FAIRFIELD COUNTY
HEALTH
BENEFIT PLAN

HELPING YOU UNDERSTAND
Your Benefit Choices

2022

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BENEFITS OFFERED

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IMPORTANT REMINDER:

Your open enrollment period begins on October 18, 2021

Your Benefit Period

January 1, 2022 – December 31, 2022

For Full-Time Employees Only

Fairfield County sponsors the Fairfield County Welfare Benefit Plan under plan number 501 and hereby provides notice of the plan changes which are effective on 1/1/2022. Please refer to the section below for an overview of benefit offerings. If you have any questions about these changes in benefits, please contact Rochelle Menningen at 740-652-7898 or Rochelle.menningen@fairfieldcountyohio.gov or Cheryl Reeves at 740-652-7898 or Cheryl.reeves@fairfieldcountyohio.gov.

EFFECTIVE JANUARY 1, 2022 Overview of Benefit Offerings:

Medical/RX: Provided through United Healthcare with no plan changes.

- $300 Single/$600 Family Deductible then 85% Coinsurance

Dental: Provided through Delta Dental with no plan changes.

- PPO $0 Single/Family Deductible
- Premier $25/Person Deductible

Vision: Provided through VSP with no plan changes.

Basic Life/AD&D: **NEW CARRIER: Symetra.** Employer paid benefit.

Voluntary Life/AD&D: **NEW CARRIER: Symetra.** Benefit for Employee, Spouse and Children.

Short-Term Disability: **NEW CARRIER: Symetra.**

Long-Term Disability: **NEW CARRIER: Symetra.**

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their *26th birthday this year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

MOBILE WALLET

ONLINE ACCESS

My Mobile Wallet Card is the easy way to find your benefits contact information.

- Benefits information
- Group numbers
- Phone numbers
- Email addresses
- Websites
- And more!

Bookmark My Mobile Wallet on your phone for quick and easy access on the go!

Scan the QR code with the camera on your phone or visit https://mymobilewalletcard.com/fairfieldco/ to get started!

The first time you visit My Mobile Wallet Card on your phone, a pop-up will appear with bookmarking instructions. This will allow you to add the wallet card to your home screen.

ELIGIBILITY
RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY
You are eligible to participate if you are full-time and work a minimum of 30 hours per week. Your coverage will be effective on the 1st of the month following 30 days from your date of hire.

DEPENDENT ELIGIBILITY
You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner; or
- Disabled dependents may be eligible if requirements set by the plan are met.

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA continuation details can be found in the notices section of this employee benefit guide.

HEALTH

MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

OUT-OF-NETWORK charges in the above plans are subject to reasonable and customary limitations, which means you are responsible for any charges that exceed the carrier's contracted amount (often referred to as balance billing). In addition, charges will be paid at the non-network deductible and coinsurance.

PPO | In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

Preventive Services | Covered at 100%

All plans recognize routine preventive services at 100%, no coinsurance, no deductible as long as the claim is submitted as "routine or preventive" and the services performed fall within the approved list of preventive services. For a complete and updated listing, please go online and search uspstf-a-and-b recommendations or visit https://www.uspreventiveservicestaskforce.org.

During your wellness visit, proactively let your physician know the reason for the appointment is for a wellness visit and that your physician needs to submit and code the visit as routine, preventive in nature. If your visit is submitted with a diagnosis, the wellness visit will not be paid at 100%, but instead, will be subject to deductible and coinsurance. Below are a few examples of services that can be recognized as preventive:

- Routine Wellness Exams, including well baby & child routine exams
- Cholesterol and lipid level screening
- Pelvic exam, pap test and screening mammograms
- Colorectal cancer screening, colonoscopies, sigmoidoscopies (age limit applies)
- Vaccines & immunizations: Hepatitis A & B, Influenza, Pneumonia, Shingles
- Contraceptives (specific list applies) & Diabetes screenings

Did You Know?

- ✓ **Preventive Services** are c**overed at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

How do I find an In-Network Provider?

In-Network providers can be found at https://www.uhc.com/find-a-doctor. You may log in to your account by selecting "Plan through your employer" or you may do a general search by selecting "Start your search".

MEDICAL
UNITED HEALTHCARE

	United Healthcare Choice Plus Plan	
PLAN BENEFITS	**In Network**	**Out of Network**
DEDUCTIBLE		
Single	$300	$650
Family	$600	$1,300
COINSURANCE *(applies after deductible is met)* **& OUT-OF-POCKET MAX**		
Plan Pays	85%	70%
Single OOP Maximum	$2,250	$3,750
Family OOP Maximum	$4,500	$7,500
MEMBER COPAYMENT(S)		
Primary Care (PCP) - Office Visit	$15 copay	30% after deductible
Virtual Visit *Amwell, Doctors on Demand & Teladoc*	$0 copay	$0 copay
Specialist - Office Visit	Premium Program Provider: $15 Network Provider: $30	30% after deductible
Preventive Care	No charge	30% after deductible
Inpatient & Outpatient Hospital Services	15% after deductible	30% after deductible
Urgent Care Facility	$20 copay	30% after deductible
Emergency Room Visit	$200 copay	$200 copay
PRESCRIPTION DRUGS	**RETAIL – 30 DAYS**	**MAIL ORDER – 90 DAYS**
Tier 1 – Generic	$4 copay	$10 copay
Tier 2 – Brand Preferred	$25 copay	$50 copay
Tier 3 – Brand Non-Preferred	$50 copay	$100 copay
Tier 4 – Specialty	$150 copay	$300 copay
EMPLOYEE CONTRIBUTIONS – PER PAY		
Single	$56.77	
Family	$135.26	

Your Care Options and When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

DENTAL
DELTA DENTAL

COMMON TERMS

PRE-TREATMENT ESTIMATE
If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE
You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total **100%.**

LIMITATIONS AND EXCLUSIONS
Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

How do I find an In-Network Provider?

Go to
https://www.deltadental.com/us/en/member/find-a-dentist.html
to find a dentist in network.

	PPO Network	Premier Network	Out-of-Network
PLAN FEATURES			
Benefit Period		**Calendar Year**	
DEDUCTIBLE			
Single/Family	$0 / $0	$25 per person	$25 per person
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive services)		
COVERED SERVICES			
CLASS I: Preventive Services *Routine oral exams and cleanings, x-rays & fluoride treatments*	Covered at 100%	Covered at 90% *With possible balance billing*	Covered at 90% *With possible balance billing*
CLASS II: Basic Services *Sealants, fillings, crown repair, root canals, periodontics & extractions*	Covered at 80%	Covered at 70% *With possible balance billing*	Covered at 70% *With possible balance billing*
CLASS III: Major Services *Crowns, bridges, implants & dentures*	Covered at 80%	Covered at 60% *With possible balance billing*	Covered at 60% *With possible balance billing*
CLASS IV: Orthodontia *Up to age 19*		Covered at 75%	
ANNUAL MAXIMUM			
Maximum Benefit *Allowed per Benefit Period*	$1,500 / person	$1,000 / person	$1,000 / person
Ortho Maximum Benefit	$1,500 / person	$1,400 / person	$1,400 / person
EMPLOYEE CONTRIBUTIONS – PER PAY			
Single	$2.41		
Family	$5.76		

VISION

VSP

	IN-NETWORK *VSP Choice Network* PROVIDER	OUT-OF-NETWORK PROVIDER
PLAN FEATURES		
Vision Exam	$10 copay	Up to $50
COVERED SERVICES – LENSES / FRAMES		
Prescription Glasses (Materials)	$20 copay	(see below)
Single Lenses	Included with Prescription Glasses	Up to $50
Bifocals	Included with Prescription Glasses	Up to $75
Trifocals	Included with Prescription Glasses	Up to $100
Progressive	$0 copay	Up to $74
Frames	$150 retail allowance, plus 20% over the allowance	Up to $70
COVERED SERVICES		
Contact Lenses	$140 allowance	Up to $105
Contact Lens Evaluation Fitting	Up to $60	No discounts
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months
Contacts	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months
EMPLOYEE CONTRIBUTIONS – PER PAY		
Single	$0.58	
Family	$1.39	

Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating In-Network provider?

Visit www.vsp.com/find-eye-doctors

Search by location, doctor name, or office name.

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year **(January 1st through December 31st)**. The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at **www.irs.gov.**
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at www.**fsastore.com.**

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | $2,750

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

LIMITED PURPOSE FSA | ADDITIONAL REQUIREMENTS

- If you open or contribute to a Health Saving Account (HSA), you may only enroll in a Limited Purpose FSA.
- If you enroll in a HDHP (High Deductible Health Plan) and elect a Health FSA, you will automatically be enrolled in the Limited Purpose FSA.
- A limited purpose FSA will reimburse you for dental and vision expenses, but you cannot claim the same expense on both the FSA and HSA Accounts.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **$5,000** annually in pre-tax dollars, or **$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

“USE IT” OR “LOSE IT”

Unused FSA funds do not roll over from year to year. ***If you don’t use the funds in your account by December 31, 2022, you’ll lose them.***

Claims for reimbursement must be submitted by March 31st of the following year.

NOTE: FSA elections do not automatically continue from year to year. You must actively enroll each year.

***ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:**

1.‘Care’ for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;

2.‘Care’ for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or

3.‘Care’ for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

‘Care’ is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

HERE'S HOW IT WORKS

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $110.42 based on a 24-pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $574.

		Without FSA	With FSA
Gross Income		$30,000	$30,000
FSA Contributions		$0	-$2,650
TAXABLE INCOME		**$30,000**	**$27,350**
Estimated Taxes			
	Federal	$3,090*	-$2,817*
	State	$1,104**	$1,106**
	FICA	$2,295	$2,092
AFTER TAX EARNINGS		**$23,511**	**$21,435**
Eligible Out-Of-Pocket Expenses		$2,650	$0
AVAILABLE/SPENDABLE INCOME		**$20,861**	**$21,435**

That's a savings of $574 for the year!

This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

**Varies, assumes 10.30%;*
***Varies, assumes 3.68%*

OVER-THE-COUNTER (OTC) MEDICATION REMINDER

Health Care Reform legislation requires that certain over-the-counter (OTC) items require a "prescription" in order to be considered an eligible Health Care FSA expense. You will only need to obtain a "one-time prescription" for the 2022 plan year.

You can continue to purchase your regular prescription medications with your debit card. However, the debit card may not be used as payment for an OTC item, even when accompanied by a prescription.

ELIGIBLE HEALTH FSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Artificial teeth/dentures
- Blood pressure monitors
- Braces
- Braille-books & magazines
- Breast pumps & lactation supplies
- Chiropractors
- Co-insurance, co-pay & deductibles
- Cost of operations & related treatments
- Crutches
- Diabetic supplies
- Drug addiction treatment
- Eye exams, eye glasses, contacts
- Hearing devices & batteries
- Hospital services
- Operations
- Pregnancy tests
- Radial keratotomy & lasik eye surgery
- Smoking cessation programs
- Speech therapy
- Surgical fees
- Vaccines
- Walkers & wheelchairs
- X-rays and more.

A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

IMPORTANT: PAYING FOR ELIGIBLE SERVICES & EXPENSES

Visit the FSA Store at **www.FSAstore.com,** where you can purchase FSA-eligible products without a prescription online.

Although you do not need to file for reimbursement when using your FSA debit card, you may be required to submit documentation, so be sure to save your receipts.

If you use a personal form of payment to pay for eligible expenses* out-of-pocket*, you can submit an FSA claim form along with your original receipts for reimbursement.

BASIC LIFE
COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

BASIC LIFE INSURANCE

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost	
Coverage Amount	Flat $50,000 Benefit
Accidental Death and Dismemberment (AD&D)	Amount equal to your Life benefit

ADDITIONAL PLAN PROVISIONS

Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.
Accelerated Death Benefit	90% of Basic Life amount

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

SUPPLEMENTAL LIFE
COVERAGE OPTIONS FOR YOU & THE FAMILY

SUPPLEMENTAL **LIFE INSURANCE**

Employees have the opportunity to enroll in Supplemental Life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents.

PLAN OPTIONS			
Cost of Coverage	Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.		
Coverage Options	**Employee Coverage** Choose in $10,000 increments up to $300,000	**Spouse Coverage** Choose in $10,000 increments up to the lesser of 100% of the amount you elect for yourself or $150,000 **Coverage terminates at age 70*	**Dependent Coverage** Choose in $5,000 increments up to $10,000 **Coverage from birth to age 26*
Do I have to take a health exam to get coverage?	If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.		
Guaranteed Issue	**Employee** $200,000	**Spouse** $50,000	**Dependent** $10,000

PLAN PROVISIONS	
Cost Calculation	Age Rated Benefit (Spouse Life based on employee's age)
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.

*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

During the upcoming scheduled Open Enrollment for 1/1/2022, coverage can be elected without submitting EOI, subject to the Guaranteed Issue limit. Employees that were previously denied coverage are not eligible.

During subsequent annual enrollments, coverage can be increased up to 5 increment levels without submitting EOI, subject to the Guaranteed Issue limit. Employees that were previously denied coverage are not eligible.

DISABILITY

SHORT-TERM | LONG-TERM

SHORT-TERM DISABILITY (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs.

Short Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

LONG-TERM DISABILITY (LTD)

Serious illnesses or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months – even years.

Long Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

PLAN FEATURES	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Cost of Coverage	**Voluntary Benefit** Employee is responsible for 100% of the cost	**Voluntary Benefit** Employee is responsible for 100% of the cost
Elimination Period *This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.*	Benefits begin on the **15th day of an accident or an illness (including pregnancy)**.	Your elimination period is **180 days**.
Benefit Duration *The maximum number of weeks you can receive benefits while you are sick or disabled.*	**Payments may last up to 24 weeks** You must be sick or disabled for the duration of the waiting period before you can receive a benefit payment.	**Payments will last for as long as you are disabled, or until you reach Retirement Age (age 65), whichever is sooner** You must be sick or disabled for the duration of the elimination period before you can receive a benefit payment.
Coverage Amount	Covers **60% of your weekly income,** up to a maximum benefit of **$1,500 per week.**	Covers **60% of your monthly income,** up to a maximum benefit of **$10,000 per month.**
What's covered?	**A variety of conditions and injuries.** Typical claims would include pregnancy, injuries and joint, back and digestive disorders.	**A variety of conditions and injuries.** Typical claims would include cancer, back disorders, injuries and poison, cardiovascular, joint disorders.
Definition of Earnings	**Base Salary** *(excludes commissions and bonuses)*	**Base Salary** *(excludes commissions and bonuses)*
ADDITIONAL PLAN PROVISIONS		
Benefit Payment Frequency	**Weekly benefit** may be reduced or offset by other sources of income.	**Monthly benefit** may be reduced or offset by other sources of income.
Waiver of Premium	Not included.	If you're disabled and receiving benefit payments, you cost may be waived until you return to work.
Pre-Existing Condition Limitation	None.	You have a pre-existing condition if you have received: medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

Certain exclusions and any pre-existing condition limitations may apply.
Please refer to the Provider's detailed benefit summary for details.

WELLNESS CLINIC

Fairfield County & First Medical Occupational Health

Lower Level of First Medical Urgent Care
1199 River Valley Blvd.
Lancaster, Ohio 43130
Phone 740-689-4404

Clinic Hours:
Monday, Wednesday &Friday: 9am – 4:30pm
Tuesday & Thursday: 10am-5:30pm

Minor Illnesses
- Allergy symptoms
- Earaches
- Flu-like symptoms
- Gout
- Indigestion
- Mononucleosis
- Mouth conditions/pain
- Nausea/vomiting/diarrhea
- Pink eye & styes
- Sinus infections/congestion
- Sore throat
- Upper respiratory infections
- Urinary tract infections
- Yeast infections

In-Clinic Lab Tests
- Strep test
- Glucose
- Mono test
- Urine dip stick
- Pregnancy test

Vaccines/Injections
- Allergy (must bring serum)
- Birth control (must bring medication)

Minor Injuries
- Bug bites & stings
- Tick bites
- Cholesterol screenings
- Minor burns
- Minor cuts/blisters/wounds
- Splinter removal – superficial
- Sprains, strains, joint pains
- Suture & staple removal

Wellness/Physicals
- Physicals – basic wellness only
- Routine/school/sport/work permit/camp
- Ear wax removal
- Pregnancy tests
- Smoking cessation assessment & follow-up visits
- Weight loss assessment & follow-up visits

Skin Conditions
- Acne
- Athlete’s foot
- Chicken pox
- Cold, canker, mouth sores
- Dermatitis, rashes, skin irritations

OPERS RETIREMENT PLAN

BENEFIT OVERVIEW

PLAN OVERVIEW	Member Contribution	Employer Contribution
TRADITIONAL PENSION PLAN		
Contributions	10%	14%
OPERS manages investments		
Lifetime retirement payments are based on a formula that includes your length of service and salary history		
Survivor and disability benefits		
Access to healthcare		
MEMBER-DIRECTED PLAN		
Contributions	10%	7.5%
Member manages investments		
Employer contributions into Retiree Medical Account		4%
Mitigating Rate: 2%*		
Lifetime retirement payments are based on your vested account balance and age at retirement		
Vested account balance is available in the case of death or disability		
COMBINED PLAN		
Contributions	10%	12%
Member manages member contributions		
OPERS manages employer contributions		
Mitigating Rate: 2%*		
Lifetime retirement payments are based on a formula that includes the length of service and salary history, plus your vested account balance and age at retirement.		
Survivor and disability benefits		
Access to healthcare		

**If OPERS determines the number and demographic characteristics of members who have elected to participate in the Member-Directed or Combined Plan results in a negative financial impact on the Traditional Pension Plan, a portion of the employer contribution may be withheld and credited to the Traditional Pension Plan. This is called the mitigating rate.*

Investments

Two methods for new members to manage investments in the Member-Directed and Combined plans:

- OPERS Target Date Funds: simple, easy, automatically adjust quarterly
- OPERS Core Funds: six funds ranging from lower-risk, income-oriented options to higher-risk, growth-oriented options

More Information

To access the Plan Comparison Calculator, log on to www.opers.org. For additional details about the OPERS Retirement Plan, call 866-673-7748.

WELLBEATS FITNESS

ON DEMAND FITNESS OVERVIEW

Stream Wellbeats Anywhere

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- 600+ classes including yoga, HIIT, strength training, cycling, running/walking, mindfulness, office breaks, recovery
- Nutrition education and recipes
- Kid-friendly activities and pre/post-natal classes
- Easy-to-use navigation and interface
- Recommended classes according to your personal preferences
- Coached by a team of certified, supportive instructors
- Stay accountable with goal-based challenges
- Track your progress with personal statistics
- No equipment options available

To learn how to use Wellbeats, watch the 5-minute Navigation Tour Videos at www.wellbeats.com/faqs

Wellbeats Login Information

Username: your work e-mail address

Password: be on the lookout for an email from Wellbeats (support@wellbeats.com) which includes your temporary password

FAIRFIELD COUNTY
HEALTH
BENEFIT PLAN

REQUIRED NOTICES

& FEDERAL MANDATES

REQUIRED NOTICES

Federal regulations require employers to provide certain notifications and disclosures to all eligible employees. This section of your benefit guide is dedicated to those disclosures for 1/1/2022-12/31/2022. If you have any questions or concerns please contact your plan administrator as follows:

Human Resources
740-652-7898

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) of 1993 was designed to provide eligible employees with up to 12 workweeks per year of job-protected leave to address critical personal and family matters. It is the policy of **your employer** and its U.S. subsidiaries to provide eligible employees with a leave of absence in accordance with the provisions of FMLA.

You are eligible for an FMLA leave of absence under this policy if you meet the following requirements:

- You have completed at least 12 months of employment (need not be consecutive, but employment prior to a continuous break in service of seven or more years may not be counted).
- You have worked at least 1,250 hours during the 12-month period immediately preceding the commencement of the requested leave.
- You are employed at a work site where 50 or more employees are employed by the Company within 75 miles of that work site ("eligible employees").

To the extent permitted by law, leave taken pursuant to FMLA will run concurrently with Workers' Compensation, Short Term Disability, and all other Company leave policies.

The *"break in service cap"* doesn't apply if it:

- is attributable to fulfillment of National Guard or Reserve military service obligations; or
- is addressed in a written agreement, including a collective bargaining agreement, that expresses the employer's intent to rehire the employee after the break in service, such as a break to pursue education or raise children.

Procedure for Applying for FMLA Leave

If you desire and require an FMLA leave of absence under this policy, you must notify your manager and your Human Resources Department and call your FMLA Administrator at least 30 calendar days in advance of the start of the leave when the need for such leave is reasonably foreseeable (as in the case of a birth, the placement for adoption of a son or daughter, or a planned medical treatment for a serious health condition).

However, if the date of the birth, placement, or planned medical treatment requires leave to begin in less than 30 calendar days, you must provide such notice to the aforementioned parties as soon as it is both possible and practicable. Failure to provide timely notice may result in a delay or denial of FMLA leave.

IRS CODE SECTION 125

Premiums for medical, dental, vision insurance, and/or certain supplemental plans and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to an employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employees may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse, or dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of the qualifying event.

Examples Of Qualifying Events:

- Legal marital status (for example, marriage, divorce, legal separation, annulment);
- Number of eligible dependents (for example, birth, death, adoption, placement for adoption);
- Employment status (for example, strike or lockout, termination, commencement, leave of absence, including those protected under the FMLA);
- Work schedule (for example, full-time, part-time);
- Death of a spouse or child;
- Change in your child's eligibility for benefits (reaching the age limit);
- Change in your address or location that may affect the coverage for which you are eligible;
- Significant change in coverage or cost in your, your spouse's or child's benefit plans;
- A covered dependent's status (that is, a family member becomes eligible or ineligible for benefits under the Plan);
- Becoming eligible for Medicare or Medicaid; or
- Your coverage or the coverage of your Spouse or other eligible dependent under a Medicaid plan or state Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- You, your spouse or other eligible dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance.

Qualifying Events, which ARE NOT available for a Health Care FSA program, if applicable:

- Coverage by your spouse or other covered dependent permitted under the spouse's or covered dependent's employer's benefit plan due to a Change Event;
- The availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO is added to or deleted from the Medical Program);
- An election made by your spouse or other covered dependent during an open enrollment period under your spouse's or other covered dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your spouse's open enrollment period is in July and your spouse changes coverage); or
- The cost of coverage during the Plan Year, but only if it is a significant increase or decrease.

Available for Dependent Care FSA Only, If applicable:

- Your dependent care provider or cost of dependent care (a significant increase or decrease).

Additional Change Events For Health Care Options:

In addition to the above Change Events, you may also change elections for the Medical, Dental, Vision and Health Care FSA Programs if:

- You, your spouse, or other covered dependent become eligible for continuation coverage under COBRA or USERRA;
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child;
- You, your spouse, or other covered dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- You, your spouse, or other covered dependent become eligible for a Special Enrollment Period.

REQUIRED NOTICES
CREDITABLE COVERAGE (PART D MEDICARE)

HEALTH COVERAGE REMINDER

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage or pay a penalty. You may obtain coverage through your employer or through the Marketplace.

- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.

Visit **www.healthcare.gov** for Marketplace information.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact Human Resource Department

MICHELLE'S LAW NOTICE

The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact your Human Resource Department as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

THE GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

Genetic Information Non-Discrimination Act (GINA) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

NOTICE OF ELIGIBILITY FOR HEALTH PLANS RELATED TO MILITARY LEAVE

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service; or
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed within the time period specified by USERRA, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect Continuation Coverage Under USERRA.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group Health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

REQUIRED NOTICES

MEDICARE PART D CREDITABLE COVERAGE NOTICE
Your Prescription Drug Coverage and Medicare

Important Notice from Fairfield County About Your Prescription Drug Coverage and Medicare Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Fairfield County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Fairfield County has determined that the prescription drug coverage offered by the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th . 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 Fairfield County coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Fairfield County coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Fairfield County 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 October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage contact the Human Resources Department.

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 Fairfield County changes. You also may request a copy of this notice at any time.

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).

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

REQUIRED NOTICES
COBRA

COBRA COVERAGE

Federal law requires **Fairfield County** to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

To Qualify For COBRA Coverage:

Employees – As an employee of **Fairfield County** covered by our health plans**,** you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Spouses – As the spouse of an employee covered by our health plans**,** you have the right to choose continuation coverage for yourself if you lose group health coverage under **our health plans,** for any of the following reasons:

- The death of your spouse who was a **Fairfield County e**mployee;
- A termination of your spouse's employment (for reasons other than gross misconduct);
- A reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

Dependent Children

Dependent children of **Fairfield County** employees covered by our health plans, have the right to continuation coverage if group health coverage under our plans, is lost for any of the following reasons:

- The death of a parent who was a **Fairfield County** employee;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with **Fairfield County;**
- Parents' divorce or legal separation;
- A parent who is an employee of **Fairfield County** becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the terms of our health plans.

Please note that it is the employee's responsibility to notify the Human Resources/Benefits Department of any communication regarding loss of coverage and communication regarding such between the employee and the insurance carrier. Please note that employees must also provide notice of other events (e.g., divorce) to the Human Resources Department.

Continuation of Coverage Rights Under COBRA

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

You may have other options available to you when you lose group health coverage.

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

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plans as a "dependent child."

When Is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How Is COBRA Continuation Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

COBRA COVERAGE (cont.)

Disability Extension Of 18-month Period Of COBRA Continuation Coverage

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

Second Qualifying Event Extension Of 18-month Period Of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

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

For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Administrator Informed Of Address Changes*

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

REQUIRED NOTICES
CHIP

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

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

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

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

REQUIRED NOTICES
CHIP

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
P: 866.444.EBSA (3272)

U.S. Department and Human Services Center for Medicare & Medicaid Services
www.cms.hhs.gov
P: 877.267.2323 Menu Option 4, Ext. 61565

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

REQUIRED NOTICES
NOTICE OF PRIVACY PRACTICES

NOTICE OF HIPAA PRIVACY PRACTICES

The privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) became effective April 14,2003. These federal regulations require covered entities, such as health plans, to provide plan participants with a notice of privacy practices describing the health-related information that is collected, how it is used, and the ways in which the regulations permit it to be disclosed. These privacy notices also provide information on a participant's right to access, review and, if necessary, to have this information amended.

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.

"We," "us", and "Plan" refer to all the health benefit plans and programs presented herein. "Plan Sponsor" refers to **your employer.** ''You" or "yours" refers to individual participants in the Plans.

PHI is information that may identify you and that relates to past, present, or future health care services provided to you, payment for health care services provided to you, or your physical or mental health or condition.

Your employer Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);
2. Your privacy rights with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to:

1. Maintain the privacy of your PHI;
2. Provide you with certain rights with respect to your PHI;
3. Provide you with this Notice of our legal duties and privacy practices regarding your PHI; and
4. Abide by the terms of this Notice as it may be updated from time to time.

We protect your PHI from inappropriate use or disclosure. Our employees and those of our Business Associates are required to protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to determine coordination of benefits or services. We will not disclose your PHI to anyone for marketing purposes.

USES AND DISCLOSURES OF PHI

Primary Uses and Disclosures of PHI: The main reasons for which we may use and may disclose your PHI are in order to administer our health benefit programs effectively and to evaluate and process requests for coverage and claims for benefits.

The following describes these and other uses and disclosures together with some examples:

Treatment*: Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. We may disclose your PHI to health care providers to provide you with treatment. For example, we might respond to an inquiry from a hospital about your eligibility for a particular surgical procedure.

Payment*:Payment refers to our activities in collecting premiums and paying claims for health care services you receive. We may use your PHI or disclose it to others for these purposes. For example, if you had insurance coverage from a spouse's employer, we might disclose your PHI to the other insurer to determine coordination of benefits or services. Payment also refers to the activities of a health care provider in obtaining reimbursement for services. We may disclose your PHI to a provider for this purpose.

Health Care Operations Purposes*

1. We may use your PHI or disclose it to others for quality assessment and improvement activities.
2. We may use your PHI or disclose it to others for activities relating to improving health or reducing health care costs, development of health care procedures, case management, and care coordination.
3. We may use your PHI or disclose it to others for the purpose of informing you or a health care provider about treatment alternatives.
4. We may use your PHI or disclose it to others for the purpose of reviewing the competence, qualifications, or performance of health care providers, or conducting training programs.
5. We may use your PHI or disclose it to others for accreditation, certification, licensing, or credentialing activities.
6. We may use your PHI or disclose it to others in the process of contracting for health benefits or insurance covering health care costs.
7. We may use your PHI or disclose it to others for purposes of reviewing your medical treatment, obtaining legal services, performing audits or obtaining auditing services, and detecting fraud and abuse.
8. We may use your PHI or disclose it to others in our business management, planning, and administrative activities. As an example, we might use your PHI in the process of analyzing data about treatment of certain conditions to develop a list of preferred medications.

Business Associates: We contract with various individuals and entities (Business Associates) to perform functions on behalf of the Plans or to provide certain services. To perform these functions, our Business Associates may receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to safeguard your PHI.

Plan Sponsor: We and our Business Associates may also disclose PHI to the Plan Sponsor without your written authorization in connection with payment, treatment, or health care operations purposes or pursuant to a written request signed by you. Such disclosures may only be made to the individuals authorized to receive such information. If PHI is disclosed to the Plan Sponsor for these purposes, the Plan Sponsor agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Other Covered Entities: your employer (including the insured plans) together are called an "organized health care arrangement. "The Plans may share PHI with each other for the health care operations purposes of the organized health care arrangement.

**The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purpose, as defined under the HIPAA rules.*

OTHER POSSIBLE USES AND DISCLOSURES OF PHI

In addition to using and disclosing your PHI for treatment, payment, and health care operations purposes, we may (and are permitted) to use or disclose it in the following circumstances:

To Persons Involved in Care and for Notification Purposes: We may disclose PHI to a family member, relative, close personal friend, or any other person identified by you, provided that the PHI is directly relevant to that person's involvement with your care or payment related to your care. In addition, we may use or disclose PHI to notify a member of your family, your personal representative, or another person responsible for your care of your location, your general condition, or your death.

In Regard to Abuse, Neglect, or Domestic Violence: In certain circumstances, we may disclose your PHI to a government authority that is authorized to receive reports of cases of abuse, neglect, or domestic violence.

To Coroners, Medical Examiners, and Funeral Directors: We may disclose PHI to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other purposes authorized by law. We may disclose PHI to funeral directors to enable them to carry out their duties.

For Public Health Activities: We may disclose PHI to public authorities for the purpose of preventing or controlling disease, injury, or disability. Under some circumstances, when authorized by law, we may disclose PHI to an individual who is at risk of contracting or spreading a contagious disease or condition. We also may disclose PHI to appropriate parties for the purpose of activities related to the quality, safety, or the effectiveness of products regulated by the U.S. Food and Drug Administration.

To Avert a Threat to Health or Safety: We may, under certain circumstances, disclose PHI to avert a serious threat to the health or safety of a person or the general public.

Organ and Tissue Donations: We may, under certain circumstances, disclose PHI for purposes of organ, eye, or other medical transplants or tissue donation purposes.

REQUIRED NOTICES
NOTICE OF PRIVACY PRACTICES

To Comply with Workers' Compensation Laws: We may disclose your PHI to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs.

For Law Enforcement and National Security Purposes: In certain circumstances, we may disclose PHI to appropriate officials for law enforcement purposes; for example, if it is required by law or legal process. In addition, we may disclose your PHI if you are or were armed forces personnel or to authorized federal officials for conducting national security and intelligence activities.

In Connection with Legal Proceedings: In certain cases, we may disclose PHI in connection with the legal proceedings of courts or governmental agencies. For example, we may disclose your PHI in response to a subpoena for such information but only after certain conditions required by HIPAA are met.

For Health Oversight Activities: We may disclose PHI to a governmental agency authorized by law to oversee the health care system, compliance with civil rights laws, or government benefit. Health oversight activities include audits, inspections, investigations, or legal proceedings.

Military Personnel: If you are in the armed forces, we may disclose your PHI for activities that military authorities consider necessary to the accomplishment of a mission.

Inmates: If you are incarcerated, we may disclose your PHI to appropriate authorities who tell us they need it for your health care, your safety, the health or safety of other persons, or general administrative purposes.

Research: Under certain circumstances, we may disclose PHI for research purposes.

Health Information: We may contact you with information about treatment alternatives and other health-related benefits and services.

As Required by Law: We may disclose your PHI when required to do so by federal, state, or local law.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures we are required by law to make:

Disclosures to the Secretary of the U.S. Department of Health & Human Services: We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with HIPAA.

Disclosure to You: We are required to disclose to you most of your PHI. We will also disclose your PHI to an individual whom you have designated as your personal representative. However, before we can disclose your PHI to such person, you must submit a written notice of his/her designation along with documents supporting his/her qualification (such as a power of attorney). In limited situations HIPAA permits us to elect not to treat the person as your personal representative if we have reasonable belief that it could endanger you.

OTHER USES AND DISCLOSURES OF YOUR PHI WITH AUTHORIZATION

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. You may revoke an authorization at any time by providing written notice to us. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in reliance on the authorization. To obtain an Authorization for Release of Information, call the **Human Resources Department.** You may revoke an authorization by contacting the Health Information Privacy Officer identified at the end of this Notice.

YOUR RIGHTS

Right to Request Restrictions on Uses and Disclosure

You may ask us to restrict uses and disclosures of your PHI for treatment, payment, or health care operations purposes, or to restrict disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care, or to restrict disclosures for notification purposes. However, we are not generally required to comply with your request for restrictions except in those situations where the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment), and the PHI pertains solely to a health care item or service that was paid out of pocket in full. You may exercise this right by contacting the Health Information Privacy Officer identified at the end of this Notice who will provide you with additional information including what information is required to make a restriction request.

Right to Inspect, Copy, and Amend Your PHI

As long as we maintain records containing your PHI, you have a right to inspect and copy such information. These rights are subject to certain limitations and exceptions. For example, if the requested information contains psychotherapy notes or may endanger someone, it may not be available. You may request a review of any denial to access. If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. If you believe your PHI held and created by us is incorrect or incomplete, you may request that we amend your PHI. You will be required to provide the reason the amendment is necessary. Requests for access to your PHI or amendment of your records should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to a List of Disclosures

You have a right to an accounting of certain disclosures of your PHI by us. The accounting will not include those items which are not required to be provided such as disclosures made at your request or disclosures made for treatment, payment, or health care operations. A request for a list of disclosures should be directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to Request Confidential Communications

We will accommodate a reasonable request by you to receive communications from us by alternative means or at an alternative location if you believe that disclosure of your PHI could pose a danger to you. For example, you may request that we only contact you by mail or at work. Requests for confidential communications should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to be Notified of a Breach

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to Receive Paper Copy

You have the right to receive a paper copy of this Notice from the Plan upon request even if you have previously agreed to receive copies of this Notice electronically. Requests for a paper copy should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI we maintain. If we change this Notice, you will receive a new Notice. Active employees will receive the Notice by distribution in the workplace; inactive employees (including retirees) will receive the Notice by mail.

Complaints: If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below under "Health Information Privacy Officer" or with the office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Health Information Privacy Officer: You may exercise the rights described in this Notice by contacting the office identified below, which will provide you with additional information.

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Flexible Spending Account (FSA) – The Flexible Spending Account (FSA) is a healthcare benefit that allows employees to set aside funds annually to cover the costs of qualified medical expenses.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

IMPORTANT CONTACT INFORMATION

The Mobile Wallet Card keeps all of your benefit contacts in one place. For easy access to your benefit carriers' group numbers, phone numbers and websites visit https://mymobilewalletcard.com/fairfieldco/

United Healthcare Medical	**Group Number: 0909120**
Customer Service	(866) 844-4864 www.myuhc.com
Flexible Spending Account (FSA)	(800) 331-0480 FSA Group Number: 912912 www.myuhc.com
Wellness Clinic	
Fairfield County Employee Health & Wellness Clinic	(740) 689-4404
Delta Dental	**Group Number: 1471**
Customer Service	(800) 524-0149 www.deltadental.com
VSP Vision	**Group Number: 30069927**
Customer Service	(800) 877-7195 www.vsp.com
Symetra Life/AD&D & Disability	
Customer Service	(877) 377-6773 www.symetra.com/MyGO
Optum EAP	
Employee Assistance Program	(866) 248-4094 www.liveandworkwell.com Access Code: FairfieldCo
OPERS Retirement Plan	
Customer Service	(800) 222-7377 www.opers.org

FAIRFIELD COUNTY
HEALTH
BENEFIT PLAN

This Benefit Enrollment Guide Is Provided By:

NFP