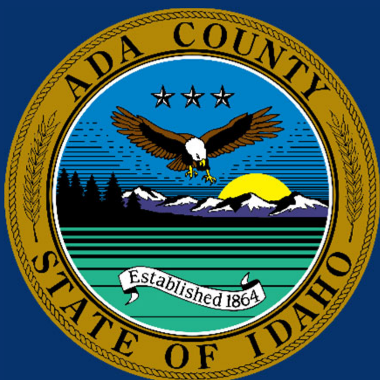
EMPLOYEE
Benefits Summary



ADA COUNTY

October 1, 2022 – September 30, 2023

October 1, 2022 through September 30, 2023

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Ada County is proud to offer a comprehensive benefits package to eligible employees who work 20 hours or more per week. The complete benefits package is briefly summarized in this booklet.

You share the costs of some benefits (medical, dental and vision), and Ada County provides other benefits at no cost to you (life, accidental death & dismemberment and short-term disability insurance). In addition, there are voluntary benefits with reasonable group rates that you can purchase through Ada County payroll deductions.

Benefits Include:

» Medical

» Dental

» Vision

» Basic Life Insurance w/ AD&D

» Additional Voluntary Life Insurance

» Short-Term Disability

» Voluntary Long-Term Disability

» Flexible Spending Account (FSA)

» Deferred Compensation Plan 457(b)

» PERSI Retirement & PERSI Choice 401(k)

» Aflac

» Paid Time Off

» Paid Parental Leave

» Paid Bereavement Leave

Who is Eligible?

You and your dependents are eligible for Ada County benefits on the first of the month following 30 days of continuous employment.

Eligible dependents are your legal spouse, children under age 26 or disabled dependents of any age. Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying life event (QLE).

If you become ineligible for benefits due to a change in work hours or through separation of employment, benefits coverage will end on the last day of the month during which that event takes place.

Employees will electronically enroll in and make changes to their benefits in AdaCentral.

Enrolling as a New Hire

You will participate in New Employee Orientation (NEO) generally within the first two weeks of your first day of work. In NEO, you will receive your benefit enrollment information. You will have 30 days from your start date to complete your online enrollment and return your required forms to Human Resources. Your benefits will then be in effect on the first day of the month following 30 days of continuous employment.

For example, if you were hired on March 13, your benefits would become effective on May 1.

Required Documents

You must provide documentation that proves the relationship of an eligible dependent. Documents are to be provided to Human Resources. If your dependent(s) is/are currently enrolled in Ada County benefits, electronic documentation is not required. Below are common documents used to establish proof of eligibility:

» Tax Returns; Birth Certificates; Court Documents
Other documents may be acceptable; please contact Human Resources for a more comprehensive list.

Making Changes to Your Enrollment Throughout the Year

You may qualify for a Special Enrollment Period throughout the plan year if you experience a qualifying life event (QLE). If the QLE is marriage, birth of a child, adoption or an eligible dependent becomes eligible for premium assistance with Medicaid or CHIP, you **must** login online to provide proof of dependent documents to HR **within 60 days** from the date of the QLE. If the QLE is gain/loss of other coverage, divorce, legal separation or exhaustion of COBRA, you must provide proof **within 30** days from date of the QLE. If the online request is not completed within the given timeline, you will have to wait until the next annual open enrollment period.

If you have a question about whether your life event is considered a QLE, please contact Human Resources at 208.287.7123 or employeebenefits@adacounty.id.gov.

Medical/Pharmacy Benefits

Administered by Regence BlueShield of Idaho

Ada County offers you a Preferred Provider Organization (PPO) medical plan. With the PPO, you may select where you receive your medical services. If you use in-network providers, your costs will be less.

Find In-Network Providers at: www.regence.com

	PPO In-Network	Out-of-Network
Lifetime Benefit Maximum	No Lifetime Maximum	
Annual Deductible	$350 individual / $700 family	$700 individual / $1,400 family
Annual Out-of-Pocket Maximum	$3,500 individual / $7,000 family	$7,000 individual / $14,000 family
Coinsurance	25%	40%
Doctor's Office		
Office Visits — Primary Care	$20 copay / visit	40% coinsurance after deductible
Office Visits — Specialist	$40 copay / visit	40% coinsurance after deductible
Wellness Care *(routine exams, x-rays/tests, immunizations, well baby care and mammograms)*	No charge	40% coinsurance after deductible
Prescription Drugs		
Retail — Preferred Generic Drug *(30-day supply)*	$15 copay	$15 copay
Retail — Non-Preferred Generic Drug *(30-day supply)*	$25 copay	$25 copay
Retail — Preferred Brand Name *(30-day supply)*	$50 copay after $350 deductible	$50 copay after $350 deductible
Retail — Non-Preferred Brand Name *(30-day supply)*	$100 copay after $350 deductible	$100 copay after $350 deductible
Mail Order — Preferred Generic Drug *(90-day supply)*	$30 copay	$30 copay
Mail Order — Non-Preferred Generic Drug *(90-day supply)*	$50 copay	$50 copay
Mail Order — Preferred Brand Name *(90-day supply)*	$100 copay after $350 deductible	$100 copay after $350 deductible
Mail Order — Non-Preferred Brand Name *(90-day supply)*	$200 copay after $350 deductible	$200 copay after $350 deductible
Speciality Drugs *(30-day supply)*	$150 copay after $350 deductible	$150 copay after $350 deductible
Hospital Services		
Emergency Room	25% coinsurance after $150 copay / visit	25% coinsurance after $150 copay / visit
Inpatient	25% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery	25% coinsurance after deductible	40% coinsurance after deductible
Ambulatory Surgical Center	10% coinsurance after deductible	40% coinsurance after deductible
Ambulance Service	20% coinsurance after deductible	20% coinsurance after deductible
Mental Health Services		
Inpatient Services	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Services	$20 copay / visit	40% coinsurance after deductible
Substance Abuse Services		
Inpatient Services	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Services	$20 copay / visit	40% coinsurance after deductible
Other Services		
Maternity Services	25% coinsurance after deductible	40% coinsurance after deductible
All Other Maternity Hospital / Physician Services	25% coinsurance after deductible	40% coinsurance after deductible
Spinal Manipulations *(20 spinal manipulations per claimant per plan year)*	25% coinsurance after deductible	50% coinsurance after deductible
Physical, Occupational and Speech Therapy Services	50% coinsurance after deductible	80% coinsurance after deductible
TMJ and Related Services *($2,000 lifetime maximum benefit)*	25% coinsurance after deductible	40% coinsurance after deductible
Home Health Care	25% coinsurance after deductible	40% coinsurance after deductible
Other Services *(Artificial limbs and other prosthetic devices; orthotic devices)*	25% coinsurance after deductible	40% coinsurance after deductible

Preventive Care

Administered by Regence BlueShield of Idaho

Preventive care and early detection are important for your long-term health. Ada County's Medical Plan covers in-network Preventive Services at 100%, with no copays, deductibles, or out-of-pocket costs. (services must be billed as preventive by your provider's office in order to be covered 100%). Examples of covered preventive care services include:

- Physical Exams for adults and children
- Prescribed Contraceptives
- Preventive Drugs – Covered 100%
- Colorectal cancer screening for adults
- Diabetes (Type 2) screening
- Immunizations for adults and children
- Blood Pressure Screening and tests to screen for high cholesterol and diabetes
- Hepatitis B Screening
- Hepatitis C Screening for adults at increased risk.
- Breastfeeding equipment and supplies
- Breast Cancer Screenings Breast cancer genetic test counseling (BRCA) for women at higher risk
- Breast cancer mammography screenings

Hearing Benefit

Your Regence BlueShield insurance will cover 100% of one ROUTINE in-network hearing examination per enrolled member every plan year. Hearing Aids are not subject to a deductible and the plan pays a maximum benefit of $3000 per plan year. Hearing aids are limited to two devices every 4 plan years.

Employee Assistance Program (EAP)

Administered by UPRISE Health

How well we deal with life's challenges is a key component to healthy living. Uprise offers several programs that help you balance your commitment to work with your commitment to your family. At no cost to you, you and your household members, or anyone dependent on your income, may receive up to six confidential counseling sessions for many issues, including those related to parenting, relationships, anxiety, and work stress.

Other services offered are:

» 24-Hour Crisis Help
» Short-term Counseling
» Online Consultations
» Legal Services
» College Preparation
» Online Legal Forms
» Home Ownership Resources
» Identity Theft Services
» Financial Services
» Online and Digital Resources

You can use EAP more than once. New sessions are available for each different problem you face. To access EAP services, simply call 800.395.1616 or go to https://uprisehealth.com/ and use the access code of: **GOADACOUNTY.**

Telehealth

Administered by Doctor On Demand

Telehealth for medical and behavioral health care
Doctor On Demand provides convenient care when you need it. Visit a doctor or therapist via video chat.

Your health plan includes telehealth powered by Doctor On Demand, a national leader in quality care. You can talk to any of Doctor On Demand's board-certified physicians, licensed counselors and psychiatrists by video chat using your computer or the app—
7 days a week, 365 days a year.

Common ailments treated via telehealth include:

Medical

- Allergy
- Cold and flu
- Constipation
- Ear problems
- Headache
- Infections
- Sinus infection
- Sore throat
- Sunburn
- UTI
- Nausea
- Pink eye
- Rashes

Behavioral Health

- Addictions
- Anxiety
- Depression
- Relationship issues
- Grief and loss
- Trauma and PTSD
- Stress management

Partners In Care

Administered by Regence BlueShield of Idaho

Support you can count on

Health care can be confusing and stressful, especially when you're dealing with a chronic condition or serious illness. The Partners In Care Program is here to make sure you have support, the right resources, and a listening ear. You will be connected with a Partners In Care ambassador who can be by your side on your health care journey.

How we can help

Partners In Care works with members dealing with long-term health care needs, chronic illness, transplants, frequent hospital admissions and complex claims issues. If this is you, your Partners In Care ambassador can:

- Coordinate care, including scheduling appointments and checking authorization status.
- Find a specialist, medical supplies you need or a pharmacy near you.
- Help you understand your benefits, coverage and out-of-pocket costs.
- Translate complex claims and address billing or payment issues.
- Identify potential gaps in your care and suggest additional support resources.

Want to learn more? Call the number on the back of your member ID card or reach out to us at PartnersInCare@regence.com.

Hinge Health

A no cost benefit for your back and joint health

Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your condition and a personal care team of experts. Best of all, there's no additional cost to you - 100% covered by your employer as part of your Regence health plan.

Sign up today for help with any of the following:

- Conquer pain or limited movement
- Recover from a recent or past injury
- Prepare for and recover from surgery
- Keep joints healthy and pain free

Eligibility: Participants must be 18+ and enrolled in a Regence BlueShield of Idaho medical plan.

To learn more call (855) 902-2777, or apply at HINGEHEALTH.COM/REGENCE-IDAHO

Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association. Hinge Health® is a separate and independent company that provides digital MSK services for Regence members.

Supplemental Programs

Aflac Supplemental Programs

Aflac pays cash benefits directly to you if you or an immediate family member is injured in an accident or becomes sick. Aflac pays regardless of any other benefits you may receive. You pay for Aflac coverage with after-tax dollars through convenient payroll deductions. You may enroll or discontinue Aflac policies at any time.

Please contact AFLAC to enroll: 208-609-3565

Dental Plan Options

Administered by Delta Dental of Idaho or Willamette

Ada County offers two dental plan options. Carefully review the Delta Dental PPO plan and the Willamette Dental Group plan to understand your options and determine which one is right for you and your family.

With **Delta Dental**, you may visit any licensed dentist; however, you will get the maximum benefit if you visit a PPO Provider for dental services.

When you visit a "Premier" Provider, you may pay more for services and reach your annual maximum quicker.

	Delta Dental	
	PPO Providers	**Premier Providers**
Annual Deductible	$25 Individual/ $75 Family	$25 Individual / $75 Family
Annual Benefit Maximum (Per Year)	$1,500 Per Member	
Covered Services		
Preventive/Diagnostic *(cleanings, exams, x-rays)*	Covered 100%	Covered 80%
Basic Services *(fillings, root canal therapy, oral surgery)*	Covered 80%	Covered 70%
Major (*extractions, crowns, inlays, onlays, bridges, dentures, repairs)*	Covered 50%	Covered 40%
Orthodontia Services (dependent children only)	Covered 50% up to a lifetime maximum of $1500	Covered 50% up to a lifetime maximum of $1500

Ada County offers access to the Amplifon hearing discount program through Delta Dental. The package provides custom hearing solutions, a risk-free 60-day trial, continuous care, and a hearing aid low price guarantee. To learn more, visit www.amplifonusa.com/ddid or call 1.866.921.3974.

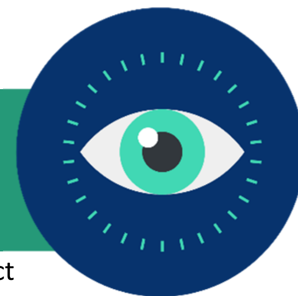
Willamette Dental Group offers you and your family value-based benefits while you pay predictable, low copays. Here's how the plan works:

- No annual maximum, deductible or waiting periods with predictable out-of-pocket costs
- Benefit coverage at Willamette Dental Group locations only
- Extended hours: Monday – Friday 7am – 6pm and rotating Saturdays regionally
- Easy appointment scheduling – just call 1.855.433.6825
- Emergency services available in-person in 48 hours or less and on-call 24/7
- All dental specialty services available, including orthodontics for all ages

	Willamette Dental
Annual Deductible	Members can only receive services from providers at Willamette Dental Group Clinic
Annual Deductible	None
Annual Benefit Maximum (Per Year)	None
Office Visit Copay	$15 Copay
Diagnostic & Preventive Services	Covered with Office Visit Copay
Cleanings (1x per year)	Covered with Office Visit Copay
Fillings	Covered with Office Visit Copay
Crown	$150 Copay
Bridge (Per Tooth)	$150 Copay
Root Canal Therapy (Anterior/Bicuspid/Molar)	$60/$90/$120 Copays
Routine Extraction (Single Tooth)	Covered with Office Visit Copay
Surgical Extraction	$80 Copay
Comprehensive Orthodontia	$2000 Copay
Dental Implant Surgery	Benefit Maximum of $1500 per Calendar Year

Vision Plan

Administered by VSP



Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages.

Service	In-Network (any VSP provider)	Out-of-Network (any qualified non-network provider of your choice)
Eye Exam — *once every 12 months*	$20 copay for exam and/or eyewear	$20 copay for exam and/or eyewear. Then, the plan pays $46 and you pay the rest
Lenses — once every 12 months		
Polycarbonate lenses for children — once every 24 months	$0	Not covered
Single Vision Lenses	$0	The plan pays $55 and you pay the rest
Lined Bifocal Lenses	$0	The plan pays $75 and you pay the rest
Lined Trifocal Lenses	$0	The plan pays $95 and you pay the rest
Frames — *once every 12 months*	$150 Allowance towards frames (non-featured), $170 for featured brands, $80 for Costco frames, 20% discount for anything over the coverage limit.	The plan pays $50 towards your frames or contact lenses and you pay overage
Contact Lenses — *once every 12 months if you elect contacts instead of lenses/frames*	$150 allowance for contacts; copay does not apply. Contact lens exam (fitting and evaluation) Up to $60 copay	

No need for an ID card. To take advantage of your VSP vision benefit, simply contact a VSP provider and let them know you have VSP coverage — they handle the paperwork for you.

VSP members will continue to receive an extra $20 to spend when choosing a featured frame brand like bebe®, Calvin Klein, Flexon®, Lacoste, Nike, and more.

VSP also offers a hearing aid discount program through its partner, TruHearing. You can enroll in the TruHearing MemberPlus Program by going to www.truhearing.com/vsp/.

Flexible Spending Accounts (FSA)

Administered by PeakOne Administrators

You can save money on your healthcare and/or dependent care expenses with a FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to a FSA.

IRS FSA Contribution Limits for 2022	Annual Amount	Per Month Deduction
Annual Minimum	$24	$2
Annual Maximum	$2,850	$237.50

IRS Dependent Care Contribution Limits for 2022	Annual Amount	Per Month Deduction
Annual Maximum	$5000	$416.67

Here's How an FSA Works

1. You decide the annual amount you want to contribute to either or both FSAs based on your expected healthcare and/ or dependent childcare/ elder care expenses.
2. Your contributions are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA account.
3. You can pay with the Healthcare FSA **debit card** for eligible healthcare expenses. For dependent care, you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim online or you may use the debit card.
4. You are reimbursed from your FSA. So, you actually pay your expenses with tax-free dollars.

Life & Disability Benefits

Insured by New York Life

Basic Life and Accidental Death & Dismemberment Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump-sum payment if you die while employed by Ada County. The County provides Basic Life Insurance at no cost to you if you are a benefit eligible employee.

Basic Life and Accidental Death & Dismemberment Insurance		
Employee Basic Life Insurance	1x annual salary	Up to maximum of $50,000
Accidental Death Insurance	1x annual salary	Up to maximum of $50,000

Short-Term Disability Insurance

Short-Term Disability (STD) insurance provides income if you become disabled due to an injury or illness and is provided to you at no cost. Benefits begin on the seventh day of any injury, hospitalization or illness and can continue for up to 26 weeks.

Benefit Amount — 60% of weekly covered earnings

Benefit Maximum — $1,000 per week

Please contact Human Resources for more details.

Ada County offers Basic Life Insurance, Accidental Death & Dismemberment and Short Term Disability at **no** cost to you. Additional Life and Disability Insurances can be elected at your discretion.

Voluntary Life Insurance

You can purchase additional life insurance for you, your spouse and your children. You pay the cost of coverage with after-tax dollars, but you can do so with convenient payroll deductions.

You may purchase life insurance in addition to the company-provided coverage. You may also purchase life insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage as a new hire (up to five times your salary with a maximum of $150,000, and up to $30,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee — Lesser of 5 times salary or $500,000 maximum amount in increments of $10,000

Spouse— Up to $250,000 in increments of $10,000 (Spouse Life Insurance benefits cannot exceed 50% of employee's Life Insurance Benefits)

Children 15 days to 26 years — Up to $10,000 in increments of $1,000

Voluntary Decreasing Term Life Insurance — Idaho NCPERS Plan

Administered by Member Benefits

As an eligible PERSI participant, you may also enroll in a voluntary decreasing term life insurance program, the Idaho NCPERS Plan. You may enroll at the time you begin working for Ada County or during Open Enrollment for $16 a month.

NCPERS Members				Dependent Group Decreasing Term Life	
Member's Age at Time of Claim	Group Decreasing Term Life	Group AD&D	Total Benefit for Accidental Death	Spouse/ Domestic Partner	Child(ren)*
Less than 25	$225,000	$100,000	$325,000	$20,000	$4,000
25 to 29	$170,000	$100,000	$270,000	$20,000	$4,000
30 to 39	$100,000	$100,000	$200,000	$20,000	$4,000
40 to 44	$65,000	$100,000	$165,000	$18,000	$4,000
45 to 49	$40,000	$100,000	$140,000	$15,000	$4,000
50 to 54	$30,000	$100,000	$130,000	$10,000	$4,000
55 to 59	$18,000	$100,000	$118,000	$7,000	$4,000
60 to 64	$12,000	$100,000	$112,000	$5,000	$4,000
65 and over	$7,500	$7,500	$15,000	$4,000	$4,000

Voluntary Long-Term Disability Insurance

Administered by New York Life

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your ability to earn an income. Ada County offers the option for employees to enroll in Long- Term Disability (LTD) insurance coverage. LTD coverage provides income when you have been disabled for 180 days or more. Your benefit is 60% of your monthly earnings, up to $6,000 per month. This amount may be reduced by other deductible sources of income or disability earnings. You are guaranteed coverage if you enroll as a new hire. If you wait to enroll, you will have to go through the evidence of insurability process that ensures you are in good health before benefits are issued.

Retirement Benefits

PERSI Plans

PERSI Base Plan

Participation in the PERSI Base Plan is mandatory. The Base Plan is a pension plan, designed to provide long-term benefits when you choose a career in public service. The County makes sizable contributions on your behalf. These are combined with your pretax contributions to provide a valuable source of future income. You are fully vested in the Base Plan after 60 months of credited service.

The Base Plan offers three types of retirement:

» Service retirement

» Early retirement (including the rule of 80/90, which means you may receive an unreduced retirement allowance if your years of credited service plus your age equal 90 (general members) or 80 (certified Members).

» Disability retirement

Your PERSI Base Plan Benefits Contributions

	County Contributions	Employee Contributions
General Members	11.94% of annual salary	7.16% of annual salary
Certified Members	12.28% of annual salary	9.13% of annual salary

PERSI Choice Plan 401(k)

Participation in the Choice Plan is voluntary, but you must be eligible for the Base Plan in order to participate. With the Choice Plan 401(k), you set aside a percentage of your income on a pretax basis. You can invest those contributions in a variety of investment options, although your funds will default into the PERSI Total Return Fund if you do not actively invest in other funds. You can also roll money over from another eligible retirement savings plan into the Choice Plan 401(k). Although it is not encouraged, you do have access to the money in your Choice Plan 401(k) through loans or withdrawals; you will pay taxes on the amount (if under age 59½) in addition to regular income taxes. You may also pay a 10% early-withdrawal penalty.

Ada County Deferred Compensation 457(b) Plan

Empower Retirement Services is the administrator and recordkeeper for the Ada County Deferred Compensation 457(b) Plan. With the Deferred Compensation 457(b) Plan, you contribute a percentage of your pay and the County will match your contributions up to 3% of your annual salary. You can select from a robust lineup of funds for your account investments, including target date funds that make managing your investments a lot easier. They are timed to the date you plan to retire and are professionally managed by a financial advisor. You may contribute to the pretax and/or post tax on the Roth option.

Contribution Limits

There are IRS limits on how much you can contribute to the PERSI Choice Plan 401(k) and the Ada County Deferred Compensation 457(b) Plan. When you contribute to both the Choice Plan 401(k) and Ada County's Deferred Compensation 457(b) Plan, you may contribute the maximum contribution amount ($20,500) to each plan type for a total contribution of $41,000 in 2022. The $20,500 maximum contribution to the Deferred Compensation 457(b) Plan includes Ada County's contribution. If you will be age 50 or older in 2022, you may also make additional catch-up contributions. You can make an additional catch-up contribution of up to $6,500 to each plan for a total catch-up contribution of $13,000 and an overall contribution maximum of $54,000. Please note the IRS can change these contribution amounts each year. Annual cost-of- living increases may occur.

Paid Time Off

When you need a few days away, Ada County understands. Whether you are taking time off to be with family and friends or you're trying to recover from an illness, sick time, vacation time or holidays are available so you can get paid while you're away. Or, if you don't need all of your sick time, you can save it to help you pay for health insurance when you stop working for the County.

Holidays

Ada County recognizes 11 paid holidays each year:

- New Year's Day
- Martin Luther King, Jr. Day
- Presidents' Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Columbus Day
- Veterans Day
- Thanksgiving Day
- Christmas Day

Sick Leave Policy

The County offers a sick leave policy separate from time off for vacation. The County's policy is designed to be there for you when you need it, but it also offers some benefit if you find you don't need to use the time off.

Eligibility — You are eligible for sick leave if you regularly work 20 hours or more each week.

Rate at which your sick time builds — Generally, you accrue up to a maximum of 3.7 hours every pay period, unless you are an EMS field employee, and then you accrue up to a maximum of 4.43 hours.

Sick Leave "Sweep" — If you accumulate a balance that is more than 240 hours at the end of the last pay period of the fiscal year (varies between September 18 and September 30, depending on the year), any hours you accumulated over 240 hours will be partially credited as a dollar amount to a Post-Employment Health Plan account through Nationwide. This can help you pay for insurance premiums after you stop working for the County. That credit is paid at 50 cents on the dollar.

When you can use your sick time— You can use your sick time as soon as it is available.

Paid Parental Leave

Ada County offers up to 8 weeks of paid parental leave in the event of a birth or adoption of a child. For additional information, please contact Human Resources at 208.287.7123 or employeebenefits@adacounty.id.gov.

Paid Bereavement Leave

In the unfortunate event of the death of an employee's immediate family member (spouse, child, parent, sibling, grandparent, grandchild, or the same relation by marriage), the employee will be allowed to use up to 5 days of paid leave for bereavement purposes relating to the death.

Vacation Leave

Eligibility for paid vacation leave begins as the leave is accrued from the first day of employment. Benefit-eligible employees, who regularly work twenty (20) or more hours per week, will accrue vacation leave.

Rate at which your vacation time builds

The amount of vacation time you accrue is tied to your years of continuous service with the County. Amounts are listed in the table provided.

Years of Continuous Service	Annual Accrual	Maximum Accrual
Benefit-Eligible Employees		
0–4 years	Approx. 96 hours/year for full-time employee	3.7 hours per 80 hour biweekly pay period; 400 hours total
5–9 years	Approx. 120 hours/year for full-time employee	4.62 hours per 80 hour biweekly pay period; 400 hours total
10–14 years	Approx. 144 hours/year for full-time employee	5.54 hours per 80 hour biweekly pay period; 400 hours total
15–19 years	Approx. 168 hours/year for full-time employee	6.47 hours per 80 hour biweekly pay period; 400 hours total
20 years +	Approx. 192 hours/year for full-time employee	7.39 hours per 80 hour biweekly pay period; 400 hours total
EMS Field Personnel		
0–4 years	Approx. 176 hours/year	6.77 hours per biweekly pay period; 560 hours total
5–9 years	Approx. 200 hours/year	7.70 hours per biweekly pay period; 560 hours total
10–14 years	Approx. 224 hours/year	8.62 hours per biweekly pay period; 560 hours total
15–19 years	Approx. 248 hours/year	9.54 hours per biweekly pay period; 560 hours total
20 years +	Approx. 272 hours/year	10.47 hours per biweekly pay period; 560 hours total

Employee Contributions for Benefits

Benefit Plan	Semi-Monthly Rate
Medical	
Employee	$20.00
Employee + Spouse	$112.50
Employee + Child(ren)	$67.50
Employee + Spouse + Child(ren)	$122.50
Delta Dental	
Employee	$0.00
Employee + Spouse	$18.50
Employee + Child(ren)	$26.50
Employee + Spouse + Child(ren)	$40.00
Willamette Dental	
Employee	$0.00
Employee + Spouse	$18.50
Employee + Child(ren)	$26.50
Employee + Spouse + Child(ren)	$40.00
Vision	
Employee	$0.00
Employee + Spouse	$3.50
Employee + Child(ren)	$4.50
Employee + Spouse + Child(ren)	$7.50

Rates based on $10,000 of benefits Maximum Accrual		
	Age	Rate
Voluntary Life Insurance	Less than 20	0.50
	20–34	0.70
	35–39	0.90
	40–44	1.30
	45–49	1.90
	50–54	3.10
	55–59	4.90
	60–64	7.60
	65–69	12.80
	70–74	24.30
	75+	49.10
Rates based on $100 of Coverage		
LTD Insurance	Less than 30	.144
	30–34	.167
	35–39	.205
	40–44	.341
	45–49	.568
	50–54	.887
	55–59	1.182
	60–64	1.258
	65–69	1.303
	70–74	1.341
	75+	2.410

Calculate the Cost of your LTD Coverage

To calculate the cost of your coverage, follow these steps:

1. Enter your gross or pre-tax monthly pay. Please note this amount cannot exceed $10,000 — $ ________
2. Enter the rate for your age group (see the chart above) — $ ________
3. Multiply gross pay (line 1) by the rate of your age group (line 2) — $ ________
4. Divide by 100 to determine the amount of premium that will be deducted from your paycheck each month — $ ________

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below:

Benefit	Administrator	Phone	Other
Medical	Regence BlueShield of Idaho	855.895.1150	Attn: ASO Correspondence, Intake and Appeals P.O. Box 2998 Tacoma, WA 98401-2998 www.regence.com
	The Regence employee portal can be accessed by going to their website and completing the registration process. You will need your member ID card and an active email address. Note: each member on your plan aged 13 and older must register for their own account.		
Employee Assistance Program (EAP)	Uprise Health	800.395.1616	www.uprisehealth.com Access Code: GOADACOUNTY
Dental PPO	Delta Dental of Idaho	208.489.3580	fax: 208.344.4649 www.deltadentalid.com
	The Delta Dental employee portal can be accessed by going to their website and completing the registration process. You will need your member ID or SSN, and date of birth.		
Dental HMO	Willamette Dental Group	855.433.6825	email: info@willamettedental.com www.willamettedental.com
	Willamette does not offer an employee portal		
Vision	Vision Service Plan	800.877.7195	www.vsp.com
	The VSP employee portal can be accessed by going to their website and completing the registration process. You will need the last 4 digits of your SSN, or your member ID number.		
Flexible Spending Accounts (FSA)	Peak One Administration	866.315.1777	fax: 855.495.3669 email: MemberCare@PeakOneAdmin.com www.PeakOneAdmin.com
	The Peak One Wealthcare Portal can be accessed by going to their website and completing the registration process. Your Employer ID is PK10005. Your Employee ID is 0005, the first initial of your first name, the first initial of your last name, and the last 5 digits of your SSN.		
Life Insurance and Disability	New York Life	800.644.5567	www.myNYLGBS.com
	The NYL employee portal can be accessed by going to their website and completing the registration process. You will need your name, date of birth, and zip code.		
Idaho NCPERS Life Insurance	Member Benefits	800.525.8056	ncpers@memberbenefits.com
	Member Benefits does not offer an employee portal		
Supplemental Benefits	Aflac	208.609.3665	
	Aflac does not offer an employee portal		
Base Plan (Pension)	PERSI	208.334.3365 800.451.8228	www.persi.idaho.gov
	The PERSI employer portal can be accessed for the first time by visiting mypersi.idaho.gov, and clicking “Register” and “Request New Pin”. For the security of your identity, a pin will be mailed to the address on file. Once you receive your pin, you may register your PERSI account. You will need your pin, SSN, name, date of birth, and email address.		
Choice 401(k)	PERSI	866.437.3774	www.mypersi401k.com
	The PERSI 401(k) employee site portal can be accessed for the first time by visiting mypersi401k.com and selecting the “register” button. Select “I do not have a PIN” and follow the prompts. The website will guide you through the registration process.		
Deferred Compensation 457(b)	Empower Retirement	800.701.8255	Retirement Plan Advisor 844.446.8658 ext. 20433 www.empower-retirement.com
	The Empower Retirement employee portal can be accessed for the first time by calling Customer Service at 800.701.8255, Monday-Friday 6 am-8 pm MST and Saturday 7 am-3:30 pm MST. Using the voice activated system, you will provide your SSN; when prompted for a pin, ask for a representative, and have your personal information readily available to verify your account and protect your identity.		
COBRA	Peak One Administration	887.404.9443	fax: 855.495.3669 email: Benefits@PeakOneAdmin.com www.PeakOneAdmin.com https://peak1.member.hrissuite.com
	The Peak One Wealthcare Portal can be accessed by going to their website and completing the registration process. Your Employer ID is PK10005. Your Employee ID is 0005, the first initial of your first name, the first initial of your last name, and the last 5 digits of your SSN.		

Availability of SBC (Summary of Benefits & Coverage) & Other Important Plan Notices

Federal law requires plan sponsors or issuers to provide a Summary of Benefits & Coverage (SBC) for each medical plan available. Plan sponsors are also required to provide a Summary Plan Description (SPD). In addition to these, there are other important plan notices that may be included in the SPD, and we encourage you to read these notices at your convenience. Your Summary of Benefits & Coverage (SBC), Summary Plan Document (SPD) and other Important Plan Notices are made available to you on your employee enrollment site to access anytime. To request a paper copy of please feel free to contact Ada County's HR Team and a printed copy will be provided to you at no cost.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that addresses the privacy and security of certain individually identifiable health information, called protected health information (or PHI). You have certain rights with respect to your PHI, including a right to see or get a copy of your health and claims records and other health information maintained by a health plan or carrier. For a copy of the Notice of Privacy Practices, describing how your PHI may be used and disclosed and how you get access to the information, contact Human Resources.

Patient Protection Notice

This health plan offered by Ada County allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from this health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan administrator or refer to your plan booklet for more information.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

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

1. All stages of reconstruction of the breast on which mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses.
3. Treatment of physical complications of the mastectomy, including lymphedema.

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the plan administrator.

Notice of Marketplace Coverage

Beginning in 2014, there is a new way to buy health insurance: The Health Insurance Marketplace. This notice provides some basic information about the Marketplace to help you determine if you are eligible for a premium tax credit.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP). More information can be found on www.healthcare.gov

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. Your employer, offers health coverage to you and your eligible family members that meets the standards set by the Affordable Care Act. Because you have this offer of qualified health coverage, you and your eligible dependents are not eligible for a tax credit through the Marketplace. If you decide to complete an application for coverage in the marketplace, you will be asked to provide information regarding the health plan offered by your employer.

The coverage offered by Ada County meets the minimum value standard and the cost of this coverage to employees is intended to be affordable based on employee wages.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage and could be penalized if you receive a premium tax credit from the Marketplace.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.
If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your medical carrier.

Medicare Part D Credible Coverage Disclosure Notice

This notice has information about your current prescription drug coverage with Ada County and about your options under Medicare's prescription drug coverage. If you or your family members are not currently covered by Medicare and won't be eligible for Medicare in the next 12 months, this notice does not apply to you.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- **Ada County has determined that the prescription drug coverage offered under the plans listed below are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current Ada County coverage will not be affected. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop this employer coverage, Medicare will be your only payer. You can re-enroll in the employer plan [at annual enrollment] or if you have a special enrollment event for the plan, assuming you remain eligible.

When Will You Pay A Higher Premium (Penalty) to Join a Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Ada County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1- 800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

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

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

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

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

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

WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022

UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Continued from previous page...

General Notice of COBRA Rights

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage.

Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Notes:

Booklet Developed in Partnership With

MURRAY GROUP