County of Pulaski, PSA and DSS

Benefits Enrollment Guide

2018 - 2019

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The following descriptions of available benefit elections options, are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

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ONEDIGITAL HEALTH AND BENEFITS

Enrollment and Eligibility

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Locate your enrollment/change forms.
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state unless your company covers domestic partners
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Open Enrollment is the only chance to make changes, unless you experience a "change in status."

Advanced Resolution Team

Insurance is complicated, OneDigital understands.

We respond. We act. We help.

Through our **Advanced Resolution Team**, you have access to live representatives who will help you get the most out of your benefits and answer your questions. The OneDigital Advanced Resolution Team can help educate you about your benefits and teach you how to navigate within the healthcare system.

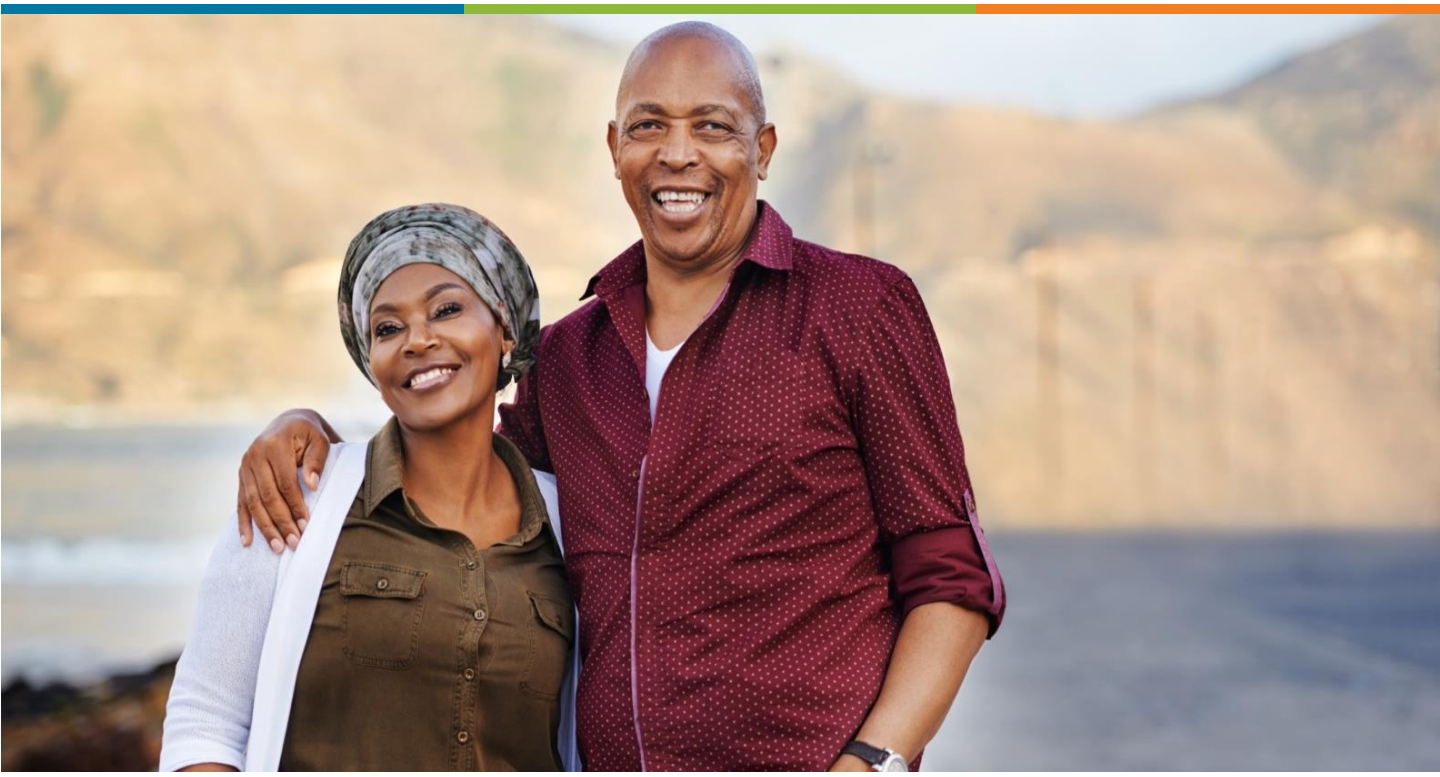
- Help you facilitate enrollment changes in status including ID requests
- Coverage assistance
- Facilitate resolution on eligibility/billing issues
- Assist you with claims
- Locate in-network providers
- And much, much more

ONEDIGITAL
HEALTH AND BENEFITS

Advanced Resolution Team
Call: 1.866.802.6311
Email: art@onedigital.com

Monday through Friday 8am to 5pm (EST).
We are available by phone, email, fax, or online chat.

Package Overview & Contact Information



County of Pulaski offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards.

Effective July 1, 2018:

- Medical benefit plans with Anthem
- Dental benefit plan with Delta Dental
- Voluntary Vision benefit plans with EyeMed
- Voluntary Accident, Critical Illness and Cancer with SunLife
- EAP with Optima
- Flexible Spending Accounts with Flexible Benefit Administrators
- HSA plan with H S A Administrators

Medical Plan Options

For this plan year, you can choose from the following medical options. Refer to the carrier benefits summaries for the exact benefit levels associated with your plan choice.

In Network Benefits	Anthem Keycare PPO 1350/20% H S A	Anthem Keycare 20/40 PPO
Referrals Required	No	No
Plan Accumulator	Calendar Year	Calendar Year
Annual Deductible*	$1,350 Individual $2,700 Family	No deductible No deductible
	*Non-embedded	
Coinsurance	20% after deductible	Most services are copays/ 20% coinsurance
Maximum Out-of-Pocket	$5,000 Individual $10,000 Family	$2,500 Individual $5,000 Family
Preventive Care	Covered at 100%	Covered at 100%
Physician's Office Visits- PCP **Physician's Office Visits- Specialist**	20% coinsurance, after deductible 20% coinsurance, after deductible	$20 copay $40 copay
Urgent Care	20% coinsurance, after deductible	$40 copay
Emergency Room	20% coinsurance, after deductible	$250 copay 20% coinsurance ER doctor and other services
Inpatient Services	20% coinsurance, after deductible	$300 copay per day up to 5 days per admission
Outpatient Services	20% coinsurance, after deductible	$300 copay
Diagnostic Lab Services	20% coinsurance, after deductible	20% coinsurance – Office $300 Co-Pay- Outpatient Hospital
Advanced Diagnostic Services	20% coinsurance, after deductible	20% coinsurance - Office $300 Co-Pay- Freestanding Radiology Center or Outpatient Hospital
Routine Vision Exam	$15 copay; does not apply to the deductible	$15 copay
Pharmacy Prescription Drugs **(Tier 1/Tier 2/Tier 3/Tier 4)**	After the deductible: $10/$30/$50/$50	$10/$30/$50/$50
Mail Order Prescription Drugs **(Tier 1/Tier 2/Tier 3/Tier 4)**	After the deductible: $10/$60/$150 $50 Tier 4- 30-day supply for home delivery	$10/$60/$150 $50 Tier 4 - 30-day supply for home delivery
Out of Network Benefits	**Anthem Keycare PPO 1350/20% H S A**	**Anthem Keycare 20/40 PPO**
Annual Deductible	$1,350 Individual $2,700 Family	$750 Individual $1,500 Family
Maximum Out-of-Pocket	$10,000 Individual $20,000 Family	$3,750 Individual $7,500 Family
Co-Insurance	40%	30%

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

Health Savings Account (HSA)

Option for High Deductible Health Plan (HDHP)

For employees who elect the HDHP, you have the option to open a Health Savings Account** (HSA). The HSA-eligible plan provides a way to save money for health care expenses . Our partner for H S A accounts is Health Savings Administrators.

- In 2018, individuals can contribute up to $3,450 and families can contribute up to $6,900 to their HSA (these totals represent the total of employee and employer contributions).
- For July 2018/2019, County of Pulaski will contribute the following in to the HSA account:
  - $630 for Employee only in July 2018 and $1,260 in January 2019*
  - $1,254 for Employee + Spouse in July 2018 and $2,508 in January 2019*
  - $1,254 for Employee + Child(ren) in July 2018 and $2,508 in January 2019*
  - $1,254 for Family coverage in July 2018 and $2,508 in January 2019*
  - (You will make your H S A election on the Payroll election form)

  *the January 2019 contribution will be a fully funded amount for the 2019 plan year.

  ****If you want to receive the contributions from County of Pulaski, you MUST have or open a Health Savings Account.**
- For 2018, if you are 55 or older, you can make a $1,000 catch-up contribution.
- Contributions to an HSA can be made on a pre-tax or post-tax basis, and funds within the HSA grow without incurring taxes. Funds are withdrawn tax-free for healthcare related needs without having to file receipts, although you should keep your receipts in case you are ever audited.
- Money deposited in the HSA by the employee AND employer immediately become the employee's asset and is portable.

Tax-Advantaged Plan	What is this account and how does it work?	Maximum Contribution Allowed (2018)	Can money in accounts be "rolled over?"
Health Savings Account (HSA)	An HSA account can be funded with pre-tax dollars by you, your employer or both to help pay for eligible medical expenses.	Employee only coverage: $3,450 Family coverage: $6,900 Catch up contribution (55 year of age or older): $1,000	Yes, amounts left in your HSA account can be rolled over year to year and is portable if you leave employment of the company

Flexible Spending Accounts (FSA)

FSA Vendor partner – Flexible Benefit Administrators

Who is Eligible and When:

All Full-Time Employees working at least 30 hours each week.

Benefits You Receive:

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

The 2018 plan year maximum for County of Pulaski employees is $2,550

This program lets employees pay for certain IRS-approved medical care expenses and prescriptions not covered by their insurance plan with pretax dollars. There are limits on salary reduction contributions to a health FSA offered under a cafeteria plan and is applicable to both grandfathered and non-grandfathered health FSAs. This limit will be indexed for cost-of-living adjustments. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA

The Dependent Care FSA lets employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Limited Flexible Spending Account

FSA Vendor partner – Flexible Benefit Administrators

Who is Eligible and When:

All Full-Time or Part-Time Employees working at least 30 hours each week.

Limited Flexible Spending:

With a Limited Flexible Spending Account your are able to pay for eligible dental and vision care expenses with pre-tax dollars.
This account can be opened if you have a high deductible health plan.

Contribution Limits:

The maximum for the plan year is $2,550

Some examples of eligible expenses include:

- Orthodontia (braces)
- Crowns
- Fillings
- Checkups
- Eyeglasses
- Prescription Sunglasses
- Routine Eye Exam
- Lasik Eye Surgery
- Contact Lenses

For a more comprehensive list of covered and non-covered services, refer to the benefit summary.

Dental Plan

For this plan year, you can choose from the following dental option. Refer to the carrier benefits summary for the exact benefit level associated with your plan.

Delta Dental Premier	
Type of Service	**In Network**
Annual Maximum	$1,000 per enrollee
Annual Deductible	$0
Preventive Services (exams, cleaning, x-rays, fluoride treatments, sealants, etc.)	0%
Basic Services (fillings, root canals, periodontal services, complex oral surgery, etc.)	20%
Major Services (crowns, dentures, implants)	50%
Orthodontic Services – Child Only Coverage (up to age 19)	50% $1000 lifetime max benefit

Delta Dental Premier	
Type of Service	**Out of Network**
Annual Maximum	$1,000 per enrollee
Annual Deductible	$0
Preventive Services (exams, cleaning, x-rays, fluoride treatments, sealants, etc.)	0%
Basic Services (fillings, root canals, periodontal services, complex oral surgery, etc.)	20%
Major Services (crowns, dentures, implants)	50%
Orthodontic Services – Child Only Coverage (up to age 19)	50% $1000 lifetime max benefit

Learn More!

Find more information about oral health from the American Dental Association:

http://www.mouthhealthykids.org/en/educators/smile-smarts-dental-health-curriculum

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Vision Plan

Did you know?

Scientific evidence shows that early detection and treatment can prevent some blindness and vision impairment.*

*Source: CDC Vision Health Initiative
https://www.cdc.gov/visionhealth/basic_information/vision_loss.htm

For this plan year, you can choose from the **Standard** or **Enhanced** vision option. Refer to the carrier benefit summary for the exact benefit level associated with your plan.

EyeMed Voluntary Vision - STANDARD		
Type of Service	**In Network**	**Out of Network**
Vision Exam	$10 copay	Reimbursement up to $40
	Exam – once every 12 months	
Lenses		
Single Vision Lenses	$20 Copay	Reimbursement up to $40
Bifocal Lenses	$20 Copay	Reimbursement up to $60
Trifocal Lenses	$20 Copay	Reimbursement up to $80
Standard Progressive	$85 Copay	Reimbursement up to $60
Premium Progressive Lens	$105 - $130 Copay	Reimbursement from $60 up to $80
	Lenses - Once every 12 months*	
Frames	$0 copay; $130 allowance 20% off balance over $130 allowance	Reimbursement up to $45
	Frames - Once every 24 months	
Conventional Contact Lenses	$0 copay, $125 allowance 15% off balance over $125	Reimbursement up to $125
Disposable Contact Lenses	$0 copay, up to $125 allowance	Reimbursement up to $125
Medically Necessary	$0 copay, paid in full	Reimbursement up to $125
	Contact Lenses - Once every 12 months	

***You can use the lense benefit for EITHER glasses lenses or contact lenses once every 12 months**

Vision Plan

EyeMed Voluntary Vision - ENHANCED		
Type of Service	**In Network**	**Out of Network**
Vision Exam	$15 Copay	Reimbursement up to $40
	Exam – once every 12 months	
Lenses		
Single Vision Lenses	$15 Copay	Reimbursement up to $40
Bifocal Lenses	$15 Copay	Reimbursement up to $60
Trifocal Lenses	$15 Copay	Reimbursement up to $80
Standard Progressive	$15 Copay	Reimbursement up to $60
Premium Progressive Lens	$35 - $60 Copay	Reimbursement from $60 up to $80
	Lenses - Once every 12 months*	
Frames	$0 copay; $130 allowance 20% off balance over $130 allowance	Reimbursement up to $45
	Frames - Once every 24 months	
Conventional Contact Lenses	$0 copay, $150 allowance 15% off balance over $150	Reimbursement up to $150
Disposable Contact Lenses	$0 copay, $150 allowance	Reimbursement up to $150
Medically Necessary	$0 copay, paid in full	Reimbursement up to $150
	Contact Lenses - Once every 12 months	

***You can use the lense benefit for EITHER glasses lenses or contact lenses once every 12 months**

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Employee Assistance

The Optima Employee Assistance Program (EAP) is a confidential service available to employees and household members – at no cost to you. Trained professionals can easily refer you to the following resources:

- **Face to Face Counseling** – You and your household member are eligible for up to 3 visits for each personal situation, as needed. Short-term, solutions-focused counseling to address a wide range of personal and professional challenges.

- Legal - one, initial 30-minute office or telephonic consultation per separate legal matter at no cost. Retention of the attorney for the matter may be provided at a 25% discount off normal, hourly fees. (Some limitations apply.)
- Financial – one telephonic consultation per separate financial matter at no cost. Consultation is typically limited to 30-60 minutes.
- Identity Theft – one, 30-minute telephonic consultation with a fraud recovery specialist, who will offer counsel on identity restoration steps.

To contact Optima EAP, please call us toll-free at 1-800-899-8174. You can also visit www.optimahealth.com.

Accident

Sun Life OFF THE JOB ACCIDENT PLAN – Some sample benefits (payments per incident)		
	Low Plan	**High Plan**
Wellness Benefit	**$50 per benefit year**	**$50 per benefit year**
Accident Hospitalization	$500 once per year, per covered person; then $150 per day of hosptial confinement, up to 365 days per covered accident	$1,000 once per year, per covered person; then $250 per day of hosptial confinement, up to 365 days per covered accident
Intensive Care Unit	$750 once per year; then $300 per day, up to 14 days	$1,500 once per year; then $500 per day, up to 14 days
Emergency Room	$100	$150
Dislocations	$50 to $2,000 (benefit amount dependent on area and type of dislocation)	$100 to $4,000 (benefit amount dependent on area and type of dislocation)
Fractures	$90 to $3,000 (benefit amount dependent on area fractured)	$175 to $6,000 (benefit amount dependent on area fractured)
Follow-up Physical Therapy	$25 per visit up to 10 visits per covered accident	$25 per visit up to 10 visits per covered accident
Ambulance	$100 - Ground Transportation $750 - Air Transportation	$200 - Ground Transportation $1,500 - Air Transportation
Additional Covered Conditions	Burns, paralysis, surgery, coma, concussion, lacerations, diagnostic exams (CT, CAT, EKG, MRI, X-ray)	Burns, paralysis, surgery, coma, concussion, lacerations, diagnostic exams (CT, CAT, EKG, MRI, X-ray)
Accidental Death	$15,000	$25,000
Accidental Death by Common Carrier	$30,000	$100,000

Critical Illness

Sun Life CRITICAL ILLNESS	
Wellness Screening Benefit	$50 for employee $50 for spouse (must be covered on plan) $50 Child (must be covered on plan)
Coverage Amount Options	Employee: From $5,000 to $20,000 in $5,000 increments Spouse: From $2,500 to $10,000 in $2,500 increments; Child: from $2,500 to $5,000 in $2,500 increments *Employee must elect coverage in order to elect coverage for any dependent.
Guarantee Issue amount	Employee: $20,000 Spouse: $10,000; Child: $5,000 *Employee must elect coverage in order to elect coverage for any dependent.
Included Illness at 100%	Heart attack, End-stage kidney disease, Occupational HIV/Hepatitis B, C or D, Major organ failure, Stroke, Invasive cancer, Blindness, coma, brain tumor, paralysis, severe burns, Advanced ALS. The plan also pays 100% for a variety of Childhood conditions.
Included Illness at 25%	Coronary artery bypass graft, non-invasive cancer, advanced Parkinson's or Alzheimer's
Additional Childhood Conditions:	Down's syndrome, cystic fibrosis, type 1 diabetes mellitus, complex congenital heart disease, cerebral palsy, cleft lip/palate, muscular dystrophy, spina bifida
Recurrence Benefit	There is 6 month waiting period for the Additional occurrence benefit and12-month waiting period between diagnoses for any recurrence benefit (if benefit available)
Pre-existing Conditions	12/12 months* If you have received care or taken medication in the 12 months prior to the effective date, benefits will not be paid for that condition until the earlier of 12 months treatment free or 12 months of continuous insurance under the plan

*the pre-existing condition clause can be waived if you have coverage under a similar plan. See the SunLife representative for additional information.

Cancer

SunLife Cancer Insurance	
Benefits	Cancer screening, 2nd surgical opinion, surgery and general anesthesia, hospital confinement, in-hospital doctor visits, radiation and chemotherapy, blood and plasma, skin cancer, prosthesis, extended-care facility, hospice, ambulance
Cancer screening	$50
2nd Surgical Opinion	$200
Surgery and General Anesthesia	$50 to $1,815 for Anesthesia; $150 to $5,500 for Surgery
Skin Cancer	$100 to $600
Prosthesis	Surgically implanted - $2,000; Other devices - $200
Hospital Confinement	$200 per day up to a maximum to 90 days
Radiation and Chemotherapy	$150 to $450
Hospice	$100 per day up a maximum of 100 days
Extended-care Facility	$200 per day up to a maximum to 90 days *the extended care confinement must occur withing 30 days of a period of hospital confinement
Pre-existing Conditions	12/12/12 months* If you have received care or taken medication in the 12 months prior to the effective date, benefits will not be paid for that condition until the earlier of 12 months treatment free or 12 months of continuous insurance under the plan

Required Notices

Newborn and Mothers' Health Protection Act

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 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 newborn earlier than 48 hours (or 96 hours are applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess for 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy , including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.

Required CHIP Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

Alabama – Medicaid	Florida – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
Alaska – Medicaid	**Georgia – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
Arkansas – Medicaid	**Indiana – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**Iowa – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

Required CHIP Notice

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.df Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

Required CHIP Notice

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment- program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acsinc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

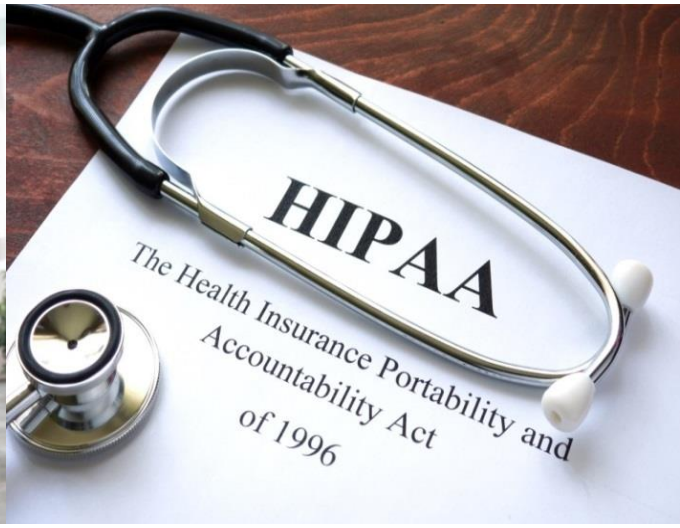
To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

Required CHIP Notice



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.

Required HIPPA Notices

HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants.

All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI.

If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

More information can be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

Link to model notice:
http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/nppbooklet_health_plan.pdf
http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/npp_fullpg_healthplan.pdf
http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/npp-booklet-healthplan-spanish.pdf
http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/npp-fullpg-healthplan-spanish.pdf

Model Special Enrollment Notice

The following is language that group health plans may use as a guide when crafting the special enrollment notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Tammy Safewright, Human Resources Director, 540-980-7705, tsafewright@pulaskicounty.org.

More information can be found at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance

Link to model notice: http://www.dol.gov/ebsa/pdf/CAGAppC.pdf

GINA Notice

GENETIC INFORMATION

Title II of the Genetic Information Nondiscrimination Act of 2008 ("GINA") protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. For further information on GINA, please see the poster "Equal Employment Opportunity is The Law," which should be posted in a common area at your employment location.

COBRA – Continuation Coverage

Continuation Coverage Under COBRA Notice

This notice applies to everyone with healthcare coverage under the Plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you 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 Plan 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; or
- 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. You must provide this notice to: Tammy Safewright, 143 Third Street, NW, Suite 1, Pulaski, VA 24301

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

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:

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

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 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.

Plan contact information

County of Pulaski
Tammy Safewright
143 Third Street, NW, Suite 1
Pulaski, VA 24301
(540) 980-7705

Confidentiality Notice

OneDigital Health and Benefits, a division of Digital Insurance, Inc., does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date or birth and Social Security number

- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction;

- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment:

- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.

- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information conditionality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or authorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and student standards.

MEDICARE D NOTICE

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

OMB 0938-0990

Important Notice from County of Pulaski 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 County of Pulaski 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. **County of Pulaski has determined that the prescription drug coverage offered by Anthem 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 through 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.

CMS Form 10182-CC Updated April 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.

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MEDICARE D NOTICE

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990
FOR USE ON OR AFTER APRIL 1, 2011

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 **County of Pulaski** coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current **County of Pulaski** coverage, be aware that you and your dependents will 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 [Insert Name of Entity] 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 person listed below for further information. **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 **County of Pulaski** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

CMS Form 10182-CC Updated April 2011

MEDICARE D NOTICE

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990
FOR USE ON OR AFTER APRIL 1, 2011

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	April 25, 2018
Name of Entity/Sender:	County of Pulaski
Contact--Position/Office:	Tammy Safewright – County of Pulaski
Address:	143 Third Street, NW, Suite 1 Pulaski, VA 24301
Phone Number:	540-650-7705

CMS Form 10182-CC Updated April 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.

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Carriers, Vendors & Contacts

Program	Vendor	Contact Information
Medical/Rx Customer Service	Anthem	www.anthem.com
Dental	Delta Dental of Virginia	www.deltadentalva.com
Vision	EyeMed	www.eyemed.com *use the INSIGHT network
Accident, Critical Illness and Cancer	SunLife	www.sunlife.com
Flexible Spending Account/Dependent Care/Limited Flexible Spending Account	Flexible Benefit Administrators	www.flex-admin.com
HSA Administration	Health Savings Administrators	www.healthsavings.com
EAP	Optima	www.optimahealth.com
Advanced Resolution Team	One Digital	art@onedigital.com 1-866-802-6311

Know Where to Go!


ONEDIGITAL
HEALTH AND BENEFITS