

Polk County Government Employee Benefits



We've Got You Covered

Polk County Benefits Brochure

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NOTE: BENEFITS BECOME EFFECTIVE ON THE FIRST DAY OF THE MONTH FOLLOWING THE EMPLOYMENT START DATE.

**Examples: An employee starting on February 1st is eligible on March 1st.
An employee starting on February 27 is also eligible on March 1st.**

About This Guide

This guide describes the benefit plans and policies available to you as a Polk County Government employee. The details of these plans and policies are contained in the official plan policy documents. This guide does not contain all of the details that are included in your Summary Plan Description and/or Certificates of Coverage.

Introduction

We've Got You Covered

Polk County Government is pleased to offer a comprehensive benefits program. This benefits guide contains important information you will need to understand your benefit options and enroll in the plans that will best meet needs of you and your family.

Please carefully review this guide and if you need assistance in order to fully understand the benefit options available to you, please contact your Benefits Office for assistance. By being a wise health care consumer, you can save both time and money.

Benefit Eligibility

If you are full-time or regular part-time employee working the minimum number of hours required by your constitutional office, you are eligible for of the benefits in this booklet.

The following benefits are available to your eligible dependents:

- Medical
- Vision
- Dental
- Dependent Life Insurance
- Employee Assistance Program (EAP)

Being a Wise Health Care Customer

Polk County is committed to making a significant investment in the health and welfare of our employees. It is important that both Polk County and our employees find ways to control rising health care costs and we encourage everyone to be a wise health care consumer. Controlling health care costs must be a partnership between you and Polk County. Together we can ensure a continued quality health care program that meets your needs in a cost efficient way.

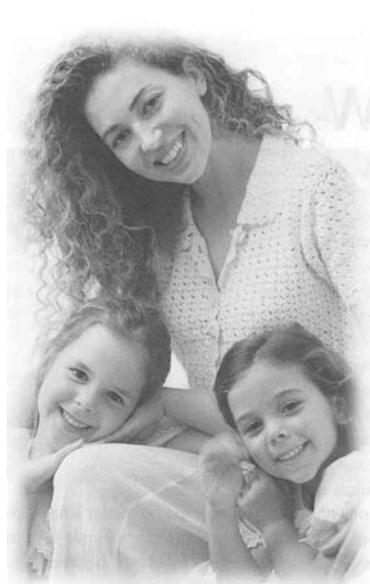
Part of being a wise health care consumer is asking questions of your providers if you don't understand something, getting second opinions when appropriate, and carefully reviewing your bills and Explanation of Benefits (EOB) for accuracy. The more you do to control costs, the better off you and the County will be in the long run.

Some other ways to do this include:

- Use network providers
- User generic and /or formulary drugs
- Practice preventive health care through disease management and a healthy life style
- Inform your Benefit Office when a dependent is no longer eligible
- Use walk-in clinics instead of emergency room care whenever possible; and/or access Aetna's 24 hour Informed Health Line, via website or the toll-free number on your ID card, for help in assessing the need for immediate care, if concern is not life-threatening

When Benefits Start and End

- Benefits become effective on the first day of the month following the employment start date. Examples: An employee starting on February 1st is eligible on March 1st. An employee starting on February 27 is also eligible on March 1st.
- Benefits are terminated on the last day of the month you become ineligible due to change in employment status or family status change.



Paying For Your Benefits

Benefit costs paid by you will be deducted from your paycheck, either before or after your taxes are calculated. Premiums for applicable benefits, as identified below, are automatically deducted by the County before taxes; however, you may opt out of this Premium Conversion provision on the Flex form provided with this booklet and all of your premiums will be deducted after taxes.

- Medical, Dental and Vision premiums, and premiums for Supplemental Life insurance up to \$40,000 may be deducted from your paycheck before your taxes are calculated.
- Supplemental Life over \$40,000, Dependent Life Insurance and optional (Option B) Long-Term Disability premiums must be deducted from your paycheck after your taxes are calculated.

Why pay for some benefits with before-tax money?

There is a definite advantage to paying for applicable benefits with pre-taxed premiums. Taking the money out before your taxes are calculated reduces your taxable income; therefore, you pay less in taxes. Premium Conversion is one of three Flex Plan accounts that employers are able to offer employees under prescribed IRS guidelines. Refer to the Flex Plan details on page 15 for more details.

Making Changes

Generally, you can only start, change, or end benefit coverages during the designated annual open enrollment period. Open enrollment for Medical, Life/LTD, Dental, Vision, and Flex is in November for a January 1st effective date. However, mid-year elections and/or changes are permitted if you have a family status change. Family status changes include:

- your marriage
- your divorce or legal separation
- birth, adoption or placement for adoption of an eligible child
- receipt of a Qualified Medical Child Support Order (QMCSO)
- change in your (or your spouse's) work status affecting benefits eligibility; such as, starting a new job, leaving a job, changing from part-time to full-time, starting or returning from an unpaid leave of absence.
- a significant change in health plan coverage/premiums for benefits provided through your spouse's employment
- a change in your child's eligibility for benefits
- becoming eligible for Medicare or Medicaid during the year
- death of your spouse or covered child

If you have a family status change, you must notify your Benefits Office ***within 31 days of the change***. Dependent upon the type of change, you may need to provide written documentation; such as a copy of your marriage certificate or a letter identifying an effective/termination date of other coverage, signed by an authorized employer or insurance company representative.

If you do not notify your Benefits Office within 31 days of the qualifying event, you will have to wait until the next annual enrollment period to make benefits changes (unless you have another family status change).

Any requests for benefit changes must be directly related to the family status change.



Dependent Eligibility

Eligible dependents are defined as follows:

- Employee's legal spouse
- Any dependent child from birth through the end of the calendar year they reach age 25, provided the child meets the following criteria:

Must be dependent upon employee for support, ***and*** must be living in the employee's household ***regardless of student status, or*** be a full-time or part-time student if living outside the employee's household. (See note below regarding Dependent Life student status requirement.) Dependent must be unmarried and have never been married.

- A totally disabled child, regardless of age, will continue to be covered if the child remains unmarried and dependent upon you for support. (Proof of disability will be required.)

***Dependent Life is available for dependent children up to age 19 and students up to age 25.**

Continuing Your Coverage

Under certain circumstances, health plan coverage may be continued when it would otherwise end. This provision is made available through COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). The County's COBRA plan is administered by AETNA and Initial Notices are mailed to the homes of every new employee to provide a detailed plan overview. If you and/or your dependents become eligible for COBRA, a personalized packet will be mailed to the last known address.

COBRA applies to the following plans:

- Medical
- Dental
- Prescription Drug
- Vision
- EAP/Mental Health & Substance Abuse
- Flex

When can I continue coverage under COBRA?

You and/or your dependents are eligible to continue health care coverage under COBRA if coverage is lost because:

- you leave Polk County employment for any reason other than "gross misconduct"
- your work hours are reduced
- you die
- you become entitled to and enroll in Medicare prior to losing coverage you
- you divorce
- your dependent loses dependent status

The chart below shows how long you can continue your COBRA coverage.

If you lose coverage because...	Then you can continue coverage for...
you are no longer eligible	18 months
You are no longer eligible and either you or a dependent is disabled (according to the Social Security definition) within 60 days of you loss of eligibility	29 months
If your dependent loses coverage because...	Then your dependent can continue coverage for...
of your death (or divorce)	36 months
you became eligible for Medicare after your COBRA election begins	36 months
he or she is no longer a dependent (because of age or marriage)	36 months

When COBRA Ends

COBRA coverage will end before the end of the eligibility period (see chart) if:

- you become covered under another group health plan after your coverage with Polk County ends (assuming your new plan complies with the HIPAA requirements regarding waiver of preexisting condition limitations)
- you become eligible for Medicare after your COBRA election begins
- you do not make premium payments with the designated grace period
- all Polk County group benefit plans are discontinued

If you have any questions about COBRA, please contact your Benefits Office.

Medical Insurance

For most people, medical insurance is no longer a "want" -it's a need. We've all seen the cost of medical care skyrocket over the years, so we need insurance to help protect not only our physical health, but our financial health as well. That's why the County offers two Medical plan choices to meet your needs:

(Aetna Choice POS II)
(Aetna Open Access Select)

The Health Plan is self-funded and AETNA is our Third Party Administrator. A comparison between these two plans can be found on page 7 of this booklet. Their customer service (**1-800-942-7154**) and/or the www.aetna.com web site may be accessed for network provider information, regardless of plan enrollment.

All plan participants are encouraged to log on to the *Aetna Navigator* web site to access personalized benefits/claims information, complete a Health Assessment and access a variety of other services.

Group #: 811370



About the Plans		
Please see the chart below for some important information about your Medical plan options.		
	Choice POS II	Open Access Select
Can you go to any doctor you want and receive benefits?	Yes, but you receive a higher level of benefits when you use providers in the network.	No, you must use providers in the network to receive benefits.
Must a Primary Care Physician (PCP) be designated and notice of a change in PCP be provided to anyone?	No. However, in most cases your PCP should be your first point of contact when you need medical care.	No. However, in most cases your PCP should be your first point of contact when you need medical care.
Does the plan require a referral from a PCP to a Specialist?	No	No
Is there a set limit to how much you would have to be pay in one year for the portion of covered expenses not paid by the plan?	Yes. There is a set out-of-pocket maximum that accumulates after deductible has been satisfied.	Yes and No. An out-of-pocket maximum is set; however, co-payment responsibilities are not limited.
Will you be "balance billed" for the difference above reasonable and customary charges?	Yes, but only when you use providers outside the network	No

Medical Plan Options

The Choice POS II and Open Access Select plans have identical nationwide network provider participation and the covered benefits are also the same; however, they differ considerably in the way eligible benefits are processed for payment. The Choice POS II covers eligible services provided by both in-network and out-of-network providers; whereas the Open Access Select plan has no out-of-network benefit except for required hospital emergency room services. The plan comparison on page 7 highlights a number of covered benefits to focus on the differences in claims processing and patient responsibility.

2008 Bi-Weekly Employee Premium Contributions	
Choice POS II	24 deductions/Year
- Employee Only	\$32.50
- Employee + One	\$80.00
- Employee + Two or More	\$115.00
Open Access Select	
- Employee Only	\$36.00
- Employee + One	\$89.50
- Employee + Two or More	\$129.00



The employee premiums listed above represent only a fraction of the plan costs. The Board of County Commissioners contributes the vast majority of the health plan's total cost.

Key Terms

Co-payment

The charge a plan participant is required to pay for certain eligible expenses. This would be a defined dollar amount and would be payable when services are received.

Co-insurance

A percentage of eligible expenses a plan participant is required to pay after the claim is processed and the plan has paid a certain percentage of eligible expenses. The amount the member pays will be applied toward the Out-of-Pocket Maximum.

Deductible

The dollar amount payable toward covered medical expenses each year before the plan issues any payments.

Out-of-Pocket Maximum

Covered expenses payable at a defined percentage (co-insurance) accumulate until a specified dollar amount is reached during a calendar year (January through December). The plan participant's co-insurance becomes 0% when the maximum is met and covered expenses are payable at 100%.

Reasonable and Customary

The amount usually charged by providers in a specific geographical location for a particular medical service. The Reasonable & Customary (R & C) limit is the standard on which claim payments are generally based unless there is a clearly defined schedule of benefit payments.

What you Pay

Service	CHOICE POS II		OPEN ACCESS SELECT
	When you use the network, YOU PAY...	When you do not use the network, YOU PAY...	When you use the network, YOU PAY... (No out-of-network benefit)
Annual Deductible* - per person - per family	\$250 \$750	\$400 \$1,200	None None
Out-of-Pocket Maximum** - per person - per family	\$1,500 \$4,500	\$3,000 \$9,000	\$2,000 \$6,000
Doctor's Office Visit (including Lab/X-ray)	20%*	40%*	\$20 (Primary Care Physician) \$30 (Specialists)
Diagnostic Services (Lab/X-ray except above)	20%*	40%*	10%
Well-child Care - office visit - specified immunizations	20%* 20%*	40%* 40%*	\$20 Zero
Adult Preventive Care (annual physical; prostate/ GYN exams)	20%*	40%*	\$20
Outpatient Surgery - Hospital/Surgical Center - Doctor's Office	20% 20%	40%* 40%*	\$100 Office Visit copay only
Maternity Care - Global fee for pre/post natal + delivery)	20%	40%*	10%
Hospital Care - pre-admission testing - with an overnight stay - no overnight stay	20%* 20%* 20%*	40%* 40% 40%*	10% 10% 10%
Emergency Treatment - emergency room - ambulance service	20%* 20%*	20%* 20%*	\$100 No Charge
Chiropractic Care	20%*	40%*	\$20
Lifetime Maximum Benefit	\$2,000,000	\$2,000,000	\$2,000,000

* After deductible has been satisfied

**Deductible and/or Co-payment amounts applied do not go toward the Out-of-Pocket (OOP) Maximum; therefore the Choice POS II has a 'true' OOP max but under the Open Access Select plan, co-payments will still apply after OOP max has been met. (Choice POS II network and non-network deductible/OOP accumulations cross-apply.)

This is not a complete list of covered services. Please refer to your Summary Plan Description (SPD) booklet.

Prescription Drug Plan

The County's Prescription Drug plan is managed and administered through PharmaCare (CVS/Caremark). Services may be provided through a number of national chain pharmacies, in addition to the PharmaCare affiliated CVS stores, and benefit is also available through some independent retail pharmacies for a 30-day supply or 90-day supply. Mail Order Service is available for a 90-day supply through PharmaCare Direct; which provides a savings of one-half of a co-payment, as co-payments are 2.5 times (instead of 3 times) that of the 30-day supply. The Prescription Drug Plan is provided to you at no additional cost in conjunction with the Medical Plan and cannot be purchased separately by an employee.



Visit the pharmacare.com web site to print a temporary ID card and obtain information about specific medications, network pharmacies, plan design, or other concerns. Or you may contact their customer service at 1-888-645-9303. Group Number = Z5M127538

A clinical pharmacist is available, onsite in the Risk Management Division, to assist plan members with their pharmaceutical regimen, as well as to coordinate participation in Disease Management programs that are designed to help ensure compliance to drug protocol while providing **free** medications to eligible program participants. The pharmacist may be reached at 534-5506.

Retail and Mail Service Co-Payments			
At a pharmacy (30-day supply) - Generic - Preferred Brand Name - Non-Preferred Brand Name	<u>Member Pays:</u> \$5.00 \$25.00 \$50.00	<u>Effective July 1, 2006</u> - All Brand Name Proton Pump Inhibitors (PPIs)	<u>Member Pays:</u> 50% of plan cost
Mail Order (90-day supply) - Generic - Preferred Brand Name - Non-Preferred Brand Name	<u>Member Pays:</u> \$12.50 \$62.50 \$125.00	- Weight loss; smoking cessation; brand name non-sedating antihistamines; anti-fungal and impotency drugs	<u>Member Pays:</u> 100% of plan cost (substantial discounts off retail price; no quantity limitations or prior authorizations)

- If you receive a brand name drug when a generic is available, you will pay the brand name co-payment plus the difference between the cost the generic and that of the brand name drug. Generic drugs will be automatically dispensed unless restricted by prescribing physician. If the prescribed drug has no generic equivalent, you can talk to the prescribing physician about generic alternatives in 'same class'.
- Non-Preferred brand-name drugs are identified in an alpha non-formulary list that is maintained and provided by the plan administrator. Please refer to it for less costly alternatives and take it with you to the physician's office. It can also be accessed via the pharmacare.com web site.

Vision Care Plan

SPECTERA SightSelect is our vision care vendor. Through a nationwide network of providers, employees and their eligible dependents can receive the following services subject to co-payments listed below, when services and materials are within the SightSelect standard level of benefits. In-network charges above and beyond the scope of the plan will be patient responsibility. Provider network information is available via the *spectera.com* web site or 1-800-638-3120. **No group # or ID cards issued.**



\$10 Exam Co-Payment
\$25 Material Co-Payment

- Complete Eye Examinations
- Eyewear – Lenses and Frames
- Contact Lenses in lieu of glasses, including:
 -four boxes (12 pair) of disposable Selection Lenses
 -\$105 allowance for Non-Selection Lenses
- Refractive Eye Surgery Discount

Out-of-Network Provider Benefit Availability:	
Service	Amount
Exam	Up to \$40
Single Vision Lenses	Up to \$40
Bifocal Lenses	Up to \$60
Trifocal Lenses	Up to \$80
Lenticular Lenses	Up to \$80
Frame	Up to \$45
Elective Contacts	Up to \$105
Medically Necessary Contacts	Up to \$210

In/Out-of-Network Benefit Availability:
Examinations: Every 12 months
Lenses: Every 12 months
Frame: Every 24 months
Contact Lenses: Every 12 months

2008 Bi-Weekly Employee Premium Contributions	
	24 deductions/Year
- Employee Only	\$3.32
- Employee + One	\$6.10
- Employee + Two or More	\$9.60

Dental Care Plan

Many people think they don't need dental coverage because their teeth are fine; but, if you want to keep your fine teeth, getting semi-annual checkups and cleanings is highly recommended.

Our MetLife group dental plan covers three main types of dental expenses, generally as shown below.

- **Preventive** (exams, cleanings, bitewing x-rays)
- **Basic** (extractions, fillings, sealants)
- **Major** (crowns, dentures)



BOTH OPTIONS \$50 Annual deductible	HIGH OPTION	LOW OPTION	
LOW OPTION \$1,250 Annual Max. HIGH OPTION \$1,750 Annual Max	When you see a network/non-network dentist, the plan pays...	When you see a network dentist, the plan pays...	When you see a non-network dentist, the plan pays...
Preventive Procedures	100% of a Preferred Dentist Program (PDP) negotiated fees in-network; 100% of usual and customary non-network fees.	100% of a Preferred Dentist Program (PDP) negotiated fees	Scheduled Allowable Benefit
Basic Procedures	80% of a PDP negotiated fees in-network; 80% of usual and customary non-network fees. (includes periodontics/endodontics)	73% of a PDP negotiated fees	Scheduled Allowable Benefit
Major Procedures	50% of a PDP negotiated fees in-network; 50% of usual and customary non-network fees.	48% of a PDP negotiated fees (includes periodontics/endodontics)	Schedule Allowable Benefit
Orthodontia*	No Benefit	No Benefit	No Benefit

* All County employees are eligible for discounts from Dr. Leo Durrett (25%); Dr. Timothy Ellis (10%) and PDP orthodontist agree to maximum fee.

- There are some benefit variations between the two plans. **See the Highlight Sheet** for benefit details.
- Preventive services are not subject to the deductible.
- The PDP provider network is the same for both plans and care may be provided from any dentist you choose under both plans. However, your out-of-pocket expenses would be less under both plans when a network provider is utilized.

• **Group #123509**

Visit the www.metlife.com web site for updated provider directory. Call **1-800-GETMET8** for any questions/concerns.

2008 Bi-Weekly Employee Premium Contributions	
High Option	24 deductions/Year
- Employee Only	\$13.47
- Employee + One	\$23.45
- Employee + Two or More	\$39.22
Low Option	
- Employee Only	\$6.49
- Employee + One	\$10.78
- Employee + Two or More	\$18.78

Life and AD&D Insurance

To paraphrase a television ad, “life insurance isn’t for you; it’s for the ones you leave behind.” Life insurance is an important part of your financial security, especially if others depend upon you for support. Everyone needs some life insurance. The need may not be as great if you’re single, but your beneficiary can use your life insurance to pay off your debts and other financial expenses.

That’s why Polk County provides:

- Basic Life Insurance for you at **no cost to you**
- Basic Accidental Death & Dismemberment (AD&D) Insurance for you at **no cost to you**
- Supplemental Life Insurance for you when purchased by you
- Dependent Life Insurance for your family when purchased by you

Basic Life and AD&D Insurance

- **Basic Life Insurance = \$10,000**
- **Basic AD&D Insurance = \$10,000**

Evidence of Good Health

If you do not enroll when you are first eligible or you choose insurance over certain limits, a Personal Health Statement (PHS) containing a series of health related questions must be submitted for Hartford Life underwriting approval.

What is AD&D Insurance

Accidental Death & Dismemberment Insurance – also called Accident or AD&D Insurance and it is similar to regular life insurance. If you die in an accident – for example, an automobile accident – the amount of your coverage is paid to your beneficiary. However, AD&D Insurance also pays a benefit if you are seriously injured in an accident. Part of your benefit may be paid to you lose a limb (like your arm) or the ability to see, hear or talk, or become physically disabled.



You will need to provide Evidence of Good Health if:

- You elect no coverage when eligible and later opt for coverage
- You want to increase your coverage during the annual benefits enrollment period by more than one coverage increment

For more information on any of the afore-mentioned Life insurance benefits, and/or Long-Term Disability insurance, you may refer to your Summary Plan Description or contact Hartford Life at 1-800-523-2233, or visit the www.hartfordlife.com web site.

Supplemental and Dependent Life Insurance

In addition to the employer paid \$10,000 Basic Life insurance, Supplemental Life insurance may be purchased by you to increase you death benefit, as well as Dependent Life coverage for your family.

<p>Supplemental Life Insurance:</p> <p>Current rate is \$0.39/\$1,000 of coverage. To assist you in determining your cost, a form is located in the inside back pocket of this booklet that identifies the bi-weekly and monthly premiums based on one times (1x) annual salaries ranging from \$5,000 to \$50,000.</p>	<p>Benefit Available: .5 to 5 times your annual salary up to \$400,000 maximum.</p> <p>Initial enrollment is your only opportunity to purchase up to 5x your annual salary without evidence of good health. During every annual open enrollment period, employees can increase their Supplemental Life by .5 or 1x their salary without completing a Personal Health Statement. If a new employee does not elect a Supplemental Life benefit at time of initial enrollment, a (PHS) must be submitted for underwriting approval (unless there is a related qualifying event).</p>																												
<p>Dependent Life Insurance:</p> <p>Cannot exceed 50% of the combined Basic Life & Supplemental Life coverage maintained by the employee. Benefit is based on the spouse's coverage amounts whether or not employee is married. A Plan costs cover unlimited number of dependents and is marketed as a packaged plan.</p>	<p>Six plans of varied coverage levels available:</p> <table border="1"> <thead> <tr> <th></th> <th>Spouse</th> <th>Children</th> <th>Cost/Payday</th> </tr> </thead> <tbody> <tr> <td>Plan 1</td> <td>\$25,000</td> <td>\$12,500</td> <td>\$2.12</td> </tr> <tr> <td>Plan 2</td> <td>\$20,000</td> <td>\$10,000</td> <td>\$1.69</td> </tr> <tr> <td>Plan 3</td> <td>\$15,000</td> <td>\$ 7,500</td> <td>\$1.27</td> </tr> <tr> <td>Plan 4</td> <td>\$10,000</td> <td>\$ 5,000</td> <td>\$0.85</td> </tr> <tr> <td>Plan 5</td> <td>\$ 5,000</td> <td>\$ 2,500</td> <td>\$0.68</td> </tr> <tr> <td>Plan 6</td> <td>\$ 2,500</td> <td>\$ 2,500</td> <td>\$0.54</td> </tr> </tbody> </table> <p>Children from birth to 6 months are eligible for \$100 maximum benefit.</p>		Spouse	Children	Cost/Payday	Plan 1	\$25,000	\$12,500	\$2.12	Plan 2	\$20,000	\$10,000	\$1.69	Plan 3	\$15,000	\$ 7,500	\$1.27	Plan 4	\$10,000	\$ 5,000	\$0.85	Plan 5	\$ 5,000	\$ 2,500	\$0.68	Plan 6	\$ 2,500	\$ 2,500	\$0.54
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<p>Portability Provisions</p> <p>Supplemental/Dependent Life Insurance may be continued when eligibility under the County ceases due to change in employment status or benefit eligibility.</p> <p>Conversion Privileges Note:</p> <p>Written application and required premium for either option must be received by Hartford within 31 days of the date group coverage terminates.</p>	<p>If member is under age 75, 50%, 75% or 100% of amount in effect may be maintained under a group portability policy at the same cost per \$1,000 (eff. 01/01/07). However, coverage will be reduced by 35% at age 65 and again at age 70. At age 75 the policy will terminate.</p> <p>A 'conversion policy' is available when loss of coverage occurs at any age and it is subject to a considerably higher age-rated group premium. The full amount of coverage lost (including Basic Life) may be converted.</p>																												

Long-Term Disability Insurance

How do you see yourself five or ten years from now? Chances are, you don't see yourself disabled. However, a surprising number of people do find themselves disabled and unable to work at some point in their lives.

The Long-Term Disability Plan helps you pay your household expenses if you become disabled and cannot work for an extended period of time. Core Long-Term Disability Insurance (**Option A**) is provided for you at **no cost to you**. If you want to enhance your coverage, you may pay an additional premium (**\$0.33/\$100**) and receive the benefits of the LTD Buy-Up (**Option B**).

When are you disabled?

You don't have to be bed-ridden to be considered disabled. However, you do have to be under a doctor's care. You are considered disabled if you cannot perform your job duties as a County employee.

Long-Term Disability	
Percent of your base pay that you will receive	60%
Maximum monthly benefit you can receive	You choose between two options: <ul style="list-style-type: none"> • Option A: \$1,000 • Option B: \$6,000
When benefits start	<p>Option A: After you have been disabled for 180 days</p> <p>Option B: After you have been disabled for 90 days</p>
How long you may receive benefits	Until you reach your Social Security normal retirement age, or 42 months, whichever is greater. If you become disabled after age 63, you may receive benefits past your normal retirement age.



EAP and Mental Health / Substance Abuse

An Employee Assistance Program (EAP) is designed to help employees and their families address problems that can create stress which affects both mental and physical well-being. AETNA has been selected to provide you and your eligible dependents with access to professional counseling at **no cost to you**.

You and your immediate family members may receive up to **three counseling sessions per problem per year** under the EAP benefit. Participation in the County's medical plan is not required for EAP benefit; however, additional care may be coordinated by AETNA under the Mental Health/Substance Abuse benefits provision, if you participate in the County's Medical Plan.

EAP Program Services

Counseling is available through the EAP for assistance with the following life challenges, as well as others:

- crisis situations
- parental concerns
- marital/relationship issues
- anxiety/depression
- alcohol and/or drug dependency
- stress/burnout
- illness or death of someone else
- anger management
- legal or financial questions/concerns
- dependent care questions/concerns

Confidentiality is Guaranteed

Any assistance you receive through AETNA EAP is completely confidential, as provided by law. Your name or treatment information will not be shared with anyone without your written permission.

How to Use the EAP

You can contact the Aetna EAP by calling:
1-888-AETNA-EAP (1-888-238-6232)

The nature of the call will determine how it is handled. You and/or your eligible dependent will communicate by phone with one of the program's personnel. If a face-to-face consult is requested, several provider names will be given from which to choose. The caller may schedule his/her own appointment or it will be handled for them. The provider will be given authorization for services and if the member makes their own appointment, they must get back in contact with Aetna EAP before seeing the provider. To access service or information online, log on to the www.aetnaEAP.com site using the company ID code: **POLKSEAP**

Schedule of Mental Health & Substance Abuse Benefits	
Inpatient Mental Health/Substance Abuse:	
Coverage:	Same as Hospital Inpatient for base medical plan
Annual Max:	30 days
Outpatient Mental Health/Substance Abuse:	
Coverage:	1 st Visit – No Copay Visits 2-10 -- \$10 Copay Visits 11-30 -- \$20 Copay
Annual Max:	30 visits
Deductible/co-insurance limits and Lifetime Maximum are combined with the Medical	

Flex Plan

FLEX accounts allow employees to pay for premiums and certain non-covered expenses before taxes are accessed, thereby reducing their taxable income. A Flexible Spending Account (FSA) is a great way for you to **save money**, as well as increase your take home pay! The plan runs from January through December and there are 24 payroll deductions per year. Participants in the Health Care/Dependent Care Flexible Spending Accounts must conservatively determine their annual expenses and designate the amount to be deducted each pay period.

• Health Care Reimbursement FSA –

Allows you to set aside money tax-free for payment and/or reimbursement of eligible expenses not paid by your insurance; including but not limited to deductibles, co-pays and/or co-insurance amounts for expenses in connection with medical, dental, vision, prescription drugs, hearing, and also eligible over-the-counter health care related expenses incurred for you or any family member. Participation in the County's medical plan is not required.

• Dependent Care Reimbursement FSA –

Allows you to set aside money on a tax-free basis to help you pay for child/elderly dependent care services that are necessary for you, (or you and your spouse, if married) to be gainfully employed.



AETNA FSA Streamlined vs. Debit Card

A debit card will be issued to allow you to pay for eligible goods and services directly from your FSA account. However, there are limitations as to when this debit card may be utilized. All **Aetna Medical and MetLife Dental** claims will be 'streamlined' and the debit card may not be used. With the 'streamline' feature turned on, the member will pay out-of-pocket expenses that are payable up-front (such as co-pays), at the point of service. The claim will be processed and it will be determined what the member owes and that amount is 'streamlined' over to the FSA system, and reimbursement is sent to the member. No paper claim will be required and the need for substantiation is eliminated. **(If the member prefers, they may turn the streamline feature on/off as they wish; the debit card still may not be used.)**

The Aetna FSA debit card may be used for prescription drug and over-the-counter purchases and generally no substantiation will be required. **(See highlight sheet for more details)** Vision plan out-of-pocket expenses are also eligible debit card purchases; however, substantiation must be presented for amounts other than the defined co-pays under the Spectra Vision plan.

Paper claims must be filed and substantiation will be required for services not received through the County's Aetna medical and MetLife dental plans.

Real-time account information may be accessed online via the Aetna Navigator, or you may use the following phone/fax numbers:

Phone: 1-888-238-6226

Fax: 1-888-238-3539