providers. • Members have the ability to seek services from non-network provider, at a higher share of cost. • The member pays towards a \$500 deductible/individual (\$1000 for family). • Members are not required to identify a Primary Care Physician. • Plan pays 90% after deductible (60% non-network)
<p>Humana CoverageFirst 1000 (National POS Cov- erage First Coin- surance 80/50 Plan)</p>	<ul style="list-style-type: none"> • The plan pays the first \$500 of eligible expenses from network providers for each member, other than co-payments. (Benefit Allowance) • Once a member has used the \$500 Benefit Allowance, the member pays towards the \$1000 deductible/individual (\$2000 for family). • After the \$1000 deductible is met, the member is responsible for coinsurance and co-payments up to the medical co-insurance and co-payment maximum. • Plan pays 80% after deductible (50% non-network).
<p>Humana CoverageFirst 2500 (National POS Cov- erage First Coin- surance 100/70 Plan)</p>	<ul style="list-style-type: none"> • The plan pays the first \$500 of eligible expenses from network providers for each member, other than co-payments. (Benefit Allowance) • Once a member has used the \$500 Benefit Allowance, the member pays towards the \$2500 deductible/individual (\$5000 for family). • After the \$2500 deductible is met, the member is responsible for coinsurance and co-payments up to the medical co-insurance and co-payment maximum. • Plan pays 100% after deductible (70% non-network).



Medical Insurance: plans at a glance

Medical Benefit	
Benefit Allowance per covered member	Network
	Non-Network
Annual Deductible co-payments not applied towards meeting annual deductible	Network
	Non-Network
Physician Services - Primary Care Physician	Network
	Non-Network
Physician Services - Specialist Physician And Eye Exams one per 24 month period	Network
	Non-Network
Facility Services - Inpatient	Network
	Non-Network
Facility Services - Outpatient	Network
	Non-Network
Facility Services - Hospital Emergency Services	Network
	Non-Network
Urgent Care	Network
	Non-Network
Other Medical Services - <ul style="list-style-type: none"> • Skilled Nursing Facility - 60 days per calendar year (HMO-100 days per calendar year) • Home Health Care - unlimited • Therapy (physical, cognitive, speech, hearing) - 60 combined total visits per calendar year • Durable Medical Equipment - unlimited 	Network
	Non-Network
Chiropractic Services <ul style="list-style-type: none"> • 25 visits per calendar year 	Network
	Non-Network
Behavioral Health Services <ul style="list-style-type: none"> • Mental health and substance abuse • Inpatient services • Outpatient sessions 	Network
	Non-Network
Medical Co-insurance/Medical Co-Payments Maximum (per calendar year, includes medical co-payments and coinsurance amounts. Pharmacy co-payments do not apply.)	Network
	Non-Network
NEW! Plan Out-Of Pocket Maximum (per calendar year, includes deductible, coinsurance, medical and pharmacy co-payments)	Network
	Non-Network
Lifetime Maximum Benefit	
Prescription Drugs See Next Pages	

Medical Insurance: plans at a glance



Humana CoverageFirst 2500 National POS Coverage First Coinsurance 100/70 Plan	Humana CoverageFirst 1000 National POS Coverage First Coinsurance 80/50 Plan	Humana National POS 500 National POS Copayment 90/60 Plan
\$500	\$500	Not Applicable
Not Applicable	Not Applicable	Not Applicable
\$2,500 Individual \$5,000 Family	\$1,000 Individual \$2,000 Family	\$500 Individual \$1000 Family
\$7,500 Individual \$15,000 Family	\$3,000 Individual \$6,000 Family	\$1,500 Individual \$3,000 Family
\$25	\$20	\$30
70% after deductible	50% after deductible	60% after deductible
\$40	\$35	\$45
70% after deductible	50% after deductible	60% after deductible
100% after deductible	80% after deductible	90% after deductible
70% after deductible	50% after deductible	60% after deductible
100% after deductible	80% after deductible	90% after deductible
70% after deductible	50% after deductible	60% after deductible
\$200 copayment	\$200 copayment	\$200 copayment
\$200 copayment	\$200 copayment	\$200 copayment
\$40 copayment	\$35 Specialist Co-Payment	\$75 copayment
70% after deductible	50% after deductible	60% after deductible
100% after deductible	80% after deductible	90% after deductible
70% after deductible	50% after deductible	60% after deductible
\$40 Specialist Co-Payment	\$35 Specialist Co-Payment	\$45 Specialist Co-Payment
70% after deductible	50% after deductible	60% after deductible
Inpatient: 100% after deductible Outpatient: \$25 Co-Pay	Inpatient: 80% after deductible Outpatient: \$20 Co-Pay	Inpatient: 90% after deductible Outpatient: \$30 Co-Pay
70% after deductible	50% after deductible	Inpatient: 60% after deductible Outpatient: 60% after deductible
\$2,000 Individual \$4,000 Family	\$2,000 Individual \$4,000 Family	\$2,000 Individual \$4,000 Family
\$6,000 Individual \$12,000 Family	\$6,000 Individual \$12,000 Family	\$6,000 Individual \$12,000 Family
\$6,350 Individual \$12,700 Family	\$6,350 Individual \$12,700 Family	\$6,350 Individual \$12,700 Family
Unlimited	Unlimited	Unlimited
Unlimited	Unlimited	Unlimited



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.

Diabetes Drugs on Tier 1, 2, or 3 require **\$0 co-payment** for covered members. *Diabetes related medications on Tier 4 will require payment. This does not apply to Diabetic Supplies.*

	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	25% up to \$500 for 3 month supply

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 injectable 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)
 - 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.
 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

Vision Insurance: Voluntary HumanaVision



Vision Care Plan		
Exam with dilation as necessary	Participating Provider	100% after \$10 copay
	Non-Participating	\$35 allowance
Lenses: • Single • Bifocal • Trifocal	Participating Provider	<ul style="list-style-type: none"> • 100% after \$25 copay • 100% after \$25 copay • 100% after \$25 copay
	Non-Participating	<ul style="list-style-type: none"> • \$25 allowance • \$40 allowance • \$60 allowance
Frames	Participating Provider	\$50 wholesale frame allowance
	Non-Participating	\$50 retail allowance
Contact Lenses - • Elective (conventional & disposable) • Medically necessary	Participating Provider	<ul style="list-style-type: none"> • \$110 allowance • 100%
	Non-Participating	<ul style="list-style-type: none"> • \$110 allowance • \$210 allowance
Frequency (based on date of service) • Examination • Lenses or contact lenses • Frame	Participating Provider	<ul style="list-style-type: none"> • Once every 12 months • Once every 12 months • Once every 24 months
	Non-Participating	<ul style="list-style-type: none"> • Once every 12 months • Once every 12 months • Once every 24 months

Locate a Provider

To find a participating provider, you can log on to HumanaVisionCare.com or call 1-866-537-0229.

Health Care Shopping Tool: Clear Cost Health

All employees enrolled in a County medical plan are able to access the ClearCost Health healthcare shopping tool. The online tool allows employees to search for healthcare services by cost and quality.

Learn More And Register By Going Here:
<https://www.clearcosthealth.com/HamiltonCounty/Landing.aspx>

Dental Insurance



WHO is eligible for dental coverage?

- Any Permanent Full-Time Employee, or one who is regularly scheduled to work an average of 30 or more hours per week. Eligible dependents include:
 - Spouse
 - Children under age 26
 - Dependents who are mentally or physically disabled and incapable of self-support, even if they are older than age 25.



WHEN is my coverage effective?

- All new hires are eligible for coverage the first of the month following 60 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 1/1/2016.



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!**

The Dental Care
PLUS GROUP
The plus is service.



Dental Insurance

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 Plan Benefit per member. The network of provider dentists is identical across the two plans.

	DCP - Premium	DCP - Basic
Website	www.dentalcareplus.com	www.dentalcareplus.com
Description	<ul style="list-style-type: none"> Offers access to 2200+ dentists. (96% locally) Services must be obtained from a network dentist. Includes orthodontia coverage. 	<ul style="list-style-type: none"> Offers access to 2200+ dentists (96% locally) Services must be obtained from a network dentist. No orthodontia coverage.
Deductible	None.	None.
Preventative Services Examples: teeth cleaning, routine exams, x-rays, juvenile fluoride treatments	Plan pays 100% of allowed charges.	Plan pays 100% of allowed charges.
Basic Services Examples: most oral surgery, fillings, simple root canals, simple extractions	Plan pays 80% of allowed charges.	Plan pays 80% of allowed charges.
Major Services Examples: crowns, dentures, bridges, inlays, dental implants, and onlays.	Plan pays 60% of allowed charges.	Plan pays 50% of allowed charges.
Orthodontia For the employee and/or eligible dependent children under age 19.	Plan pays 50% of allowed charges	Not Covered.
Max Ortho Benefit	\$2000 Lifetime Max per eligible member	Not Applicable.
Max Plan Benefit	\$2000 per year per member (excluding orthodontia)	\$1000 per year per member

Is my dentist in the Dental Care Plus Network?

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



Long-Term Disability Insurance



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. 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, or one who is regularly scheduled to work an average of 30 or more hours per week.



WHEN is my coverage effective?

- All new hires are eligible for coverage the first of the month following 60 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 1/1/2016.



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 60 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 age, salary, and service credit at time of disability. Refer to www.opers.org for more details.
Where can I get more details?	Please refer to the Certificate of Coverage.	www.opers.org



FSA: Healthcare Spending Account



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

A Healthcare flexible 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. Participants are permitted to carryover up to \$500 at the end of the plan year into the new plan year. Participants still have the 90 day run-out period to submit claims that were incurred prior to the end of the plan year.

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 2016, then you are not able to submit any FSA claims for them in 2016.



How much can I contribute?

Minimum: \$260 annually
Maximum: \$2550 annually



WHEN is my election effective?

- All full-time and part-time new hires are eligible for participation on the first of the month following 60 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 1/1/2016.

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 permanent County employee.



Where can I get more information?

www.chard-snyder.com
askpenny@chard-snyder.com
513-459-9997





More facts about the Healthcare Spending Account:

<p>WHAT TYPES OF EXPENSES ARE COVERED?</p>	<ul style="list-style-type: none"> • Any co-pays and deductibles not fully paid by your medical insurance. • Hearing aids and batteries. • Elective eye surgery, glasses, contact lenses, saline solution, other vision care. • Annual physicals, immunizations and vaccines <p><i>Note: over the counter medications are not an eligible expense without a prescription. 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.</i></p>
<p>What types of expenses are NOT covered?</p>	<ul style="list-style-type: none"> • Expenses claimed as a deduction on income tax returns • Health care insurance premiums • Expenses reimbursed under another program, like Medicare or the MERP. • Expenses for funerals or burials • Expenses for Maternity clothes, diaper services, or house help. • Expenses for toiletries/cosmetics • Expenses for over the counter medications, without a Rx.
<p>When must I incur the expenses?</p>	<p>Between your coverage effective date and the end of the plan year (12/31), or your termination in the plan, whichever comes first. However, your balance at the end of the year, up to \$500, will be carried over to the next pan year.</p>
<p>When can I request reimbursement?</p>	<p>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 date in which coverage ends. Further participation is dependent upon COBRA rules/ enrollment.</p>
<p>How do I request reimbursement?</p>	<p>Reimbursements are processed through our vendor, Chard-Snyder. Please refer to chard-snyder.com for more details.</p>
<p>How do I get Reimbursed?</p>	<p>Chard-Snyder processes the reimbursements and will either mail a check or direct deposit the funds into an account of your choosing.</p>
<p>Benny Card-Prepaid Benefits Card</p>	<p>Pre-paid benefits card —Your entire healthcare FSA balance may be used any time when using the Benny Card. NOTE: This is not a credit card and can only be used to pay for eligible expenses. The amount of purchases will be deducted automatically from your account and payment will be electronically transferred to the provider/ merchant. Don't toss it each plan year, the same card works for 5 years.</p>
<p>What happens if I have money left at year-end?</p>	<p>You have until March 31 to submit claims for reimbursement for the prior plan year.</p> <p>If unspent, up to \$500 of your account balance will be carried over to the new pan year.</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.) Further participation governed by COBRA. You must submit all claims within 90 days of termination in plan.</p>



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.***



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 full-time and part-time new hires are eligible for participation on the first of the month following 60 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 1/1/2016.



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?

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 hours in your home each day.



More facts about Dependent Care Spending Accounts

<p>WHAT 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"> • In or out of your home • In a day care center • By a housekeeper as part of his/her job. <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"> • Costs for care provided by your spouse. • Care provided by your child under age 19. • Care provided by anyone you claim as a tax exemption. • Costs for kindergarten
<p>When must I incur the expenses?</p>	<p>Between your coverage effective date and the end of the plan year (12/31/2016), 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, 2017. 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.. Those claims must be submitted within 90 days of plan termination.</p>
<p>How do I request reimbursement?</p>	<p>Reimbursements are processed through our vendor, Chard-Snyder. Please refer to chard-snyder.com 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 Chard-snyder.com (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, following the plan year. 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. You must submit all claims within 90 days of termination in plan.</p>



Where can I get more information?
www.chard-snyder.com
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 1 times your annual salary rounded up to the nearest \$1,000 (up to policy maximum of \$300,000). This insurance is provided through Symetra.

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 or one who is regularly scheduled to work an average of 30 or more hours per week.



WHEN is my coverage effective?

- The first of the month following 60 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. To make a change, employees should contact your department payroll officer.



WHAT is Supplemental Life Insurance?

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



WHO is Eligible for Supplemental Life Insurance?

- Any Permanent Full-Time Employee or one who is regularly scheduled to work an average of 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?

- The first of the month following 60 days of service.
- For existing County employees, the changes made during the open enrollment process will be effective 1/1/2016.



WHEN can I make changes?

- During Open Enrollment.
- 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)
Coverage Increments	\$10,000	\$5,000	\$2,000
Maximum Coverage Amount	The lesser of \$1,000,000 or 5 times your annual salary	50% of employee's supplemental life insurance coverage, up to \$250,000	\$10,000
Guaranteed Issue Amount - New Hires	\$100,000	\$25,000	\$10,000
Guaranteed Issue Amount - Current Employees	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 Evidence of Insurability 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. 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?

You can enroll online in Paycor during open enrollment. Or, at any time during the plan year by completing the SmartCommuter Enrollment/Change Form.



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?	Minimum Monthly Election: \$10/Month Mass Transit Monthly Maximum: \$230 Parking Monthly Maximum: \$230
What expenses are covered?	<ul style="list-style-type: none"> • Parking at or near work (excluding residence) • Mass transit passes and tokens • Commuter van pooling fares
When must I incur the expenses?	Between your coverage effective date and the end of the plan year, 1/1 to 12/31 or termination in the program, whichever occurs first.
When can I request reimbursement?	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).
How do I request reimbursement?	Reimbursements are processed through our vendor, Chard-Snyder. Please refer to chard-snyder.com , 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 Chard-Snyder.com and click on SmartCommuter.
What happens if I have money left at year-end?	Funds will be carried over to the next year.
What types of expenses are <u>NOT</u> covered?	<ul style="list-style-type: none"> • Taxicab fares, car pooling, tolls, vehicle operation expenses • Expenses incurred prior to enrollment in plan • Expenses incurred after termination of employment or after termination of participation in plan



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 and his/her dependent are eligible to participate.

In fact, anyone residing in an employee's home can contact the EAP.

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



Voluntary Benefits: Accident Insurance

How do I enroll?

During Open Enrollment you may contact 1-888-592-1839 to schedule an appointment. Mon-Fri, 9 am – 6 pm EST.

WHEN can I make changes?

- During the annual enrollment period each year.
- Employees not employed at the time of the annual enrollment period are unable to enroll until the next annual enrollment period.
- Employees who wish to cancel coverage should consult with the provider directly.

This policy offers the flexibility to vary your coverage by selecting one of two benefit levels. There are no annual maximums. Benefits start all over with each accident, and are paid in addition to any other coverage in place. Payroll deduction for your premiums makes it easy, too.

Product base	Group			
Coverage type	Accident insurance that provides expense reimbursement for actual charges up to policy maximum. Covers off-the-job coverage for accidental injuries, hospital care, and accidental death benefits. There is no coverage for sickness. Two benefit levels available. Coverage is available to the insured, spouse, and children, and is renewable to age 70.			
Benefit amount	<input type="checkbox"/> Level Two	<input type="checkbox"/> Level Four		
<ul style="list-style-type: none"> > Accident medical expense: Pays the actual expenses up to the amount selected for diagnosis or treatment by a physician or in an emergency room. ER subject to a \$50 deductible. > Ambulance: Pays actual expenses up to the amount selected if injury requires ground or air ambulance transportation. > Hospital indemnity: Pays a benefit equal to the amount selected if an injury requires inpatient hospital confinement, including a room charge, that starts within 30 days after the accident. The benefit is limited to 30 days per accident. > Accidental death, dismemberment and loss of sight (AD&D): <ul style="list-style-type: none"> Loss of life Any combination of two or more hands, feet, or eyes Loss of single hand, foot or eye Multiple fingers and/or toes Single finger or toe 	<ul style="list-style-type: none"> \$ 1,000 \$ 500 \$ 150 \$ 10,000 \$ 10,000 \$ 5,000 \$ 1,000 \$ 500 	<ul style="list-style-type: none"> \$ 2,000 \$ 1,000 \$ 300 \$ 20,000 \$ 20,000 \$ 10,000 \$ 2,000 \$ 1,000 		
Additional included benefits	<p>Total disability premium waiver: If the insured becomes disabled before age 60 and as the result of injuries suffered in an accident, premiums will be waived after six months of total and continuous disability.</p> <p><input type="checkbox"/> Fracture and dislocation: Pays a benefit when a covered person suffers one of the fractures or dislocations listed. The benefit payable will equal the percentage shown, of the unit selected, for the injury. Pays 150% of the larger loss of two or more covered losses.</p> <p><input type="checkbox"/> \$1,500</p> <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top;"> <p>Fractures</p> <ul style="list-style-type: none"> • Hip bone (pelvis) or femur 100% • Vertebra 75% • Skull (depressed or ping-pong fracture) 65% • Leg (tibia or fibula) 50% • Bones of the foot, ankle, kneecap, hand, wrist or forearm (radius or ulna) 40% • Lower jaw, shoulder blade, collar bone 35% • Upper arm, upper jaw, skull (simple, non-depressed fracture) 25% • Facial bones (or nose) 20% • Finger, toe, rib, coccyx 6% </td> <td style="vertical-align: top;"> <p>Dislocations</p> <ul style="list-style-type: none"> • Hip 100% • Knee (does not include dislocation of the patella) 50% • Foot (does not include dislocation of the toes), ankle or shoulder 35% • Hand (does not include dislocation of fingers), lower jaw, wrist or elbow 20% • Finger, toe 6% </td> </tr> </table> <p><input type="checkbox"/> Hospital intensive care: Pays a daily benefit when a covered person is confined to a hospital intensive care unit as a result of injuries suffered in a covered accident. The benefit is payable for a maximum of 30 days for any one accident.</p> <p><input type="checkbox"/> \$300</p>		<p>Fractures</p> <ul style="list-style-type: none"> • Hip bone (pelvis) or femur 100% • Vertebra 75% • Skull (depressed or ping-pong fracture) 65% • Leg (tibia or fibula) 50% • Bones of the foot, ankle, kneecap, hand, wrist or forearm (radius or ulna) 40% • Lower jaw, shoulder blade, collar bone 35% • Upper arm, upper jaw, skull (simple, non-depressed fracture) 25% • Facial bones (or nose) 20% • Finger, toe, rib, coccyx 6% 	<p>Dislocations</p> <ul style="list-style-type: none"> • Hip 100% • Knee (does not include dislocation of the patella) 50% • Foot (does not include dislocation of the toes), ankle or shoulder 35% • Hand (does not include dislocation of fingers), lower jaw, wrist or elbow 20% • Finger, toe 6%
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Insured by Kanawha Insurance Company, a Humana company.

This is not a complete disclosure of plan qualifications and limitations. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made.

Policy: 7006 1/04 or 8006 11/04
Underwritten by Kanawha Insurance Company

Voluntary Benefits: Critical Illness



How do I enroll?

During Open Enrollment you may contact 1-888-592-1839 to schedule an appointment. Mon-Fri, 9 am – 6 pm EST.

WHEN can I make changes?

- During the annual enrollment period each year.
- Employees not employed at the time of the annual enrollment period are unable to enroll until the next annual enrollment period.
- Employees who wish to cancel coverage should consult with the provider directly.

Consider coverage that helps protect you, your family, and your assets in the event of a critical illness. It offers specialized benefits to supplement other health insurance when you and your family may be most vulnerable: during the working years. Benefit payments can assist in covering a variety of expenses associated with a critical illness: out-of-pocket medical care costs, home healthcare, travel to and from treatment facilities, rehabilitation, and other expenses.

Coverage type	Voluntary Critical Illness insurance is a group policy form that includes coverage for heart/stroke, cancer, and other critical illnesses.														
Benefit amount	Benefit amounts are available at various levels. You can choose: <input type="checkbox"/> \$5,000 to \$50,000 for employees in increments of \$1,000 Coverage is also available for your spouse and children.														
Coverage for vascular conditions	Percent of benefit amount paid at initial diagnosis: <table border="0"> <tr> <td>> Heart attack</td> <td>100%</td> </tr> <tr> <td>> Transplant as a result of heart failure</td> <td>100%</td> </tr> <tr> <td>> Stroke</td> <td>100%</td> </tr> <tr> <td>> Coronary artery bypass surgery as a result of coronary artery disease</td> <td>25%</td> </tr> </table>	> Heart attack	100%	> Transplant as a result of heart failure	100%	> Stroke	100%	> Coronary artery bypass surgery as a result of coronary artery disease	25%						
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Coverage for cancer conditions	Percent of benefit amount paid at initial diagnosis: <table border="0"> <tr> <td>> First diagnosis of internal cancer or malignant melanoma</td> <td>100%</td> </tr> <tr> <td>> Carcinoma in situ</td> <td>25%</td> </tr> </table>	> First diagnosis of internal cancer or malignant melanoma	100%	> Carcinoma in situ	25%										
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> Carcinoma in situ	25%														
Coverage for other critical illnesses	Percent of benefit amount paid at initial diagnosis: <table border="0"> <tr> <td>> Transplant, other than heart</td> <td>100%</td> </tr> <tr> <td>> End-stage renal failure</td> <td>100%</td> </tr> <tr> <td>> Loss of sight, speech, or hearing</td> <td>100%</td> </tr> <tr> <td>> Coma</td> <td>100%</td> </tr> <tr> <td>> Severe burns</td> <td>100%</td> </tr> <tr> <td>> Permanent paralysis due to an accident</td> <td>100%</td> </tr> <tr> <td>> Occupational HIV</td> <td>100%</td> </tr> </table>	> Transplant, other than heart	100%	> End-stage renal failure	100%	> Loss of sight, speech, or hearing	100%	> Coma	100%	> Severe burns	100%	> Permanent paralysis due to an accident	100%	> Occupational HIV	100%
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> Coma	100%														
> Severe burns	100%														
> Permanent paralysis due to an accident	100%														
> Occupational HIV	100%														
Additional included benefits	<p>Waiver of premium for disability: This waives an employee's premium if he or she becomes totally disabled for at least 180 days after the effective date of coverage. For employees ages 18-55.</p> <p>Benefit recurrence: This provides an additional benefit for the same condition if a covered participant is treatment-free for at least 12 months.</p> <p>Health screening: Benefit pays \$150 per calendar year for covered health screenings. There are 18 covered tests including mammograms, colonoscopies, and stress tests.</p>														

Insured by Kanawha Insurance Company, a Humana company.

This is not a complete disclosure of plan qualifications and limitations. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made.

Policy: 8011
Underwritten by Kanawha Insurance Company



IMPORTANT NOTICE ABOUT CONTINUING YOUR BENEFITS

Hamilton County

Chard Snyder

3510 Irwin-Simpson Road

Mason, OH 45040

Phone: (888) 993-4646

Fax: (513) 459-9947

Date

To: Employee Name
and Other Insured Dependents (if any)
Address
City, State Zip

Fr: Chard Snyder
Service Provider for Hamilton County

Re: General COBRA Information for:
Hamilton County Health Plan

You are receiving this notice because you have recently become covered under one or more of the group health plans sponsored by Hamilton County. Hamilton County has retained Chard Snyder to provide assistance with their COBRA responsibilities. One of our tasks is to provide you with important information about your right to COBRA continuation of coverage under one or more of the group health plans named above. The information is intended to educate you about your COBRA rights and obligations in the event that you or one of your dependents loses coverage under one or more the plans. For simplicity, the remainder of this notice will refer to the above plans collectively as the "Plan".

While no action or response is required unless you or your dependent actually have a loss of coverage under our health plan(s), both you and your spouse should read the information carefully, and keep it with your records. If you experience a loss of coverage in the future, please refer to this overview for guidance about your rights and responsibilities.

Note: This notice does not fully describe continuation coverage under COBRA or other rights under the Plan and a more complete description can be found by contacting the Plan Administrator (identified below) and/or referring to the applicable health plan Summary Plan Description. There is a more detailed description of your rights under COBRA and the coverage under the Plan(s) under which you have become covered in the applicable Summary Plan Description(s).

This Notice provides a brief overview of your rights and obligations under the current COBRA law. The Plan (as outlined below) offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

About the COBRA Law.

COBRA refers to a Federal law which applies to most employers who sponsor group health insurance plans for their employees and dependents. For COBRA purposes, a group health plan includes any major medical plan, dental plan, vision plan, health FSA, or any other employer sponsored group plan which provides medical care.

The law requires that employees and certain dependents (spouse and dependent children) who lose coverage under a group health plan must be given the opportunity to continue coverage on a temporary basis. The maximum length of time coverage may be continued depends upon the reason coverage is lost. An employee, spouse and/or dependent child who loses coverage as a result of a qualifying event is called a "Qualified Beneficiary".

**COBRA Qualifying Events.**

Listed below are "qualifying events" which result in the right to continue coverage under COBRA. Please note that the maximum period of time coverage can be continued depends on the type of qualifying event.

Eighteen (18) Month Maximum Continuation (experienced by a covered employee):

- 1.) Termination of Employment (for reasons other than "gross misconduct")
- 2.) Reduction of Work Hours

If you experience one of the events listed above, you and any other impacted qualified beneficiary will be notified of the right to elect continuation coverage.

Disability Extension to twenty-nine (29) months. This extension will apply when any Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time prior to the end of the first sixty (60) days of COBRA coverage resulting from a termination of employment or reduction of work hours, and continues to be disabled at the end of the initial 18 month period of coverage.

For the disability extension to apply, you must provide a copy of the SSA Determination of Disability letter within the 18 month COBRA period but no later than 60 days after the latest of: (1) the date of the SSA Determination of disability; (2) the date on which the qualifying event occurs; or (3) the date on which the qualified beneficiary loses coverage.

Second Qualifying Event Extension to thirty-six (36) months. If a Qualified Beneficiary experiences a second qualifying event during the 18 or 29 month COBRA continuation coverage resulting from termination of employment or reduction of work hours, then the spouse and dependent children will qualify for an extension of COBRA continuation coverage of up to 36 months from the original qualifying event. A covered employee or qualified beneficiary must provide notice of the second qualifying event within 60 days of the event in order to qualify for the extension. Events eligible for the extension of coverage are those listed below (but only to the extent that they would have caused a loss of coverage under the Plan if it was the initial qualifying event):

Thirty Six (36) Month Maximum Continuation (experienced by a covered spouse or dependent child):

- 1) Death of an Employee
- 2) Divorce or legal separation
- 3) Dependent child no longer meets the Plan's definition of a "dependent"

In addition, if you become entitled to Medicare and then experience a qualifying event or reduction in hours of employment within 18 months of the Medicare entitlement, the qualified beneficiary spouse and/or dependent children may elect to continue coverage for up to 36 months from the Medicare entitlement.

Your IMPORTANT Qualifying Event Notice Obligations.

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation, or your child no longer meets the Plan's definition of "dependent", then you, your spouse or dependent child must notify Hamilton County of the loss. Written notice must be provided no later than sixty (60) days after the event or the date coverage terminates, whichever is later. It is mandatory that you use the enclosed notification form for this purpose. It can be mailed first class or faxed to Hamilton County. A notification form is enclosed for this purpose. (Contact information is listed on the notification form and later in this document.) You may be required to provide additional information to support the qualifying event (e.g. a divorce decree, etc).

If Hamilton County is provided timely notice of the divorce, legal separation, or a child's loss of dependent status, we will notify the affected Qualified Beneficiaries of the right to elect continuation coverage.

If Hamilton County is not provided notice of the divorce, legal separation, or a child's loss of dependent status during this sixty (60) day period, COBRA continuation will not be offered. If any claims are mistakenly paid for expenses incurred after



IMPORTANT NOTICE ABOUT CONTINUING YOUR BENEFITS

the divorce, legal separation, or a child's loss of dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

If your spouse or dependent child loses coverage as a result of your death or your entitlement to Medicare, Hamilton County will automatically notify your spouse, and dependent children of the right to elect continuation coverage.

Other Notification Requirements:

In order to protect your family's rights, you should notify the Plan Administrator, Hamilton County, immediately when the name or address changes for you or any covered dependent. For your records, you should also keep a copy of any notices you send to the Plan Administrator.

COBRA Continuation Coverage:

If you lose coverage as a result of one of the qualifying events listed above, you may elect to continue the same coverage that you had immediately preceding the qualifying event; however, that continuation coverage is subject to changes made by the Employer to the same coverage maintained by similarly situated active employees. You have the same right to change your coverage that similarly situated active employees have (including any open enrollment rights to change coverage). Once you receive your election notice from the Plan Administrator, you have 60 days from the later of the date of the notice or the date coverage is lost as a result of the qualifying event to elect coverage. If you elect coverage you may be required to pay up to 102% of the applicable premium and possibly up to 150% of the applicable premium during a disability extension. The first premium is due 45 days after the date you make your election for coverage. All subsequent premiums are due the first day of the coverage period (with a 30 day grace period). Premiums are typically due on the first day of each month.

Plan Administrator:

Hamilton County is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to:

Hamilton County
Attn: Human Resource Administrator
138 East Court Street
Cincinnati, OH 45202

For More Information:

If you have questions, or need additional information, you should contact the Plan Administrator, Hamilton County, or the service provider, Chard Snyder at:

Chard Snyder
3510 Irwin-Simpson Road
Mason, OH 45040
Phone: (888) 993-4646
Fax: (513) 459-9947
Email: COBRA@Chard-Snyder.com



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This Notice describes how health information about you may be used and disclosed and how you can get access to this information. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully.

If you have any questions about this Notice, please contact Hamilton County Employee Benefits at benefits@hamilton-co.org or 513-946-4700 or 138 E. Court Street, Room 707, Cincinnati, OH 45202

1. OUR COMMITMENT REGARDING YOUR PERSONAL HEALTH INFORMATION

Hamilton County is committed to maintaining and protecting the confidentiality of our employees' personal information. This Notice of Privacy Practices applies to Hamilton County health plans, collectively, The Plans. The Plans are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices. When the Plans use or disclose your PHI, the Plans are bound by the terms of this Notice, or the revised Notice, if applicable.

2. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following describes the ways Hamilton County may use and disclose health information that identifies you. Except for the purposes written below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by contacting the Privacy Officer.

- ***For Payment.*** We may use and disclose PHI about you so that the treatment and services you receive at the hospital may be paid out of the Plan.
- ***For Treatment.*** The Plans may disclose your PHI, or your covered dependents' PHI, to a health care provider or administrator for its provision, coordination or management of your health care and related services. For example, prior to providing a health service to you, your doctor may ask the Plans for information concerning whether and when the service was previously provided to you. The Plan may use and disclose your PHI for treatment activities of a health care provider.
- ***For Health Care Operations.*** The Plans may use and disclose your PHI for our health care operations, or the health care operations of a third-party administrator of the plans. For example, the Plans may use PHI to conduct quality assessment and improvement activities. Other health care operations may include providing appointment reminders or sending you information about treatment alternatives or other health-related benefits and services. The Plans may also disclose your PHI to another health plan or provider who has a relationship with you, so that it can conduct quality assessment and improvement activities — for example, to perform case management.

SPECIAL SITUATIONS:

- ***As Required by Law.*** We will disclose Health Information when required to do so by international, federal, state or local law.
- ***To Avert a Serious Threat to Health or Safety.*** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
- ***Business Associates.*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

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- **Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.
 - **Military and Veterans.** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
 - **Workers' Compensation.** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
 - **Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
 - **Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
 - **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
 - **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
 - **Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
 - **Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
 - **National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
 - **Protective Services for the President and Others.** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.
 - **Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.



PRIVACY NOTICE cont'd

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

- Uses and disclosures of Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

3. YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

- **Right to Inspect and Copy.** You have a right to inspect and copy Health Information in certain records the Plan maintains. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Hamilton County Human Resources, 138 E. Court Street, Room 707, Cincinnati, OH 45202. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances.
- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Hamilton County Human Resources, 138 E. Court Street, Room 707, Cincinnati, OH 45202.

PRIVACY NOTICE cont'd



- **Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Hamilton County Human Resources, 138 E. Court Street, Room 707, Cincinnati, OH 45202.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Hamilton County Human Resources, 138 E. Court Street, Room 707, Cincinnati, OH 45202. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Hamilton County Human Resources, 138 E. Court Street, Room 707, Cincinnati, OH 45202. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.hamilton-co.org. To obtain a paper copy of this notice, you must make your request, in writing, to Hamilton County Human Resources, 138 E. Court Street, Room 707, Cincinnati, OH 45202.

4. CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. If this Notice is modified, it will be made available to you. The notice will contain the effective date on the first page, in the top right-hand corner.

5. FOR MORE INFORMATION OR COMPLAINTS:

If you want more information about your privacy rights, do not understand your privacy rights, are concerned your privacy rights have been violated, you may file a complaint with our office. You may also file written complaints with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

You may contact our office at: Hamilton County, Human Resources Department, 138 E. Court Street, Room 707, Cincinnati, OH 45202 or 513-946-4700.

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all of your PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.



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.

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 15th through December 31st.

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

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

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

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

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

Date:	09/15/2015
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



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact benefits@hamilton-co.org or call Employee Benefits at 513-946-4700.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Hamilton County, Ohio		4. Employer Identification Number (EIN) 31-6000063	
5. Employer address 138 E. Court Street, Room 707		6. Employer phone number (513) 946-4700	
7. City Cincinnati	8. State OH	9. ZIP code 45202	
10. Who can we contact about employee health coverage at this job? Employee Benefits			
11. Phone number (if different from above) (513) 946-4700		12. Email address benefits@hamilton-co.org	

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

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

All employees. Eligible employees are:

Some employees. Eligible employees are:

A Full-Time Employee, or one who works an average of 30 or more hours per week.

•With respect to dependents:

We do offer coverage. Eligible dependents are:

1. The legally married husband or wife of the employee.
2. The employee's biological child, stepchild, legally adopted child who is under age 26.
3. The employee's handicapped child who is over age 26, who is incapable of self-support because of a mental or physical handicap.

We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

<p>13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?</p> <p><input type="checkbox"/> Yes (Continue) 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)</p> <p><input type="checkbox"/> No (STOP and return this form to employee)</p>
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<p>14. Does the employer offer a health plan that meets the minimum value standard*?</p> <p><input checked="" type="checkbox"/> Yes (Go to question 15) <input type="checkbox"/> No (STOP and return form to employee)</p>
<p>15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.</p> <p>a. How much would the employee have to pay in premiums for this plan? \$ _____</p> <p>b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly</p>

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

<p>16. What change will the employer make for the new plan year? _____</p> <p><input type="checkbox"/> Employer won't offer health coverage</p> <p><input type="checkbox"/> Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)</p> <p>a. How much would the employee have to pay in premiums for this plan? \$ _____</p> <p>b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly</p>
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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.



Employee Benefits Guide: 2016