Larimer County

2013 Employee Benefits Summary

LARIMER COUNTY
COMMITTED TO EXCELLENCE

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Benefits Plan Overview

Welcome to Larimer County!! The County-provided plans are designed to help you in the event of illness, injury, disability, or death, as well as to help you plan and save for retirement. The following pages give a brief description of the benefit plans offered to you as a Larimer County employee. If you need more specific information on any of the plans, please see the appropriate certificate or plan description document located in the Document Library of the ADP Portal / Benefits tab.

The Human Resources staff is available to answer any questions you may have about your benefits, or any other aspect of your employment with Larimer County.

Benefits Overview

- **Medical Insurance** (two options)
- **Dental Insurance**
- **Long-Term Disability Insurance**
- **Basic Life and Accidental Death and Dismemberment Insurance**
- **Vision Service Plan**
- **Supplemental Term Life Insurance**
- **Voluntary Accidental Death and Dismemberment Insurance**
- **Flexible Spending Account Plan**
- **Mandatory Retirement Plan** (401[a] Plan)
- **Deferred Compensation Plan** (Voluntary 457 Plan)
- **Aflac**
- **Employee Assistance Program** (EAP)

Enrollment must be completed online through the ADP Portal under the Benefits tab.

Note that the following descriptions are intended to be accurate and any errors are inadvertent. If we find any errors, they will be corrected in the next update of this outline.

2013 Benefits Orientation Schedule

This orientation is designed for all new benefited Larimer County employees. Two hours have been set aside to explain all of Larimer County's benefits and answer questions. Please remember to bring your Benefits Booklet to the Benefits Orientation.

To Register for Benefits Orientation: Contact Pam Stultz, Benefits Administrator, at 498-5983 or pstultz@larimer.org

If you have any questions or concerns, please call the Human Resources Department at 498-5970.

Date	*Time*	*Location*
Wed, January 16, 2013	All Benefits Orientations are held from **8:30 – 10:30 am** **Location**: Courthouse, 200 W. Oak St. Fort Collins	Jewell Lake Room, 4th Floor
Tues, February 19, 2013		Lake Estes Room, 3rd Floor
Mon, March 18, 2013		Jewell Lake Room, 4th Floor
Wed, April 17, 2013		Jewell Lake Room, 4th Floor
Wed, May 15, 2013		Jewell Lake Room, 4th Floor
Mon, June 17, 2013		Jewell Lake Room, 4th Floor
Wed, July 17, 2013		Jewell Lake Room, 4th Floor
Thurs, August 15, 2013		Lake Estes Room, 3rd Floor
Wed, September 18, 2013		Jewell Lake Room, 4th Floor
Wed, October 16, 2013		Lake Loveland Room, 2nd Floor
Mon, November 18, 2013		Jewell Lake Room, 4th Floor
Wed, December 18, 2013		Jewell Lake Room, 4th Floor

Benefit Eligibility Dates and Information

When will my benefits become effective?

Hire Date	*Benefits Begin:*	*Example:*
1st – 15th of month	1st day of next full month	Hired March 12th, Benefits begin April 1st
16th – 31st of month	1st day of the second full month	Hired March 19th, Benefits begin May 1st

All insurance premiums you sign up for will be deducted starting with the first paycheck <u>after</u> the benefits effective date.

Flexible Spending Account (FSA)	*Retirement Plan (401a)*
The FSA participation date will be the same as the insurance effective date. The contribution amount will be deducted starting with the first paycheck after the benefits effective date.	Upon hire, employees will immediately become participants in the retirement plan. Contributions will begin with the first paycheck.

When will my benefits terminate if I leave employment?

Insurance Benefits	*FSA (Flexible Spending Account)*
Benefits coverage will terminate at the end of the month in which the employee separates from employment.	Flexible Spending Account participation will continue through the last day of employment, with deductions coming out of the final paycheck.

Covering Dependents

Regardless of which option you choose to enroll in, you can cover a spouse, same-sex domestic partner, and/or child/ren. Children are eligible to the end of the month in which the child attains age 26.

When you drop your child because they are no longer eligible because of age from the health, dental, or vision insurance coverage, they will be eligible for COBRA continuation. Please give us a current address at that time so we can forward the appropriate COBRA information.

Special Enrollment Options (In compliance with federal law)

If you are declining enrollment now for yourself or any dependent(s) because of other health insurance coverage, you will be able to enroll in the future ***as long as you apply <u>within 31 days</u> of the loss of the other coverage.*** **Note that you must provide us with written proof of the loss of coverage.** Also, **be sure to add new dependents within 31 days of "getting them", whether it is the result of marriage, birth, adoption, or placement for adoption.** In either of these situations, if you do not enroll within 31 days, you will have to wait for the next Open Enrollment period. You cannot change your plan year benefits election unless you make a new election <u>within 31 days</u> of an allowable "status change" as determined under the IRS regulations and the S.125 Flexible Benefits Plan Document. Please refer to the S.125 Flexible Benefits Plan page of this booklet for more details.

Annual Open Enrollment

The benefit plan choices you make when you are first hired can only be changed at Open Enrollment period. During Open Enrollment, you can make the following benefit changes: you can switch between options, you can enroll yourself in coverage if you previously waived coverage, and you can enroll or drop eligible dependents. Open Enrollment is usually in November, and any changes you make will be effective the next January 1st.

Benefits Cost Summary

Schedule for Full-Time Employees

	TOTAL COST (monthly)	COUNTY PAYS (monthly)*	YOU PAY (monthly)	YOU PAY (semi-monthly)**
Standard PPO Plan – Admin. by UMR				
Employee Only	$ 629.24	$ 586.00	$ 43.24	$ 21.62
Employee and Spouse or Domestic Partner	$ 1,204.82	$ 902.08	$ 302.74	$ 151.37
Employee and One Child	$ 865.20	$ 647.36	$ 217.84	$ 108.92
Employee and Children	$ 1,112.18	$ 832.60	$ 279.58	$ 139.79
Employee and Family	$ 1,550.38	$ 1,161.24	$ 389.14	$ 194.57
Choice PPO Plan - Admin. by UMR				
Employee Only	$ 663.10	$ 586.00	$ 77.10	$ 38.55
Employee and Spouse or Domestic Partner	$ 1,345.62	$ 902.08	$ 443.54	$ 221.77
Employee and One Child	$ 966.70	$ 647.36	$ 319.34	$ 159.67
Employee and Children	$ 1,242.22	$ 832.60	$ 409.62	$ 204.81
Employee and Family	$ 1,728.00	$ 1,161.24	$ 566.76	$ 283.38
Dental Plan - Delta Dental				
Employee Only	$ 34.40	$ 34.40	$ -	$ -
Employee and One Dependent	$ 66.94	$ 34.40	$ 32.54	$ 16.27
Employee and Family	$ 96.86	$ 34.40	$ 62.46	$ 31.23
Vision Insurance - Vision Service Plan				
Employee Only	$ 8.82	$	$ 8.82	$ 4.41
Employee and One Dependent	$ 16.68	$	$ 16.68	$ 8.34
Employee and Family	$ 24.38	$	$ 24.38	$ 12.19
Life Insurance – Hartford				
Employee Only	varies	$ .125/1000 of salary	$ -	$ -
Employee and Family	varies	$ -	$ 0.76	Monthly deduction
Long Term Disability – Hartford				
Salary, up to $8333 per month	varies	.23% of salary	$ -	$ -
Other Voluntary Policies				
The costs for the Supplemental Term Life Insurance, Voluntary Accidental Death and Dismemberment, and the AFLAC supplemental plans are based on the coverage selected. See the individual brochures for current premiums.				

** This is the amount the County pays for a full-time employee. Part-time employees share the cost for health and dental coverages on a proportional basis; see the "Schedule for Proportional Benefits".*

*** Premiums will be deducted from the first two paychecks of each month. (When there is a month with three paychecks, they will not be deducted from the third one.)*

Benefits Cost Summary

Schedule for Part-Time Employees

Health Insurance:

Premiums are shown in semi-monthly amounts*. Depending on the plan option and number of dependents to be covered, a part-time employee's health insurance premium will vary, as shown below.

Standard PPO – *Employee's Cost Per Paycheck*					
# Hours Worked Per Week	Employee Only	Employee and Spouse	Employee and 1 Child	Employee and Children	Employee and Family
20 – 29	$94.87	$264.13	$189.84	$243.86	$339.72
30 – 39	$58.24	$207.75	$149.38	$191.83	$267.15
Full Time	$21.62	$151.37	$108.92	$139.79	$194.57

Choice PPO – *Employee's Cost Per Paycheck*					
# Hours Worked Per Week	Employee Only	Employee and Spouse	Employee and 1 Child	Employee and Children	Employee and Family
20 – 29	$111.80	$334.53	$240.59	$308.88	$428.53
30 – 39	$75.17	$278.15	$200.13	$256.85	$355.96
Full Time	$38.55	$221.77	$159.67	$204.81	$283.38

Dental Insurance:

Premiums are shown in semi-monthly amounts*. Depending on the plan option and number of dependents to be covered, a part-time employee's dental insurance premium will vary, as shown below.

Employee's Cost Per Paycheck:

# Hours Worked Per Week	Employee Only	Employee + 1 Dependent	Employee and Family
20 – 29	$4.30	$20.57	$35.53
30 – 39	$2.15	$18.42	$33.38
Full Time	$0.00	$16.27	$31.23

** Premiums will be deducted from the first two paychecks of each month. When there is a month with three paychecks, they will not be deducted from, or added to, the third one.*

Medical Insurance

PPO Option

As a Preferred Provider Organization (PPO) member:

- You can choose which doctor or specialist to see and you get to choose an in-network or out-of-network provider; *Note: you pay substantially less when you go to a doctor in the network.*
- You don't need to select a primary care physician and you don't need a referral to see a specialist.

Whether you choose an in- or out-of-network provider, certain services require that you satisfy a copay, deductible, and/or coinsurance. If you receive care from an out-of-network provider, your coverage will be at a lower benefit level and you will have to pay a higher deductible and coinsurance.

A Summary Plan Description is available in the Document Library.
For plan information and claims status, etc., go to www.umr.com
For a list of PPO providers, go to www.umr.com, click on 'Find a Provider' , then 'United Healthcare Options PPO'.

All members of the medical insurance plan are eligible to use The Wellness Clinic at no additional cost. More information is available on the Bulletin Board and in the brochure included in this packet.

Medical Insurance Definitions

Co-Payment: A fixed dollar amount that you pay when a medical service is received, regardless of the total charge for the service. The insurance plan is responsible for the rest of the total charge. For example, you will have a $20 copay for each doctor's office visit (non-specialist).

Coinsurance: A fixed percentage that the insurance plan pays for the medical expenses after the deductible amount is paid by the insured person. After the deductible is met, the insurance will pay either 80% or 90% (depending on the plan you choose); your share will either be 20% or 10% (again, depending on the plan you choose) until the out-of-pocket maximum is reached.

Deductible: A fixed dollar amount during the plan year (January 1st – December 31st) that you pay before the insurance plan starts to make payments for certain medical services. For example, under the Standard PPO Plan, an insured person would be responsible for the first $1000 of covered medical services (which are subject to the deductible). The plan has both an individual and family deductible. The family deductible can be met by a combination of family members.

Out-of-Pocket Maximum: You will be responsible for paying coinsurance and co-payments until you reach the specified out-of-pocket maximum. (The deductible does not count toward the out-of-pocket maximum). Once the out-of-pocket maximum has been reached, the insurance plan pays 100%, with the exception of co-pays, which you will continue to pay.

Medical Insurance Plans

Administered By UMR

UMR
A UnitedHealthcare Company

** Subject to the Deductible/Coinsurance*				
Benefit Overview	**Standard PPO**		**Choice PPO**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Individual	$1,000	$2,000	$500	$1,000
Family	$2,000	$4,000	$1,000	$2,000
Coinsurance	80%	60%	90%	70%
Out-of-Pocket Maximum - (*Does not include deductible)*				
Individual	$5,000	$10,000	$3,000	$6,000
Family	$10,000	$20,000	$6,000	$12,000
Office Visit	$20 Copay	60%*	$20 Copay	70%*
Specialist Office Visit	$40 Copay	60%*	$40 Copay	70%*
Inpatient Hospital	80%* *($250 penalty if not precertified)*	$500 copay/occurrence; 60%* *(Additional $500 penalty if not precertified)*	90%* *($250 penalty if not pre-certified)*	$500 copay/occurrence; 70%* *(Additional $500 penalty if not precertified)*
Outpatient Hospital	80%* *($250 penalty if not precertified)*	$250 copay/occurrence; 60%* *(Additional $500 penalty if not precertified)*	90%* *($250 penalty if not precertified)*	$250 copay/occurrence; 70%* *(Additional $500 penalty if not precertified)*
Prescriptions				
Generic	$10 Copay	Network Copay + 50% of Remaining Cost	$10 Copay	Network Copay + 50% of Remaining Cost
Preferred Brand	$30 Copay		$30 Copay	
Non-Preferred Brand	$50 Copay		$50 Copay	
Mail Order (90-Day Supply)	2x Retail Copay		2x Retail Copay	
Allergy Injections	No copay for injections rendered without an office visit.	60%*	No copay for injections rendered without an office visit.	70%*
Emergency Room	$150 Copay - Does Not Include X-Ray		$150 Copay - Does Not Include X-Ray	
Urgent Care	$20 Copay	60%*	$20 Copay	70%*
Ambulance	80%*		90%*	
X-Ray (Including CAT/MRI/PET/ EKG)	Bone Scan and Mammogram – 100% All Other – 80%*	60%*	Bone Scan and Mammogram – 100% All Other – 90%*	70%*
Laboratory	100%	60%*	100%	70%*
Maternity	$20 Copay Initial Visit Then 80%*	60%* $500 copay/occurrence, 60%*	$20 Copay Initial Visit Then 90%*	70%* $500 copay/occurrence, 70%*
Outpatient Physical Therapy	$20 Copay	60%*	$20 Copay	$70%*

Medical Insurance Plans

Administered By UMR

UMR
A UnitedHealthcare Company

Continued……

** Subject to the Deductible/Coinsurance*				
Benefit Overview	**Standard PPO**		**Choice PPO**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Speech, Hearing, and Occupational Therapy	$20 Copay	60%*	$20 Copay	$70%
Durable Medical Equipment	80%*	60%*	90%*	70%*
Human Organ Transplant	80%*	Not covered Out-of-Network	90%*	Not Covered Out-of-Network
Home Health Care	80%*	60%*	90%*	70%*
	(100 visits/calendar year; combined in- and out-of-network)		(100 visits/calendar year; combined in- and out-of-network)	
Hospice	80%*	60%*	90%*	70%*
Skilled Nursing Facility	80%*	60%*	90%*	70%*
	100 days/calendar year		100 days/calendar year	
Vision Care	$20 Copay/visit; 1 visit/12 months; $130 payable		$20 Copay/visit; 1 visit/12 months; $130 payable	
Massage Therapy	$25 Copay	$25 Copay	$25 Copay	$25 Copay
Chiropractic Care/ Acupuncture	$25 Copay	60%*	$25 Copay	70%*
	$1000 total calendar year maximum		$1000 total calendar year maximum	
Mental Health Care Inpatient	80%*	60%*	90%*	70%*
Substance Abuse Inpatient	80%*	60%*	90%*	70%*
Mental Health / Substance Abuse Outpatient	$20 Copay	60%*	$20 Copay	70%*
Preventative Care	100% for Routine Preventative services such as well child, routine physicals, mammograms, and colonoscopies.	60%* for Routine Preventative services such as well child, routine physicals, mammograms, and colonoscopies.	100% for Routine Preventative services such as well child, routine physicals, mammograms, and colonoscopies.	70%* for Routine Preventative services such as well child, routine physicals, mammograms, and colonoscopies.

Medical Insurance Plans
Preventive / Wellness Benefits

24-Hour Nurse Line: 866-494-4502

Phone number is also located on Insurance Card and at www.umr.com.

Preventive Care Office Visits: No copay; paid at 100% in-network

Mammogram: Plan covers one age-appropriate mammogram per year: no copay (regardless of code submitted under)

DEXA Screening: Plan covers one DEXA scan for osteoporosis screening (with referral) at 100% in-network: no copay

Colonoscopy: Plan covers recommended colonoscopies at 100% in-network; no copay

$500 Lifestyle Management Reimbursement Credit: Plan members can be reimbursed for lifestyle management educational classes.

Overview & reimbursement form can be found at www.umr.com and on the Bulletin Board: http://bboard/employee/benefits/lifestyle_management.pdf

Registered Dieticians: Plan covers nutritional counseling with a Registered Dietician: $20 copay (unlimited visits, no referral needed, currently an open network)

Providers can submit claim to UMR, or Members can pay provider and then submit Medical Claim Form to UMR for reimbursement.

Massage therapy (open network), **Acupuncture** (open network), and **Chiropractic** (in-network): $25 co-pay, $1000 bundled limit per year, no referral needed

Providers can submit claim to UMR, or Members can pay provider and then submit Medical Claim Form to UMR for reimbursement.

Tobacco Cessation Classes: Plan members can be reimbursed for tobacco cessation programs

Overview and reimbursement form can be found at www.umr.com and on the Bulletin Board. http://bboard.larimer.org/employee/benefits/Smoking_Cessation_Reimbursement_Form.pdf

Prescription and Over-The-Counter Tobacco Cessation Medications: Plan covers at 100%.

A prescription is needed for tobacco cessation medications to be processed with no copay.

NOTE: Please see the Larimer County Medical Insurance Plan Document for exact details.

Dental Insurance Plan

DELTA DENTAL

Delta Dental

Coverage Type	PPO plus Premier Dentist	Non-Participating Dentist
Type A – *Diagnostic & Preventive Services (exams, x-rays, cleanings)	100%	100% of R & C Fee**
Type B – Basic Services (fillings and other standard dental procedures)	80%	80% of R & C Fee**
Type C – Major Services (bridges and dentures, implants, TMJ, and other complex procedures)	50%	50% of R & C Fee**
Deductible* **		
Individual	$50.00	$50.00
Family	$150.00	$150.00
Annual Maximum Benefit		
Per Person	$1,500	$1,500
TMJ Maximum		
Per Person	$1,000	$1,000
Orthodontia— for children and adults	$1,000	$1,000

* ***Diagnostic and preventive care services do not count against the annual $1,500 maximum***

** R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by Delta Dental.

*** Applies only to Type B & C Services

See your Delta Dental brochure for more information on the benefits provided by the plan.

Advantages of the Delta Dental PPO Plus Premier Plan

- **Savings—**Delta Dental PPO dentists offer members the greatest savings so your annual maximum will go further. And you still save money if you need a service that is not covered. Non-covered services will be billed at a discounted rate if you go to a PPO dentist.
- **Choice**—If you choose to visit a Premier dentist, you will still see savings because Premier dentists also accept discounted fees (however, discounts are greatest when you see a PPO dentist.
- **Network**— To find a participating dentist, visit www.deltadentalco.com . Make sure you're searching for a PPO dentist. You may also call Customer Relations at 1-800-610-0201.

Vision Insurance

The County offers a comprehensive Vision program. Our plan provider is Vision Service Plan (VSP).

The benefits listed below are allowed if you use the VSP provider network. The policy pays up to a certain allowance for the following services.

If you use non-VSP providers, the policy will reimburse you a flat amount for covered services that you receive, as shown in the VSP benefit summary in the Document Library.

Vision Service Plan

This is a voluntary, employee-paid supplemental vision care plan. Note that this policy is completely separate from the one eye exam a year which is available through the medical insurance. See the *VSP Benefit Summary* for further details located in the ADP Portal / Benefits or contact the Human Resources Department @ 498-5983.

Your Coverage with a VSP Doctor

WellVision Exam®
focuses on your eye health and overall wellness

- $15.00 copay ..... ***every 12 months***

Prescription Glasses

- $15.00 copay

Lenses ..... ***every 12 months***

- *Single vision, lined bifocal, and lined trifocal lenses*
- *Polycarbonate lenses for dependent children*

Frame ..... ***every 24 months***

- *$130.00 allowance for a wide selection of frames*
- *20% off the amount over your allowance*

~OR~

Contacts (instead of glasses) ..... *every 12 months*

- *Up to $60.00 copay for your contact lens exam (fitting and evaluation)*
- *$130.00 allowance for contacts*

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam ..... *Up to $50*
Single vision lenses ..... *Up to $50*
Lined bifocal lenses ..... *Up to $75*
Lined trifocal lenses ..... *Up to $100*
Frame ..... *Up to $70*
Contacts ..... *Up to $105*

See clearly with the VSP Laser VisionCare℠ Program.

VSP Vision care for life

Find out if laser surgery is right for you.

1. Visit vsp.com.

- Get details about the program.
- Learn what to expect during surgery.
- Locate a VSP Laser VisionCare doctor.

2. Confirm your eligibility.

Before scheduling an appointment, sign on to **vsp.com** or call VSP® at **800.877.7195.**

3. Call your VSP Laser VisionCare doctor.

Verify that they participate in the program.

4. Schedule a complimentary screening.

If you decide to have laser vision correction, your VSP Laser VisionCare doctor will make arrangements with an approved laser surgeon and center, and provide your preoperative care.[1] Postoperative care is coordinated between your VSP Laser VisionCare doctor and your VSP laser surgeon.

VSP Discounted Pricing

You'll save an average 15% off the regular price or 5% off the promotional price from participating facilities[2] — which could add up to hundreds of dollars in savings.

Our Laser VisionCare Program is unique

You'll have peace of mind knowing VSP doctors and laser centers meet stringent quality standards. Plus, you'll have the assurance that your trusted VSP Laser VisionCare doctor will manage your laser vision correction care.

If you're nearsighted, farsighted, or have astigmatism, are at least 18 years old, and are in good health with no eye diseases, you could be a candidate for laser vision correction.

Contact us: **vsp.com | 800.877.7195**

[1] The laser vision correction screening and consultation with your VSP Laser VisionCare doctor are complimentary. If you have a preoperative exam and don't proceed with the surgery, your VSP doctor may charge an exam fee up to $100.

[2] The VSP Laser VisionCare Program is a discount plan only. Discounts only apply to services received from a VSP participating laser center. No monetary benefits are payable to members under this program.

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Basic Life / Accidental Death & Dismemberment and Long Term Disability

The following charts provide an overview of your Life/AD&D and long-term disability insurance plan benefits. These plans offer you and your family financial protection in the event of an illness, accident, or death. Basic Life/AD&D and Disability insurance are provided by Larimer County at no cost to you. You also may purchase optional life insurance for your dependents.

Basic Life with Accidental Death & Dismemberment

The Hartford

Coverage Type	Employee Coverage	Coverage Amount	Reduction in Coverage
Employee Coverage	100% Employer paid	Your annual salary or $10,000 (whichever is higher), up to $100,000.00. (Adjusts as salary changes)	Coverage begins to reduce at age 65: Age 65: 35% Age 75: 55% Age 80: 70%
Spouse Coverage	76¢ per month (Regardless of number of dependents covered)	$5000.00	
Dependent Coverage (Children between the age of 14 days & 6 months)		$500.00	
Dependent Coverage (Unmarried dependent children over the age of 6 months)		$2000.00	

Long Term Disability

The Hartford

Long-term disability insurance pays you a portion of your earnings if you cannot work because of disabling illness or injury.

Waiting Period	• 90 day waiting period before benefits begin
Amount Paid (Starting 4th Month)	• 60% of Insured Earnings starting the 4th month of a qualifying disability • Will pay up to 2 years (up to a max of $5000 per month), if you are disabled that long.
Amount Paid (After 2 Years)	• After 2 years, the definition of disability will change from "unable to perform your job" to "totally disabled from any job for which you are reasonably trained". • If your disability still qualifies, the policy would continue to pay you until you reach Social Security Age or until you are no longer disabled (if your disability does not qualify, the payments will stop).
Note about other group disability benefits	• This policy pays secondary to other group disability benefits (i.e., Workers Compensation, Social Security), if applicable. If you are receiving other qualifying payments, those payments will be subtracted from the amount that this policy will pay.
Pre-Existing Condition Clause	• If you have been treated for any medical condition in the three months immediately prior to your effective date and if that condition causes your disability in the first 12 months of your coverage, then no benefits will be payable under this policy. Once you have been covered for 12 months, the pre-existing condition limitation will no longer apply to you.

Supplemental Term Life Insurance

Voluntary Term Life
The Hartford

This is a voluntary, employee-paid supplemental term life insurance policy. Supplemental life insurance coverage is portable, so if you leave employment, you can take this coverage with you and continue to pay the same premium as if you were an active employee. All rates are guaranteed through 12/31/2013.

Coverage Type	Employee Coverage	Coverage Increments	Rates	Reduction in Coverage
Employee Coverage	$10,000 - $500,000	$10,000	See Chart	Coverage begins to reduce at age 65. Age 65: 35% Age 75: 55% Age 80: 70%
Spouse Coverage (Employee must be enrolled to obtain coverage for spouse)	$10,000 - $500,000	$10,000	See Chart	
Child/Children's Coverage (Employee must be enrolled to obtain coverage for children)	Up to $20,000	$2,000	$.05 per $1,000 of coverage	

Supplemental Life insurance coverage is portable, so if you leave employment, you can take this coverage with you and continue to pay the same premium as if you were an active employee.

Employee's Coverage: **Up to $500,000 (*Guaranteed Issue Amount = $150,000)**
Spouse's Coverage: **Up to $500,000 (*Guaranteed Issue Amount = $30,000)**
Child/Children's Coverage: **Up to $20,000**

(The employee must be enrolled to obtain coverage for a spouse or children)

Note: *The only time you are eligible to automatically get the "Guaranteed Issue" level of coverage is when you apply within 30 days of hire. If you don't sign up for the Guaranteed Issue Amount when you are first hired, you are subject to Hartford approval based on your health statement information if you wish to enroll or increase coverage in the future.*

SUPPLEMENTAL LIFE RATE CHART

(Cost Per Month/Per $1,000 of Coverage)

How To Use This Chart

To determine your monthly premium:

- ✓ Select the total amount of coverage you want.
- ✓ Divide by 1,000.
- ✓ Multiply the rate shown on the chart for your age.

Age of Employee or Spouse	Rate (Standard)
Less than 30	0.05
30 – 34	0.08
35 – 39	0.09
40 – 44	0.13
45 – 49	0.20
50 – 54	0.33
55 – 59	0.57
60 – 64	0.87
65 – 69*	1.68
70 and Over	2.72

Personal Health Application

New Hire applications for over the Guaranteed Issue Amount, applications for an increase in coverage, or applications after the new hire period has ended, require the completion of a Personal Health Application (available in the Document Library).

Your enrollment or increase will be subject to approval by Hartford based on the health information listed on the Personal Health Application. Hartford may contact you for further medical information, blood tests, physicals, etc., based on their review of your health statement.

Voluntary Accidental Death & Dismemberment

Voluntary Accidental Death and Dismemberment

The Hartford

Voluntary Accidental Death and Dismemberment (AD&D) insurance pays your beneficiary a death benefit if you die due to a covered accident, and also pays you a benefit for certain accidental losses. AD&D covers losses that occur away from work or at work. Benefits are paid in addition to any life insurance or Worker's Compensation benefits you collect.

Coverage	Family Member	Coverage Increments	Reduction in Coverage
◊ 100% of the amount of coverage purchased in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears. ◊ 50% for accidental loss of one limb, sight of one eye, or speech or hearing in both ears. ◊ 25% for accidental loss of thumb and index finger of the same hand	Employee	Increments of $25,000 to a maximum of $500,000	Coverage begins to reduce at age 65 Age 65: 35% Age 75: 55% Age 80: 70%
	Spouse	Increments of $25,000 not to exceed $250,000 or 100% of employee amount	
	Children	Increments of $5,000 not to exceed $25,000 or 10% of employee amount	

Rate Chart - Employee and

Amounts of Insurance	Your Cost	Spouse Cost
$25,000	$.50	$.50
$50,000	$1.00	$1.00
$75,000	$1.50	$1.50
$100,000	$2.00	$2.00
$125,000	$2.50	$2.50
$150,000	$3.00	$3.00
$175,000	$3.50	$3.50
$200,000	$4.00	$4.00
$225,000	$4.50	$4.50
$250,000	$5.00	$5.00
$275,000	$5.50	n/a
$300,000	$6.00	n/a
$325,000	$6.50	n/a
$350,000	$7.00	n/a
$375,000	$7.50	n/a
$400,000	$8.00	n/a
$425,000	$8.50	n/a
$450,000	$9.00	n/a
$475,000	$9.50	n/a
$500,000	$10.00	n/a

Rate Chart - Child(ren)

Amounts of Insurance	Child(ren)
$5,000	$.50
$10,000	$1.00
$15,000	$1.50
$20,000	$2.00
$25,000	$2.50

Flexible Spending Accounts

There are two types of Flexible Spending Accounts (FSA). The first is a Health Care Flexible Spending Account and the second is a Dependent Care Flexible Spending Account. **The plan year runs from January 1st through December 31st.**

- ✓ Your participation in a FSA plan allows a portion of your salary to be redirected to provide reimbursement for these types of expenses.
  - **Health Care:** To be eligible for reimbursement, the expense must be incurred for medical care that is not reimbursed from any other source. Medical care means the drug or service is needed to treat a medical condition.
  - **Dependent Care:** Work-related day care expenses for a qualifying dependent.

- ✓ At the beginning of each plan year, you elect a specific dollar amount for each FSA you wish to participate in.
  - **Health Care** - $2,500 maximum.
  - **Dependent Care** - $2,500 maximum if "married, filing separately" or $5,000 maximum if "married, filing jointly" or "single".

- ✓ Participation in one or both FSAs can save you money by reducing your taxable income because taxes will be calculated after the elected amount is deducted from your salary.

- ✓ Your taxable income will also be reduced for Social Security calculation; therefore, there may be a corresponding reduction in Social Security benefits.

"Use It or Lose It" Rule

Money remaining in your FSA account(s) **WILL NOT** be returned to you at the end of the plan year. Any amount remaining after the end of the run-off period (90 days from the end of the plan year) will be forfeited. Because of the "use it or lose it" rule, it is important for you to carefully estimate your out-of-pocket expenses for the upcoming plan year.

More Information

More information about the FSAs are provided on the following pages.

Available Accounts	What it covers	Contribution Maximums
Health Care	Expense must be incurred for medical care that is not reimbursed from any other source. Medical care means the drug or service is needed to treat a medical condition.	$2,500
Dependent Care	Work-related day care expenses for a qualifying dependent.	$2,500 (if 'married, filing separately') $5,000 (if 'married, filing jointly', or 'single')

Flexible Spending Accounts

WageWorks

The plan year runs from January 1st through December 31st.

What can a WageWorks Flexible Spending Account do for Me?

Save between 25% and 40% on everyday expenses.

Open a WageWorks Flexible Spending Account (FSA) during Open Enrollment and good things happen. You have money ready for eligible expenses not covered by your insurance, saving you 25% - 40%.

How does it work?

You can sign up for an FSA during open enrollment. Each paycheck, you set aside some of your pay, before taxes, to use for eligible expenses. This is how you save money: $100 put into your FSA is $100 to spend on eligible expenses. Without an FSA, you pay taxes, leaving $60 or $75 to pay for the same eligible expenses.

What is the take care®Card?

Use your **take care®** Card instead of cash or credit at health care providers and pharmacies for eligible services, goods, and prescriptions. Typical expenses include co-pays for doctor visits and prescriptions, dental and orthodontia expenses, vision care, prescribed over-the-counter (OTC) drugs and medications, and non-drug OTC items and devices.

Is it hard to use my FSA?

Using your FSA is easy.

When you elect a health care FSA, your account is funded wit the full amount you've chosen at the beginning of the year. As soon as that happens, it's ready to use for eligible expenses. Throughout the year, you 'pay your account back' with pre-tax contributions from your paycheck. Accessing your account is easy:

- **take care® Card.** Use it instead of cash at health care providers and wherever accepted for health-related services and health expenses.
- **Pay Me Back**. File a claim online, by fax, or mail for reimbursement.
- **On The Go.** Use our mobile website to view your account

You can also choose a WageWorks Dependent Care FSA to help with the cost of care for eligible children or aging parents while you are at work. A dependent care FSA works a lot loke a health care FSA, but your account is funded each payroll period, so funds are available as contributions are taken from your paycheck.

Flexible Spending Accounts

WageWorks

IMPORTANT INFORMATION

What is the take care Flexible Benefit Plan?
It's a benefit provided by your employer that lets you set aside a certain amount of your paycheck into an account before paying income taxes. Then, during the year, you can use funds in the account to pay for qualified expenses with the untaxed dollars. You are not taxed on the dollars you use in your take care account(s).

What are the benefits of participating in a Flex Plan?
Your biggest benefit is saving payroll withholding taxes. What that means to you is that you'll save $25 - $40 on every $100 you budget to pay for qualified expenses with the money in your flexible benefit account. That's because you don't pay taxes on the money you set aside each pay period for your flex account. (Your savings are based on the percentage of payroll taxes you would have paid had you not put your money into a flex account.)

What expenses qualify for payment with my Flex Dollars?
Most qualified expenses are for goods or services that you'll buy anyway. They include health care costs such as co-pays and doctors' fees; prescribed over-the-counter drugs and prescriptions; dental and eye care expenses; and day care expenses for dependents so you can work.

How do I pay for qualified expenses?
Your take care® Visa® flex benefits card is the most convenient way to pay. And what's best, you don't have to reach into your pocket when you use the card to pay qualified expenses. By paying with the card, your purchase is deducted from the appropriate balance in your take care account(s). Note: Effective January 1, 2011, you will not be able to use the take care card to pay for over-the-counter (OTC) medicines. These items must be paid for with a personal check, cash, credit or debit card and then a "Pay Me Back" claim must be submitted with a doctor's prescription for the OTC item(s) and a receipt, in order to be reimbursed from your flex benefit account.

Do I need to file claim forms?
You only need to file a claim when purchasing OTC items or when the merchant or provider does not accept your take care card. It is easy to file a claim. Just complete a claim form, attach a copy of the receipt(s), then send to your plan service provider. You'll receive your TAX-FREE reimbursement in a short time. Even if you use your take care card, you are required to keep receipts. Occasionally, you may be asked to provide documentation of purchases made with your take care card.

How does money get deposited into my account?
Through regular payroll deductions. It's that simple. Estimate how much you spend annually on the expenses that qualify to be paid from your flex account, then enroll! (See worksheet on page 6 of this booklet.)

How do I know how much is available for me to spend?
Your balance and other account details are always available online or by calling the Flex Hotline.

Must money be deposited in my account before I pay expenses or file a claim?
NO. The entire annual amount you elect for the Health Flexible Spending Account (FSA) is available on the first day and throughout the plan year. However, funds in the dependent care account are available only when they are deposited into your account.

I already have health insurance. Why should I participate in the Health Account?
The Health Account is used to pay for expenses not covered by insurance. These include co-pays, prescribed over-the-counter medications, glasses, contacts, orthodontics, and prescription drugs, just to name a few.

I don't use my employer's health insurance. Can I still save?
YES. You can still set aside money through regular payroll deductions (before taxes are taken out) to budget and pay for qualified expenses. Remember, a qualified expense paid from this plan cannot be reimbursed from another plan.

I take a dependent care credit on Form 1040. Will this Dependent Care Account save more?
The more you earn, the more you'll save. In addition, you'll also save social security tax (FICA) with a Dependent Care Account. So don't wait until April 15 to take the credit. Now you can save taxes on every paycheck. Which is best for you? Visit our website and use our easy calculator to determine your savings.

If I set aside part of my pay, won't I make less money?
NO. For every dollar you set aside to pay qualified expenses, you save FICA, federal income tax and (where applicable) state withholding. Your net take-home pay will increase by the taxes you save. Plus, when you pay a qualified expense or receive a cash reimbursement, it's TAX-FREE.

Can I change my contributions during the year?
YES, but only in certain situations. For the Health Account and Dependent Care Account, you can change your election if you have a change in status or a change in your employment or the employment of your spouse or a dependent.

What if I don't use all of the money in my account?
Generally, unused balances may not be paid to you in cash or used in a later year. However, for the Health FSA or Dependent Care Account, your employer may have elected to allow you to incur expenses up to 2-1/2 months after the plan year end and use the remaining plan year balance to reimburse those expenses.

What happens to my account if I terminate employment?
You may request reimbursement from your FSA for qualified expenses incurred prior to your termination. Check your Summary Plan Description for additional rights provided by your employer's plan.

Are there any negatives that I should know about?
Because you may not pay social security tax on the amount of gross pay you set aside for qualified expenses, your social security benefits at retirement may be slightly reduced. However most tax advisors recommend taking advantage of current tax-savings opportunities like take care. Also, if disability insurance is paid on a pre-tax basis, any future benefits you receive will be taxable.

take care®
by WageWorks

takecareWageWorks.com

TCWW_3622_TCPLB1 (Sep 2010)

Flexible Spending Accounts

WageWorks

Qualifying Expenses For Your Take Care Plan

- **Plan restrictions may apply. Check with your**
- **plan administrator.**

WageWorks

The following health care expenses qualify for reimbursement under your take care plan*

Only health care expenses not reimbursed by insurance can be claimed. **Prescription (Rx) required beginning 1/1/2011.**

- Acupuncture (excluding remedies and treatments prescribed by acupuncturist)
- Alcoholism treatment
- Ambulance
- Artificial limbs/teeth
- Chiropractors
- Christian Science practitioner's fees
- Contact lenses and solutions
- Co-payments (doctor, dental, vision, pharmacy
- Costs for physical or mental illness confinement
- Crutches
- Deductibles
- Dental fees (cosmetic procedures not eligible)
- Dentures
- Diagnostic fees
- Dietary supplements and vitamins with doctor's letter of medical necessity
- Drug and medical supplies (syringes, needles, etc.)
- Endodontist fees
- Eyeglasses prescribed by your doctor
- Eye examination fees
- Eye surgery (cataracts, LASIK, etc.)
- Hearing devices and batteries
- Home health care
- Hospital bills
- Insulin
- Laboratory fees
- Laser eye surgery
- Office visits
- Obstetrics and fertility
- Oral surgery
- Orthodontic fees
- Orthopedic devices
- Osteopath fees
- Over-the-counter drugs that are medically necessary like allergy medications, aspirin, or antacids (Rx)
- Oxygen
- Periodontist fees
- Physician fees (cosmetic procedures not eligible).
- Podiatrist fees
- Prescribed medicines
- Psychiatric care
- Psychologist and psychiatrist fees
- Radiology
- Routine physicals and other non-diagnostic services or treatments
- Smoking cessation over-the-counter drugs (Rx)
- Smoking cessation programs
- Surgical fees
- Weight loss over-the-counter drugs (Rx)
- Weight loss programs with a doctor's letter of medical necessity
- Wheelchair
- Vitamins, with doctor's letter of medical necessity
- X-rays & MRI

Items requiring a physician's letter listing a medical condition making the item necessary*

- Bedpans and ring cushions
- Boost ®/Pediasure ®
- Foot Spa
- Herbs
- Massagers
- Massages
- Minerals
- Multivitamins
- Oxygen
- Reconstructive surgery in connection with birth defect, disease, or accident
- Special supplements
- Special school for disabled child
- Special teeth cleaning system
- Therapeutic support gloves
- Vitamins
- Weight loss programs and fees pertaining to a specific disease
- Wigs for hair loss caused by disease

Health care expenses that <u>do not</u> qualify for reimbursement under an FSA plan. *

- Cosmetic surgery, procedures and/ or medications
- Dental bleaching
- Hair restoration (procedures, drugs, or medications)
- Health club or gym memberships for general health
- Marriage and family counseling
- Over-the-counter items, drugs, or medications that are not prescribed by your physician
- Weight loss programs for general health or appearance
- Mail order prescriptions from another country coverage
- Premiums you or your spouse pay for insurance coverage (Payroll-deducted premiums sponsored by your employer are eligible under the Premium Only Plan.)

*** Plan restrictions may apply. Check with your plan administrator.**

Flexible Spending Accounts

WageWorks

Accepted Over-the-Counter (OTC) items*

Antiseptics
Prescription (Rx) required beginning 1/1/2011.
- Antiseptic wash or ointment for cuts or scrapes (Rx)
- Antiseptic mouthwash (Rx)
- Benzocaine swabs (Rx)
- Boric acid powder (Rx)
- First aid wipes (Rx)
- Hydrogen peroxide (Rx)
- Iodine tincture (Rx)
- Rubbing alcohol (Rx)
- Sublimed sulfur powder (Rx)

Cold, Flu, Asthma, & Allergy Medications
Prescription (Rx) required beginning 1/1/2011.
- Allergy medications (Rx)
- Bronchodilator/Expectorant tablets (Rx)
- Bronchial asthma inhalers (Rx)
- Cold relief (liquid, tablets, or drops) (Rx)
- Cough relief (liquid, tablets, or drops) (Rx)
- Flu relief (liquid, tablets, or drops) (Rx)
- Medicated chest rub (Rx)
- Nasal decongestant spray, drops, or inhaler (Rx)
- Sinus and allergy nasal spray (Rx)
- Homeopathic sinus medications (Rx)
- Sinus medications (Rx)
- Vapor patch cough suppressant (Rx)

Diabetes
- Diabetic lancets
- Diabetic needles
- Diabetic supplies
- Diabetic syringes
- Diabetic test strips
- Glucose meters
- Glucose tablets (Rx)

Ear/Eye Care
Letter of Medical Necessity required from a physician (LOMN).
Prescription (Rx) required beginning 1/1/2011.
- Airplane ear protection (LOMN)
- Ear drops for swimmers (Rx)
- Ear water-drying aid (Rx)
- Earwax removal drops (Rx)
- Homeopathic earache tablets (Rx)
- Contact lens solutions

Health Aids
Prescription (Rx) required beginning 1/1/2011.
- Anti-fungal treatments (Rx)
- Denture adhesives
- Diuretics and water pills (Rx)
- Hemorrhoid relief (Rx)
- Lice control
- Medicated bandages
- Motion sickness tablets (Rx)
- Respiratory stimulant ammonia (Rx)
- Sleeping aids (Rx)

Pain Relief
Prescription (Rx) required beginning 1/1/2011.
- Arthritis pain reliever (Rx)
- Bunion and blister treatments (Rx)
- Itch relief (Rx)
- Orajel® (Rx)
- Pain relievers, aspirin and non-aspirin (Rx)
- Throat pain medications (Rx)

Personal Test Kits
- Cholesterol tests
- Colorectal cancer screening tests
- Home drug tests
- Ovulation indicators
- Pregnancy tests

Skin Care
Prescription (Rx) required beginning 1/1/2011.
- Acne medications (Rx)
- Anti-itch lotion (Rx)
- Bunion and blister treatments (Rx)
- Cold sore and fever blister medications (Rx)
- Corn and callus removal medications (Rx)
- Diaper rash ointment (Rx)
- Eczema cream (Rx)
- Medicated bath products (Rx)

Stomach Care
Prescription (Rx) required beginning 1/1/2011.
- Acid reducing gum, liquid, and tablets (Rx)
- Anti-diarrhea medications (Rx)
- Gas prevention (liquid, tablets, or drops) (Rx)
- Ipecac syrup (Rx)
- Laxatives (Rx)
- Pinworm treatment (Rx)
- Prilosec® (Rx)
- Upset stomach medications (Rx)

Over-the-Counter (OTC) items * Letter of Medical Necessity required from a physician (LOMN).

- Adhesive or elastic bandages
- Blood pressure meter
- Cold or hot compresses
- Eye drops (Rx)
- Foot spa (LOMN)
- Gauze & tape (LOMN)
- Gloves and masks (LOMN)
- Herbs (Rx)
- Leg or arm braces
- Massagers (LOMN)
- Minerals (Rx)
- Multivitamins (Rx)
- Saline nose drops (Rx)
- Special supplements (Rx)
- Special teeth cleaning system (Rx)
- Thermometers
- Vitamins (Rx)

OTC not acceptable *

- Aromatherapy
- Baby bottles and cups
- Baby oil
- Baby wipes
- Breast enhancement system
- Cosmetics
- Dental floss
- Deodorants
- Feminine care
- Hair regrowth
- Low “carb” foods
- Low calorie foods
- Oral care
- Petroleum jelly
- Shampoo & conditioner
- Skin care
- Spa salts
- Sun tanning products

S.125 Flexible Benefits Plan

A S.125 Flexible Benefits Plan allows you to pay for certain payroll-deducted insurance premiums with pre-tax dollars and establish pre-tax Health Care and Dependent Care Flexible Spending Accounts (FSA). Internal Revenue Code Sections 125 and 129 govern this plan, as well as the plan document. The County's plan year is January 1 through December 31.

Taxable Income Reduction: When you enroll in the S.125 Flexible Benefits Plan, you agree to reduce your taxable income. The money is, in effect, converted from income into a non-taxed benefit. This income reduction allows the County to fund your premiums and/or the eligible reimbursement accounts with pre-tax dollars. For example, if you make $2,500 per month and contribute to the FSA in the amount of $300 per month, your income is "reduced" so that you only pay income taxes on $2,200 per month. The advantage is that you are using non-taxed dollars instead of taxed dollars to pay for eligible expenses. Note that participating in the S.125 Flexible Benefits program will lower your Social Security reportable wages. This is the amount upon which your Social Security benefits are calculated.

Premium Conversion Portion: The premiums you can pay with pre-tax dollars are payroll-deducted health insurance, dental insurance, vision care insurance, and most Aflac supplemental insurance premiums (short-term disability is not pre-taxed). We will automatically deduct these premiums on a pre-tax basis, unless you request in writing to Human Resources to have them deducted after tax.

Flexible Spending Accounts Portion: You can also set up Health Care and Dependent Day Care Flexible Spending Accounts. See the Flexible Spending Accounts page for more information.

Open Enrollment Requirement: At the beginning of every new plan year (or when you are first hired), you make an irrevocable election of your benefits for the plan year. You cannot change your elections during the plan year unless you come in within 31 days of a qualified status change (see next section for more details).

Qualified "Status Changes": You cannot change your plan year benefits election mid-year, unless you make a new election within 31 days of an allowable "status change" as determined under the IRS regulations and the S.125 Flexible Benefits Plan Document. **Also Note:** Mid-year election changes will only be allowed if your change request is **consistent** with the change in status.

Qualified status changes include:

- Change in legal marital status (marriage, divorce, legal separation, annulment, spouse's death).
- Change in the number of dependents (includes birth, adoption, placement for adoption, death).
- Change in employment status of the employee, the employee's spouse, or the employee's dependent children (including ending or starting a job, or initial eligibility for insurance coverage through the employer).
- Change in coverage election on account of, and corresponding to, a change in insurance coverage under another employer's cafeteria plan, if the period of coverage for the other employer's cafeteria plan is different than the period of coverage of the County's plan.
- When a dependent satisfies, or no longer satisfies, the "dependent eligibility criteria" of the various insurance plans or the dependent day care provisions.
- Changes in coverage allowed under "special enrollment options" in compliance with HIPAA.
- Entitlement to COBRA continuation coverage.
- Gain or loss of Medicare or Medicaid entitlement for the employee or a dependent.
- Receipt of a Qualified Medical Child Support Order or similar court order either requiring the employee to provide coverage or no longer requiring the employee to do so.

Cost or Coverage Changes: You can also change your benefits election during the plan year if you make a new election within 31 days of the effective date of the following events:

1) **Premium Conversion:** If there is a significant change during the plan year in the cost of the premium(s) of any of the eligible insurance programs, or if any new eligible programs are offered by the County during the plan year.
2) **Dependent Daycare FSA:** If there is a cost or coverage change during the plan year for dependent day care which is provided by a day care provider who is not a relative of the employee
3) The cost or coverage change provision does not apply to the Health Care FSA Plan.

Plan Can Be Changed: While we expect to offer this plan for the foreseeable future, the County retains the right to amend, modify, or terminate this plan at any time.

Plan Document: Review the S.125 Flexible Benefits Plan Document for more specific information about each portion of the program, which is available in the Document Library.

Aflac Supplemental Insurance

In case of an accident or illness, Aflac insurance policies pay cash benefits directly to you, unless assigned, regardless of any other insurance you may have. Use the cash benefits for such expenses as:

- Deductibles, co-payments, out of network charges, and any other expenses not picked up by your major medical coverage.
- Travel related expenses for treatment in distant medical centers, including airfare, hotels, and meals.
- Everyday living expenses like house (or rent) payments, car notes, groceries, and utility bills.
- Lost income, resulting in a "double whammy" if the healthy spouse has to leave work to care for the recuperating one.

Plus, there's no preauthorization or strings attached.

The Product	The Benefit	The Necessity
Accident Insurance Policy	Helps provide a financial cushion if an accident occurs	An injury can be just as debilitating as an extended illness – suspending or stopping the physical capacity to earn a living.
Cancer/Specified-Disease Insurance policy	Helps with medical expenses related to cancer treatment	In the United states, men have slightly less than a 1-in-2 lifetime risk of developing cancer; for women, the risk is a little more than 1-in-3. About 1,479,350 new cancer cases were expected to be diagnosed in 2009.
Hospital Intensive Care Insurance Policy	Helps cover expenses related to confinement in a hospital intensive care unit (ICU)	ICU costs can soar well above those of a general room as well as above the benefit levels of major medical health insurance policies.
Hospital Confinement Indemnity Insurance Policy	Helps with the non-covered expenses of a hospital stay	In 2008, the average hospital expense, adjusted per inpatient day, was $1,782.28 and 63% of all surgeries were outpatient surgeries.
Short Term Disability	Helps provide a source of income in the event of a disability	About 62 million people in the United States have some disability that affects daily activity.
Specified Health Event Insurance Policy	Helps with the medical expenses related to a covered life-threatening health event.	Certain life-threatening events pose special financial risks because of their statistically high levels of incidence and cost.
Hospital Confinement Sickness Indemnity Insurance policy	Provides a physician feature that covers sickness, accident, and wellness visits in addition to the plan's basic sickness-only benefits	Illness rather than injury is the leading cause of emergency room visits.

Aflac Associates for Larimer County

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Aflac Supplemental Insurance

Rate Sheets

Colorado Payroll Premium rates are Monthly for industry Class B.
The rates shown on this insert page are for illustration purposes only they do not imply coverage. For more information about policy benefits and limitations, please refer to the accompanying product brochure for each insurance policy listed below.

ACCIDENT INDEMNITY ADVANTAGE 24-HOUR LEVEL ONE - Series A-35100

Age		Premium	Total
18-49	INDIVIDUAL	$21.71	$21.71
50-70		$21.71	$21.71
18-49	HUSBAND / WIFE	$28.99	$28.99
50-70		$28.99	$28.99
18-49	ONE-PARENT FAMILY	$32.76	$32.76
50-70		$32.76	$32.76
18-49	TWO-PARENT FAMILY	$41.21	$41.21
50-70		$41.21	$41.21

ACCIDENT INDEMNITY ADVANTAGE 24-HOUR LEVEL TWO - Series A-35200

Age		Premium	Total
18-49	INDIVIDUAL	$26.52	$26.52
50-70		$26.52	$26.52
18-49	HUSBAND / WIFE	$35.36	$35.36
50-70		$35.36	$35.36
18-49	ONE-PARENT FAMILY	$39.91	$39.91
50-70		$39.91	$39.91
18-49	TWO-PARENT FAMILY	$50.31	$50.31
50-70		$50.31	$50.31

AFLAC CANCER CARE PLAN SELECT - Series A78200

Age		Premium	IDR* (3 units)	SDR*	Total
18-75	INDIVIDUAL	$17.94	$3.51	$0.91	$22.36
18-75	INSURED/SPOUSE	$28.99	$7.80	$1.69	$38.48
18-75	ONE-PARENT FAMILY	$17.94	$3.51	$0.91	$22.36
18-75	TWO-PARENT	$28.99	$7.80	$1.69	$38.48

AFLAC CANCER CARE PLAN CLASSIC - Series A78300

Age		Premium	IDR* (3 units)	SDR*	Total
18-75	INDIVIDUAL	$31.72	$3.51	$0.91	$36.14
18-75	INSURED/SPOUSE	$53.95	$7.80	$1.69	$63.44
18-75	ONE-PARENT FAMILY	$31.72	$3.51	$0.91	$36.14
18-75	TWO-PARENT	$53.95	$7.80	$1.69	$63.44

IDR = Optional Initial Diagnosis Rider (Series A-78050) premium 1-5 units*

SDR = Optional Specified Disease Rider (Series A-78052) premium*

Aflac Supplemental Insurance

Rate Sheets

Colorado Payroll Premium rates are Monthly for industry Class B.
The rates shown on this insert page are for illustration purposes only they do not imply coverage. For more information about policy benefits and limitations, please refer to the accompanying product brochure for each insurance policy listed below.

PERSONAL SICKNESS INDEMNITY LEVEL ONE - Series A-45100

Age	INDIVIDUAL ONE PARENT FAMILY			INSURED/SPOUSE			TWO PARENT FAMILY					
	Premium	Rider*	Total	Premium	Rider*	Total	Premium	Rider*	Total	Premium	Rider*	Total
18-39	$19.90	$9.60	$29.50	$32.30	$14.40	$46.70	$36.30	$19.20	$55.50	$39.90	$23.70	$63.60
40-49	$22.60	$11.10	$33.70	$33.80	$15.00	$48.80	$39.40	$21.30	$60.70	$44.10	$25.20	$69.30
50-59	$28.10	$15.60	$43.70	$37.90	$17.10	$55.00	$49.60	$29.10	$78.70	$53.80	$30.60	$84.40
60-70	$39.10	$23.10	$62.20	$46.10	$24.30	$70.40	$67.90	$45.90	$113.80	$70.10	$47.10	$117.20

* 3 units of Optional Hospital Rider A45050 ($250 per unit) selected

AFLAC-SHORT TERM DISABILITY - Series A-57600
Elimination Period Accident/Sickness - 0/7 DAYS

Annual Income		$24,000	$26,000	$28,000	$30,000	$32,000	$34,000	$36,000	$38,000	$40,000	$42,000
Benefit Period	**Age**	**$1,200**	**$1,300**	**$1,400**	**$1,500**	**$1,600**	**$1,700**	**$1,800**	**$1,900**	**$2,000**	**$2,100**
3 MONTHS	18-49	$35.88	$38.87	$41.86	$44.85	$47.84	$50.83	$53.82	$56.81	$59.80	$62.79
	50-64	$42.12	$45.63	$49.14	$52.65	$56.16	$59.67	$63.18	$66.69	$70.20	$73.71
	65-74	$48.36	$52.39	$56.42	$60.45	$64.48	$68.51	$72.54	$76.57	$80.60	$84.63

AFLAC-SHORT TERM DISABILITY - Series A-57600
Elimination Period Accident/Sickness - 0/14 DAYS

Annual Income		$24,000	$26,000	$28,000	$30,000	$32,000	$34,000	$36,000	$38,000	$40,000	$42,000
Benefit Period	**Age**	**$1,200**	**$1,300**	**$1,400**	**$1,500**	**$1,600**	**$1,700**	**$1,800**	**$1,900**	**$2,000**	**$2,100**
3 MONTHS	18-49	$26.52	$28.73	$30.94	$33.15	$35.36	$37.57	$39.78	$41.99	$44.20	$46.41
	50-64	$32.76	$35.49	$38.22	$40.95	$43.68	$46.41	$49.14	$51.87	$54.60	$57.33
	65-74	$39.00	$42.25	$45.50	$48.75	$52.00	$55.25	$58.50	$61.75	$65.00	$68.25

Retirement Plan 401(a)

Principal Life Insurance Company
Des Moines, Iowa 50306-9394

Larimer County Contributory Retirement Plan and Trust
Contact: 8-01183

Eligibility and Entry
Effective January 1, 2010, eligible employees enter the plan upon employment

Pay
In general, pay is total pay from Larimer County, including mandatory contributions. Your employer can provide more detailed information.

For Regular Employees, you will be automatically enrolled to contribute the following amounts:

- 5% for the first 5 years in the plan.
- 7% for your 6th - 10th years in the plan.
- 8% for 11+ years in the plan.

Non-Deductible Contributions
You can increase your savings in the voluntary non-deductible (after-tax) contributions. The investment earnings are not taxable until you actually withdraw your account.

Employer Contributions
The employer contributions will be equal to the same percentage of your mandatory contributions.

Rollover Contributions
You may be allowed to rollover into this plan all or a portion of the retirement funds you have outside this plan. You may make rollover contributions immediately, prior to your entry date for other contributions as indicated above.

Vesting
You are always 100% vested in your mandatory contributions. You cannot forfeit these contributions. You are vested in Larimer County contributions based on years of service with your employer as shown below:

	< 5 Years	5+ Years
Vesting Percentage	0%	100%

Investments
Your retirement benefit plans intends to qualify as an ERISA §404(c) plan. This means that the Plan Fiduciary has transferred some responsibility for investing the retirement account to you. You are able to direct the investment of the retirement account balance by choosing among several fund options.

For the plan to qualify as an ERISA §404(c), you must be given:

- The opportunity to diversify your investment, and
- The ability to make an informed decision.

In order for you to make informed decisions, it is important that you attend the periodic educational meetings scheduled for your benefit and read the material (including prospectuses) available from your employer. You may obtain this information by calling our Client Contact Center at 1-800-547-7754.

Contributions will be automatically directed to the specific Principal LifeTime Portfolio, based on the year you turn 55, if you do not choose any investment option(s). Please contact us at 1-800-547-7754 for more details.

You may invest your contributions and employer contributions in any of the investment options offered by your plan. For detailed information about your investment options, please visit us at www.principal.com or contact us at 1-800-547-7754.

Please review the §404(c) information included in your enrollment kit. If you have any questions about the investment options available under the Plan, your 404(c) contact can assist you. The contact is:

LARIMER COUNTY BOARD OF RETIREMENT
2555 MIDPOINT DRIVE, SUITE A
FORT COLLINS, COLORADO 80525 - 4425
UNITED STATES OF AMERICA

Investment Mix Changes
You may change your investment direction for future contributions anytime.

Note that when transferring existing balances from one investment option to another, redemption fees or restrictions on transfer frequency may apply. Refer to the redemption fee and transfer restriction policy as you log into www.principal.com to view your account information or contact your Plan Administrator. Changes made through TeleTouch® (1-800-547-7754) and the internet are free. A charge will apply to all paper requests.

Account Information
You may obtain account information through:

- Retirement Plan Statement (quarterly)
- TeleTouch®
- Internet

Retirement Plan 401(a) - cont'd

Expenses
Each investment option charges an annual fund operating expense that varies depending on the investment option you choose.

When You Receive Benefits
Benefits are payable at:

- Retirement (age 55)
- Death
- Disability
- Termination of Employment

Financial Hardship
You may withdraw all, or part of, your mandatory contributions made prior to July 1, 1985, if you can prove financial hardship and are unable to meet your financial needs another way.

The hardship must impose a heavy and immediate financial need upon you for which other resources are not reasonably available. The hardship must be for one of the following reasons: certain medical expenses, to prevent your eviction from your principal residence, or the disability of you or your spouse.

Other Information
Your mandatory contributions do not affect your Social Security taxes or any of your other group benefits.

This is a brief summary of your employer's retirement plan. If there are any discrepancies between the summary and the plan document, the plan document will govern. Contact your employer if you would like to see the plan document.

Most withdrawals/distributions are subject to taxation and required withholding. Check with your financial/tax advisor on how this may affect you.

The Principal is required by the IRS to withhold 20% of any distribution eligible for rollover if not directly rolled over to another qualified retirement plan, an IRA, or used to purchase annuity to be paid over a minimum period of the lesser of 10 years or the participant's life expectancy. This withholding will offset a portion of federal income taxes you owe on the distribution.

The retirement account may be affected differently by individual state taxation rules. Contact your tax advisor with questions.

The Retirement and Investor Services - Client Contact Center at The Principal is available to answer questions about the retirement plan too. Please call 1-800-547-7754, Monday through Friday, 6:00am - 8:00pm (Mountain Time) to speak to a counselor.

Deferred Compensation Plans
Voluntary Retirement Savings

Under Section 457 of the Internal Revenue Code, public employees are able to save for retirement with pre-tax dollars by using a deferred compensation plan. The deferred compensation plan (also known as a 457 plan) allows you, on a voluntary basis, to invest part of your salary on a pre-tax basis to be paid to you at a later date. Note that the County does not make contributions to the deferred compensation plan. Neither your contributions nor your investment earnings are subject to current federal and state income taxes (but your earnings are subject to Social Security taxes). You will not owe state or federal income taxes on your 457 plan dollars until you receive payments from the plan, generally at retirement. You currently have a choice between two different companies that offer a 457 deferred compensation plan to Larimer County employees, The Hartford and Nationwide Retirement Solutions.

You can enroll in the deferred compensation plan at any time, and you may do so IN ADDITION to the County's mandatory retirement plan. For more information and enrollment forms, contact either the Human Resources Department or the Hartford or Nationwide representative(s). **See the deferred compensation plan brochures for more details** (available from the Human Resources Department or from the Hartford and/or Nationwide representatives).

Frequently Asked Questions:

1. **Do my contributions affect my Social Security Benefits?**
   No. Your total wages remain the same for Social Security purposes. Furthermore, amounts you receive from deferred compensation when you retire will not reduce your Social Security benefits.
2. **Is there a maximum amount I can invest each year?**
   Yes. The dollar limits on contributions in 2013 is $17,500. Special "catch-up" rules apply for participants age 50 and older, allowing you to make an additional "bonus" contribution. The upper limit of this extra amount is $5,500. There is also a pre-retirement catch-up, which allows you to defer up to twice the standard limit. The pre-retirement catch-up period runs for the three consecutive taxable years ending with the year before you reach our plan's normal retirement age.
3. **How does the amount I contribute affect my income taxes?**
   Your taxable income is reduced by the amount of money you defer. For example, if your annual salary is $24,000 and you contribute $2,000 to the 457 plan, your annual taxable income will show as $22,000 on your W-2 form. These adjustments are automatically made through the County's payroll system.
4. **When do I pay taxes on my account?**
   Under current law, income tax is due on amounts paid to you (contributions and earning) as you receive them. If your account balance is distributed over time, you only pay taxes each year on the amount you receive during that year.
5. **When can I stop contributing and may I restart later?**
   You may stop contributing at any time. Also, you may start your contributions at any time.
6. **Can I change the contribution amount?**
   Yes. You may increase or decrease your contribution amount as often as you like.
7. **What happens if I terminate my employment prior to retirement?**
   You may leave funds in the account; transfer them to another 457 plan; or roll them over tax-free to 401(k) and other tax-qualified plans, 403(b) annuities, other types of eligible plans that accept rollovers, or an IRA.
6. **When can I receive the money?**
   Generally at retirement, termination of employment, death, or in the event of an unforeseen, severe financial emergency. At the very latest, you begin receiving your account values no later than April 1st of the calendar year following the calendar year in which you attain age 70 ½ , unless you are still employed.
6. **What is an unforeseen, severe financial emergency?**
   The tax rules under Section 457 define a financial emergency as a real, unforeseen event which occurs for reasons beyond your control, such as unexpected unreimbursed medical expenses. Transportation, education, housing, or other expenses that can be "planned for" will not qualify for a hardship withdrawal request.
10. **Is there a 10% penalty tax imposed by the IRS on early withdrawals?**
    No. Under current law, the IRS does not impose the 10% tax penalty on early withdrawals made from a 457 plan.

Deferred Compensation Plans
Voluntary Retirement Savings

Nationwide Retirement Solutions

Securities offered through Nationwide Investment. Services Corporation, Member NASD.

~ The Smart Choice ~

457 Deferred Compensation Plan.

A deferred compensation plan is an employee benefit available to you by your employer under federal law. The program lets you defer, or "put aside", a portion of your earnings each pay period into an account for retirement.

When you contribute this portion of your income, up to a maximum of $17,500 annually in 2013, you reduce the amount that's taxable now. So you're not only investing for tomorrow, you're reducing your federal taxable income today.

- The tax advantages last for years. Not only are you deferring taxes on current income, but also deferring taxes on what your account may earn over the course of your employment.
- It's effortless. Your contributions are conveniently payroll deducted each pay period.
- It's diversified. The funding options allow you to choose among a variety of investment options, from extremely conservative to very aggressive.
- It's flexible. It's your money, so you decide how much to contribute. and when you leave public service, you choose how your money will be made available to you.

To get more information, or to enroll in this valuable program, contact your local Retirement Specialist, Joe Pugliese, at (303) 452-6300 or (970) 214-7462. You may also contact him via email at pugliej1@nationwide.com.

See the Possibilities with The Hartford

457 Deferred Compensation Plan.

A Deferred Compensation Plan (DCP) is an arrangement that permits you, on a voluntary basis, to authorize a portion of your salary to be withheld and invested for payment to you at a later date. These salary deferrals, or "contributions" are allocated to the Plan's investment choices at your instruction. Neither your contributions nor any investment earnings are subject to current federal and (in most cases) state income taxes. Taxes become payable when the deferred income plus any earnings are distributed to you -generally at retirement, or separation from service.

It is widely accepted today that in order to have a comfortable retirement, you must rely on income sources other than your pension and Social Security benefits (if covered). *Your* employer's DCP is an important and valuable means for preparing for your retirement.

Aside from helping to create a nest egg for retirement, there are many advantages of participating in the DCP:

- ***You*** decide how much you want to contribute per pay period.
- ***You*** select the investment choices that you are comfortable with.
- ***You*** enjoy the convenience of payroll deducted contributions.
- ***Your*** contributions - and any earnings that may accumulate - are tax deferred until paid to you.

Remember, withdrawals are taxed as ordinary income. Early surrenders may also be subject to a Contingent Deferred Sales Charge (CDSC). Effective in 2002, a 10% federal income tax penalty may also apply to amounts distributed from your plan, which are attributable to an IRA or other qualified plan.

For additional information contact Hartford at 800-528-9009.
Or visit our web site at: http://retire.hartfordlife.com

Retired Public Safety Officer Notice

Tax-Free Payments for Retired Public Safety Officer's Insurance Premiums

A new, optional provision of the Pension Protection Act of 2006, allows qualified public safety officers to elect to subtract a total of $3,000 annually from their gross income for retirement plan distributions used to pay for accident, health or long-term care insurance premiums. These distributions may be excluded from gross income if they come from an eligible governmental retirement plan (such as a 401(a), 403(b) or 457(b) plan) that offers this option. Distributions must be paid directly to an insurance company. Qualified health insurance premiums are premiums paid for coverage by an accident or health plan or qualified long-term care insurance contract for the participant, spouse, or dependent(s). Distributions to surviving spouses and dependents are not eligible for this tax exclusion.

Who is an eligible public safety officer?

For the purposes of this provision, a public safety officer is defined by federal—not state—law. A public safety officer is defined in federal laws as an individual serving in a public agency in an official capacity, with or without compensation, including:

- Professional firefighters
- Individuals involved in crime and juvenile delinquency control or reduction, or enforcement of the criminal laws (including juvenile delinquency), including, but not limited to police, corrections, probation, parole, and judicial officers
- Officially recognized or designated public employee members of a rescue squad or ambulance crew
- Officially recognized or designated members of a legally organized volunteer fire department
- Officially recognized or designated chaplains of volunteer fire departments, fire departments, and police departments

Eligibility is also determined by employment status. To receive the tax benefit, a public safety officer must be severed from employment due to disability or attainment of the normal retirement age of 55. Further, the participant must have been serving as a public safety officer at the time of retirement or disability. Benefits attributable to service other than as a public safety officer qualifies for favorable tax treatment provided the participant severs from employment as a public safety officer because of retirement or disability with the employer maintaining the eligible governmental plan.

Who is not eligible?

- Dispatchers, 911 operators, and administrative personnel are not eligible
- Public safety officers who retire before the normal retirement age of 55 and who are not disabled are not eligible

How can eligible public safety officers get started?

If you are interested in additional information or would like to set up insurance premiums for direct payment, please contact:

Principal Financial Group
Jeff Kropf kropf.jeff@principal.com
(800) 543-4015, ext. 35757

Nationwide Retirement Solutions
(877) 677-3678

The Hartford
(800) 528-9009

Employee Assistance Program (EAP)

Call ComPsych® GuidanceResources® anytime for confidential assistance.

Call: **800.272.7255**
Go online: **guidanceresources.com**
TDD: **800.697.0353**
Your company Web ID: **COM589**

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. ComPsych® GuidanceResources® provides support, resources and information for personal and work-life issues. GuidanceResources is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

Someone to talk to.

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

Wellness

Take charge of your health.

HealthyGuidance® helps you make positive lifestyle changes. You and your spouse or domestic partner can get the tools and support you need to make smarter decisions about your health. This confidential program includes:

- Lifestyle coaching (Earn 4 wellness points upon completion.)
- Weight management (Earn 4 wellness points upon completion.)
- Tobacco cessation (Earn 5 wellness points upon completion.)

Call for an appointment with a health coach or go online to guidanceresources.com and click on the HealthyGuidance link.

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets™, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Just call or click to access your services.

Your ComPsych® GuidanceResources® Program

CALL ANYTIME
Call: **800.272.7255**
TDD: 800.697.0353
Online: **guidanceresources.com**
Your company Web ID: **COM589**

Employee Assistance Program (EAP)

NEW FOR 2012! Larimer County is now offering **Tobacco Cessation Counseling** to employees and their family members! **FREE!**

Commit to a New, Healthier You!

HealthyGuidance® is your employer-sponsored, FREE wellness coaching program to help you make positive lifestyle changes, with tools, resources and confidential support from Certified Health Coaches. Coaching programs are available for tobacco cessation, weight management and lifestyle coaching. A coaching program typically involves a flexible five-session coaching model with the same coach every session; these are offered only telephonically.

Tobacco Cessation

Earn **5** wellness points upon completion of coaching!

Kick the habit with help from your HealthyGuidance Tobacco Cessation Program. Get personal counseling and support to help you quit smoking and stay tobacco-free. Our certified tobacco counselors provide:

- One-on-one telephone counseling
- A customized assistance plan
- Helpful ideas and resources
- Behavior modification techniques
- Strategies to help you quit smoking for good

Weight Management

Earn **4** wellness points upon completion of coaching!

Look better, feel better and reduce your risk of illness with coaching and support from your HealthyGuidance Weight Management Program. Work one-on-one with a certified health coach by phone to create a weight management program just for you.

- Meal planning
- Fitting exercise into your busy schedule
- Exercise and healthy eating maintenance

Lifestyle Coaching

Earn **4** wellness points upon completion of coaching!

Work with a wellness coach to design goals to reduce specific risks. Our certified coaches are trained experts in stress management, nutrition, exercise and behavior change. Work on:

- Stress management
- Diabetes disease prevention
- Cardiovascular disease prevention

Start Today!

Call: **800.272.7255** TDD: 800.697.0353

Online: **guidanceresources.com**

Enter your company ID: **COM589**

COMPSYCH
Guidance Resources Worldwide

Holiday Schedule

All regular, probationary, elected, and appointed employees are entitled to paid holidays and up to two floating holidays as listed below. Temporary employees do not receive paid holidays, but will be paid for hours worked on a holiday.

Holidays occurring while an employee is on paid leave will be charged only to holiday leave. In order to be paid for a holiday, an eligible employee must be in a paid status both on the workday before and the workday after the holiday (days in "paid status" consist of a normal work day, compensatory time off, or any form of paid leave). If a department must continue operations on County holidays, employees of the department who are required to work on the holiday must be given an alternative day off to observe the holiday and must be paid for all hours worked on the holiday. The appointing authority shall designate when the alternate holiday shall be observed.

When a holiday falls on Saturday, it will be observed the preceding Friday; when a holiday falls on Sunday, it will be observed on the following Monday. The following days have been designated as County holidays.

New Year's Day ..... January 1st
Martin Luther King Day ..... 3rd Monday in January
President's Day..... 3rd Monday in February
Memorial Day..... Last Monday in May
Independence Day..... July 4
Labor Day ..... 1st Monday in September
Veterans Day..... November 11
Thanksgiving Day..... 4th Thursday in November
Day after Thanksgiving..... The day after Thanksgiving
Christmas Day ..... December 25
2 Floating Holidays..... Employee's choice with approval

- Newly hired eligible employees are granted two (2) floating holidays during their first calendar year of employment when the employment start date is on or prior to June 30th. Employees hired from July 1st through November 30th are entitled to one (1) floating holiday during their first calendar year of employment.

- Maximum Carryover Limit: Effective January 1, 2010, the maximum carryover limit for holiday leave (floating, accrued, and deferred) balances is 32 hours for full time benefited employees. A proportionate maximum carryover will apply to part time benefited employees' equivalent to four workdays at the part time holiday accrual rate they are receiving as of December 31st of each calendar year. An employee's holiday leave balance is in excess of the maximum carryover limit will be forfeited as of December 31st of each calendar year.

Accrual Charts

Vacation and Sick Leave

Newly hired employees must have been employed for a full bi-weekly period in order to start accruing sick and vacation time. Employees will receive their sick and vacation accruals on the last working day of the bi-weekly pay period. Sheriff's appointed officials are exempt from vacation leave policies. Elected officials do not accrue vacation leave.

Accrual and Usage

- Vacation and Sick pay are not granted in advance of accrual.
- Paid sick leave or paid vacation leave cannot exceed the employee's accrued leave balance.
- You can carry up to 1 ½ times the annual vacation accrual rate over until your adjusted service date.
- No maximum accrual limit is placed on sick leave.
- If a holiday occurs during a period of paid vacation or paid sick time, vacation or sick is not charged for that day.
- If an employee is on paid vacation and gets sick, the leave cannot be changed to paid sick leave.
- Please refer to the chart below for vacation and sick leave accruals.

* *Appointed officials accrue vacation at a slightly different rate. For more information please refer to the*

Hours Worked Per Week	Sick Leave Hours Accrued	Vacation Leave Hours Accrued			
		0 to < 5 Years	5 to < 10 Years	10 to < 15 Years	15+ Years
20 - 24	1.85	1.85	2.32	2.77	3.25
25 - 29	2.32	2.32	2.90	3.47	4.05
30 - 34	2.77	2.77	3.47	4.17	4.85
35 - 39	3.25	3.25	4.05	4.85	5.67
Full Time	3.70	3.70	4.62	5.55	6.47

Appointed Officials:

Hours Worked Per Week	Sick Leave Hours Accrued	Vacation Leave Hours Accrued			
		0 to < 4 Years	5 to < 9 Years	10 to < 14 Years	15+ Years
20 - 24	1.85	2.32	2.77	3.25	3.70
25 - 29	2.32	2.90	3.47	4.05	4.62
30 - 34	2.77	3.47	4.17	4.85	5.55
35 - 39	3.25	4.05	4.85	5.67	6.47
Full Time	3.70	4.62	5.55	6.47	7.39

2013 Bi-Weekly Pay Schedule

Pay Period	Pay Period Start Date:	Pay Period End Date:	Pay Day
1	Dec-13	Dec-26	Jan-04
2	Dec-27	Jan-09	Jan-18
3	Jan-10	Jan-23	Feb-01
4	Jan-24	Feb-06	Feb-15
5	Feb-07	Feb-20	Mar-01
6	Feb-21	Mar-06	Mar-15
7	Mar-07	Mar-20	Mar-29
8	Mar-21	Apr-03	Apr-12
9	Apr-04	Apr-17	Apr-26
10	Apr-18	May-01	May-10
11	May-02	May-15	May-24
12	May-16	May-29	Jun-07
13	May-30	Jun-12	Jun-21
14	Jun-13	Jun-26	Jul-05
15	Jun-27	Jul-10	Jul-19
16	Jul-11	Jul-24	Aug-02
17	Jul-25	Aug-07	Aug-16
18	Aug-08	Aug-21	Aug-30
19	Aug-22	Sep-04	Sep-13
20	Sep-05	Sep-18	Sep-27
21	Sep-19	Oct-02	Oct-11
22	Oct-03	Oct-16	Oct-25
23	Oct-17	Oct-30	Nov-08
24	Oct-31	Nov-13	Nov-22
25	Nov-14	Nov-27	Dec-06
26	Nov-28	Dec-11	Dec-20

LARIMER COUNTY
2013
HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice from Larimer County About Your Prescription Drug Coverage and Medicare."

Important Notice from Larimer 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 Larimer County and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Larimer County has determined that the prescription drug coverage offered by the Larimer County Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare – General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Larimer County Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Larimer County Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Larimer County prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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 Larimer County changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

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

For more information about Medicare prescription drug coverage:

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

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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 whether or not you are required to pay a higher premium (a penalty).

Date:	October 9, 2012
Name of Entity/Sender:	Larimer County
Contact--Position/Office:	Benefits Administrator
Address:	200 W. Oak Street, Suite 3200 Fort Collins, CO 80521
Phone Number:	(970) 498-5973

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

LARIMER COUNTY
IMPORTANT NOTICE
HIPAA Comprehensive Notice of Privacy Policy and Procedures

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.

This Notice is provided to you on behalf of:

Larimer County Medical Plan
Larimer County Dental Plan
Larimer County Vision Plan
Larimer County Long -Term Disability Plan
Larimer County Flexible Benefits Plan

These plans comprise what is called an "Affiliated Covered Entity," and are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we'll refer to these plans as a single "Plan."

The Plan's Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Larimer County that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians,

pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. *However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.*

Other Uses and Disclosures of Your PHI Not Requiring Authorization.

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Larimer County) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.

- **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization:

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to have an Opportunity to Object:

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

- ***To request restrictions on uses and disclosures:*** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

  Effective February 17, 2010, you can restrict disclosure of PHI for payment or health care operations if you pay the health care provider the full out-of-pocket cost.

- ***To choose how the Plan contacts you:*** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- ***To inspect and copy your PHI:*** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- ***To request amendment of your PHI:*** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- ***To find out what disclosures have been made:*** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

A new federal law, the American Reinvestment and Recovery Act of 2009 (ARRA) has made numerous changes to the rules governing PHI that is maintained by the Plan and its service providers (business associates). Effective September 23, 2009, any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach. The notice will be provided to you if the breach poses a significant risk of financial, reputational or other harm to you.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information or to Submit a Complaint

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process,* please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

John Gamlin
Assistant Human Resources Director
(970) 498-5978

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

UMR Medical Plan
Delta Dental Dental Care Plan
Vision Service Plan Vision Plan
The Hartford Long -Term Disability Plan
WageWorks Flexible Benefits Plan

Effective Date

The effective date of this Notice is: January 1, 2013

Larimer County Employee Health Care Plan
NOTICE OF SPECIAL ENROLLMENT RIGHTS

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 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Pam Stultz
Benefits Administrator
(970) 498-5983

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

Revised October 19, 2010

Women's Health and Cancer Rights Notice

Larimer County Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Larimer County Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Standard PPO: Individual deductible $1,000/$2,000; Family deductible $2,000/$4,000
Choice PPO: Individual deductible $500/$1,000; Family deductible $1,000/$2,000

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator, UMR, at 800-826-9781

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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 July 31, 2012. You should contact your State for further information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td rowspan="3">COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website:
http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
<tr><td>IDAHO – Medicaid and CHIP</td><td>MONTANA – Medicaid</td></tr>
<tr><td>Medicaid Website:
www.accesstohealthinsurance.idaho.gov

Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov

CHIP Phone: 1-800-926-2588</td><td>Website:
http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084</td></tr>
</table>

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INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: ttp://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647

RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA – Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can 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, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)
Revised 7/31/2012

Provider Contact Information

Insurance Type	Provider	Group Number	Contact Number	Website
Basic Life Insurance	Hartford Life Insurance	GL-677800	800-523-2233	www.thehartfordatwork.com
Deferred Compensation	Hartford		Service Center 800-528-9009	www.retire.hartfordlife.com
Deferred Compensation	Nationwide	0038660001	Joe Pugliese 970-214-7462 ---------- Participant Services 877-677-3678	http://www.nrsservicecenter.com/
Dental Insurance	Delta Dental	11386	800-610-0201	http://www.deltadentalco.com
Employee Assistance Program	ComPsych	COM589	800-272-7255	https://www.guidanceresources.com
Flexible Spending Accounts	WageWorks		800-950-0105	http://www.takecareWageWorks..com
Hearing Services Plan	EPIC Hearing Healthcare		866-956-5400	www.epichearing.com
Long-Term Disability	Hartford Life Insurance	GLT-677800	800-523-2233	www.thehartfordatwork.com
Medical Insurance	UMR	76-411073	800-826-9781	www.umr.com
Prescription Plan	Kroger Prescription Plans (KPP)		800-482-1285	http://www.kpp-rx.com
Retirement Plan (401a)	Principal Financial	801183	Service Center 800-547-7754	https://www.principal.com
Supplemental Insurance Policies	Aflac		Robin Mitchell or Jean Zuber 970-207-0600	https://www.aflac.com
Vision Insurance	Vision Service Plan	12065186	800-877-7195	https://www.vsp.com/
Voluntary Accidental Death and Dismember-ment	Hartford Life Insurance	ADD-507329	800-523-2233	www.thehartfordatwork.com
Supplemental Life Insurance	Hartford Life Insurance	GL-677800	800-523-2233	www.thehartfordatwork.com