

2020 - 2021
Benefits Guide



2020-2021 Benefits at a glance

Medical Insurance

The Anthem Gold Plan provides a medical plan that includes a \$2,600 deductible per individual and 80% coverage when using an in-network provider. In addition, you have an 80% coinsurance, after deductible, for a physician office visit.

The Anthem Platinum Plan provides a medical plan that includes a \$2,000 deductible per individual and 100% coverage when using an in-network provider. In addition, you have a 100% coinsurance, after deductible, for a physician office visit.

Dental Insurance

Anthem provides rich benefits with the freedom of seeing any dentist, contracted or not; your benefits will be greater when you receive care from a contracted dentist.

Vision Insurance

Anthem provides coverage for eye exams, lenses and frames.

Critical Illness Insurance

Employees have the choice to enroll in additional coverage for critical illness. The plan would pay a cash benefit based on the diagnosis of a qualified critical illness. This can help with the costs your medical plan may not cover; such as deductibles or coinsurance.

Voluntary Accident Insurance

The accident policy offered through Sun Life offers additional coverage for accidents and injuries that may arise. The plan goes beyond your medical coverage and can help cover the costs of any accidental or unforeseen medical expenses.

Employee Assistance Program

Health Advocate is an Employee Assistance Program available to you and your dependents.

EAP Services include help locating providers, assistance with personal or financial issues, and more.

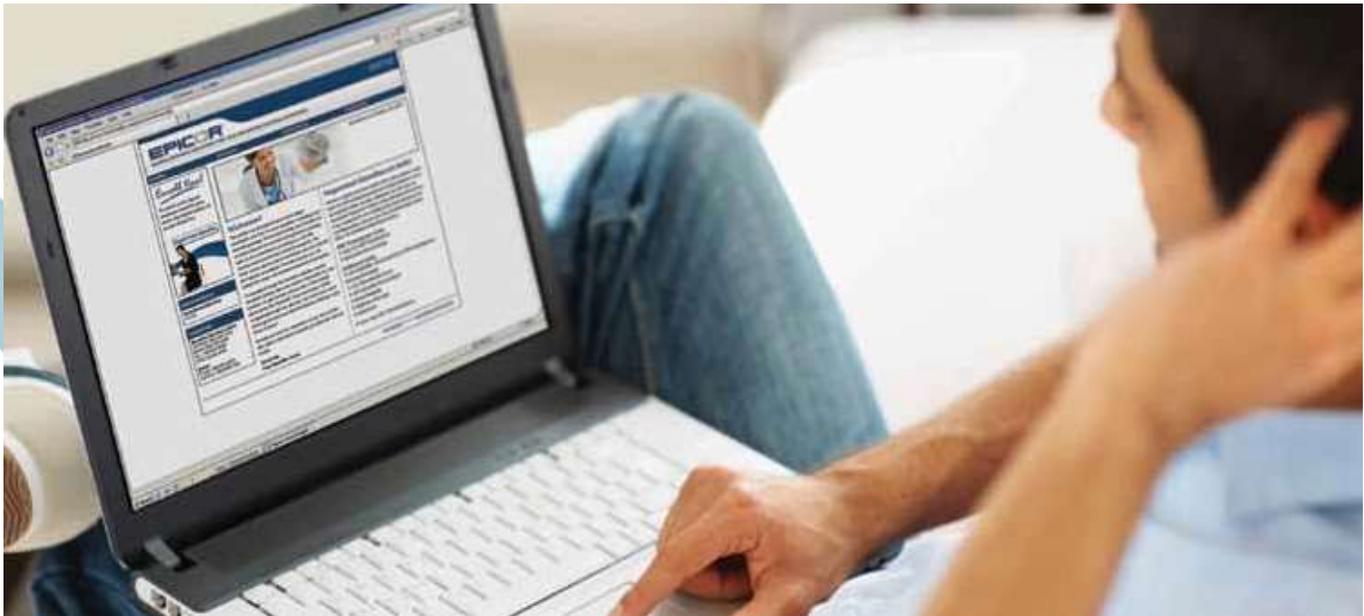
Deferred Compensation

Deferred Compensation options may be available to you through the Ohio Public Employees Deferred Compensation Program or AXA-Equitable.

Life and AD&D Insurance

Basic Life –

Colerain Township provides eligible full-time employees with basic life and AD&D insurance through Anthem up to a maximum of \$50,000



Eligibility & Enrollment

Eligibility Rules

Employees working more than 1500 hours annually are eligible to participate in the Colerain Township Employee Benefits Program. For most of our benefit plans, your coverage will become effective on your first day of employment, after the necessary enrollment forms have been completed. You must be actively at work for your coverage to be effective on that date.

You may also enroll your eligible dependents in the Colerain Township Benefit Plans. Your eligible dependents may include spouses, children whether natural, adopted, stepchildren, foster, or those for whom you have legal custody by court decree. **If your spouse has coverage available to them through their employer, they must enroll for coverage with their plan unless they are responsible for more than 50% of the cost.**

When enrolling in medical, dental or vision coverage, you may enroll any dependent child up to age 26.

When enrolling in voluntary life your child may be covered from birth to age 26.

When enrolling, you must provide proof of your dependent's eligibility in the form of:

- Federal Income Tax Return
- Court Order
- Birth Certificate
- Class Schedule (for dependents age 19-25 – dental and vision only)

When Can You Enroll?

You can sign up for Benefits at any of the following times:

- New hire enrollment period
- During the annual open enrollment period
- Within 30 days of a qualified family-status change

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

Making Changes

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your employer and another change is permitted under the plan terms.

Examples of these change in status events may include:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you have a family status change, you must timely notify your Personnel Manager and complete the necessary forms. For more information please reach out to Human Resources.

Frequently Asked Questions

What is a Deductible?

A deductible is the amount of money you or your dependents must pay toward a health claim before your insurance company makes any payments for health care services rendered. For example, if you have a \$1,500 deductible, you would be required to pay the first \$1,500, in total, of any claims during a plan year. The deductible excludes copayments where applicable.

What is Coinsurance?

Coinsurance is the amount expressed as a percentage of covered health services that you must pay after you have satisfied your plan deductible.

When do I pay a Copayment?

Expect to pay a copayment for doctor's visits, emergency room visits and urgent care center visits.

How do I know when to go to an Urgent Care Center vs. the Emergency Room?

If you need medical care when your regular doctor is not available, think about going to an urgent care center. The urgent care center should be used for minor emergencies (fever, cough, pain, etc.) when your physician's office is closed and your symptoms are too severe to wait until the office reopens or when you are out-of-town. Emergency rooms should only be used for true emergencies such as broken bones, vigorous bleeding or severe pain.

The next time you are faced with deciding where to go, be sure to evaluate all your options and choose the setting that best suits your illness or injury. Of course, in a true emergency, seek the appropriate care without delay.

What is Out-Of-Pocket Maximum?

The maximum amount (deductible and coinsurance) that an insured will have to pay for covered expenses under a plan. Once the out-of-pocket limit is reached, the plan will cover eligible expenses at 100%.

What is an Explanation of Benefits?

An EOB is a description the insurance company sends to you explaining the health care charges that you incurred and the services for which your doctor has requested payment. You should compare your EOB to the bill you receive from the doctor. All data on your EOB should match the information that appears on the statements you receive from your doctor. If it doesn't, contact the doctor's office immediately.

What is Preventive Care?

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations, well woman and well man exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early.

Remember all preventive care benefits are covered 100% under both medical plan options.

What is the difference between generic and brand name drugs?

The difference between generic and brand name medications lies in the name of the drug and the cost. Generic drugs cost much less than brand name drugs, save you and your employer money, and provide the same health benefits as brand name drugs.

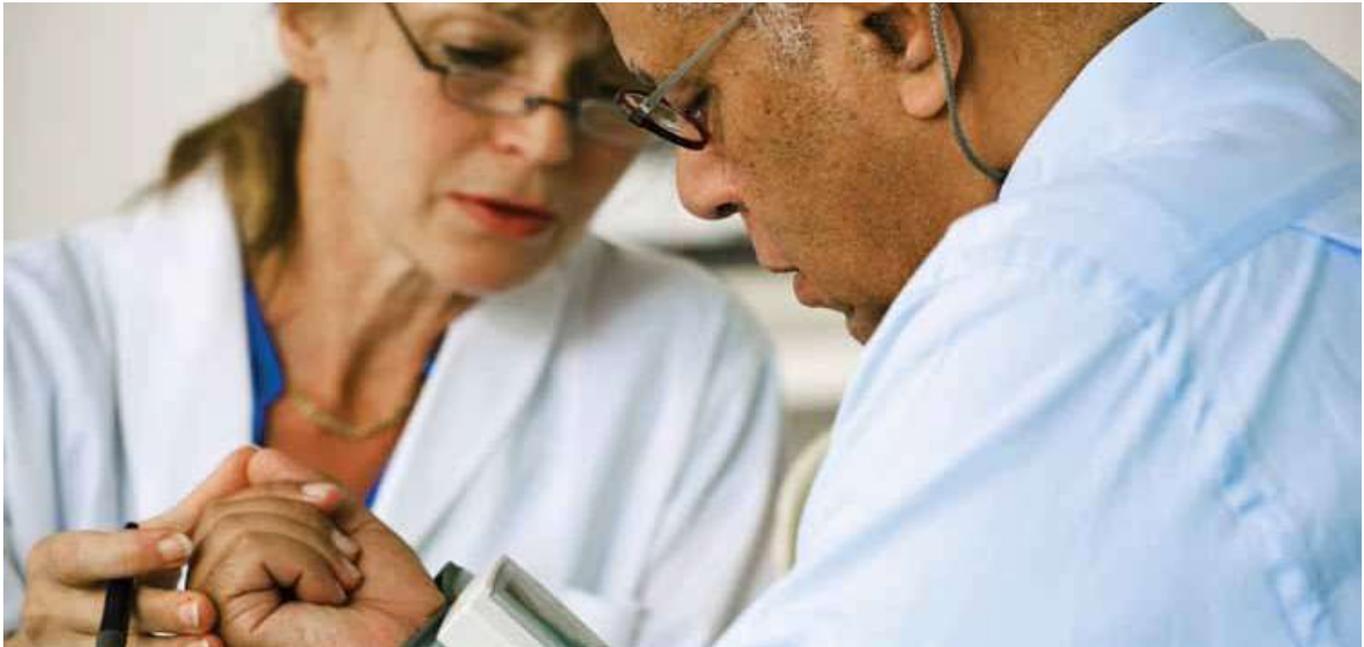
What is the benefit of Mail Order Drugs?

Mail order drugs are perfect for patients who take medication on an ongoing basis. Examples are high blood pressure medication, high cholesterol medication, insulin and birth control. Mail Order drugs are convenient because they are delivered to your door step which relieves the stress of standing in line at the pharmacy.

What should I ask my doctor?

Amazingly, many patients do not ask their doctor basic questions. "How much will my treatment cost?" "Can I be treated another way that is equally effective but less costly?" "What are the risks?" "What are the side effects?" Having a dialogue with your physician can help you better understand how his or her care decisions affect your health plan costs. It will also help your doctor get to know you better and consequently prescribe treatment that is more effective.





Cost of Coverage: *How You Pay for Health Care Costs*

You share the cost of health care services with Colerain Township and the medical plan you select. As you review the medical plan options you should consider the following types of costs:

Premium: A premium is the total cost for your medical insurance. You and Colerain Township share this cost. You pay your portion through pre-tax payroll deductions.

Deductible: A deductible is the amount you must pay before the medical plan begins sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits.

Copay: A copay is a set payment you make for a specific service. For example, in the Anthem Blue Cross and Blue Shield Medical PPO plan you will make a 80% after deductible for visits to your primary care physician.

Coinsurance: When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, in the Anthem Blue Cross and Blue Shield plan, after you satisfy your deductible, you will pay 80% for most medical care that you receive from preferred providers.

Out-of-Pocket Maximum: The annual out-of-pocket maximum protects you from major medical expenses. This is the most you would pay and includes your medical deductible, copays and coinsurance, for eligible expenses during a plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of the usual, customary and reasonable charges for the balance of the calendar year.

Your Total Costs

Remember, the total cost you pay for health care services in a plan year is the combination of your out-of-pocket costs when you access medical care and the premium payments you are required to make for coverage.

Premiums + Out-of-Pocket Costs = Total Cost of Health Care

Medical Insurance Plan

Benefit Description	Anthem Gold Plan Embedded	
	In-Network	Out-of-Network
Plan Year deductible <i>per member / family</i>	\$2,800 / \$5,400	\$7,500 / \$15,000
Calendar year out-of-pocket maximum <i>per member / family</i>	\$5,000 / \$10,000	\$10,000 / \$20,000
Physician office visit	80% after deductible	50% after deductible
Specialist office visit	80% after deductible	50% after deductible
Preventive and wellness	Covered in Full	50% after deductible
Complex Radiology	80% after deductible	50% after deductible
Inpatient hospital care	80% after deductible	50% after deductible
Emergency room services	80% after deductible	80% after deductible
Retail Prescription Drugs 30 days	After Deductible: Tier 1: \$10 copay Tier 2: \$35 copay Tier 3: \$60 copay	Tier 1: 50% after deductible Tier 2: 50% after deductible Tier 3: 50% after deductible
Mail Order Prescriptions 90 days	After Deductible: Tier 1: \$25 copay Tier 2: \$90 copay Tier 3: \$150 copay	<i>Not Covered</i>

Coinsurance percentages shown in the above plan descriptions represent the percentages paid by the health plan.

Embedded Deductible:

If you are on a family medical plan with an embedded deductible, your plan contains two components, an individual deductible and a family deductible. Having two components to the deductible allows for each member of your family the opportunity to have your insurance policy cover their medical bills prior to the entire dollar amount of the family deductible being met. The individual deductible is embedded in the family deductible.

For example, let's say Mary is enrolled in the Gold health plan, and her son Jack is covered under her plan. Mary and Jack each have an individual deductible of \$2,700, and a family deductible of \$5,400. Jack takes a fall at recess and must have a procedure that costs \$2,700. Jack has now met his individual deductible. The insurance company will begin paying 100% of covered expenses for Jack. Jack's procedure also put \$2,700 towards the family deductible (which is \$5,400). A few weeks later, Mary gets a sinus infection and pays \$100 for the doctor visit. Mary hasn't met her deductible, and the **family** deductible was not fully met by Jack, so Mary would pay the \$100 out of pocket. She now met \$100 of her individual deductible, and that \$100 also applies toward the family deductible, so as a family they have met \$2,800 of their \$5,400 deductible. Mary will continue to pay out-of-pocket for her expenses until the family deductible is met. If Jack's expenses had been \$5,400, the family deductible would have been met and both Mary and Jack's future claims would be covered 100%.

Benefit Description	Anthem Platinum Plan Non-Embedded	
	<i>In-Network</i>	<i>Out-of-Network</i>
Plan Year deductible <i>per member / family</i>	\$2,000 / \$4,000	\$4,000 / \$8,000
Calendar year out-of-pocket maximum <i>per member / family</i>	\$2,000 / \$4,000	\$8,000 / \$16,000
Physician office visit	100% after deductible	80% after deductible
Specialist office visit	100% after deductible	80% after deductible
Preventive and wellness	Covered in Full	80% after deductible
Complex Radiology	100% after deductible	80% after deductible
Inpatient hospital care	100% after deductible	80% after deductible
Emergency room services	100% after deductible	100% after deductible
Retail Prescription Drugs 30 days	100% after deductible	50% after deductible
Mail Order Prescriptions 90 days	100% after deductible	Not Covered

Coinsurance percentages shown in the above plan descriptions represent the percentages paid by the health plan.

Non-Embedded Deductible:

With a non-embedded deductible, there is not an individual deductible embedded in the family deductible. Before your insurance starts to cover their portion of your medical bills, the entire amount of the family deductible must be met first. It can be met by one family member or a combination of family members; however, there are no costs covered by your health plan until costs equaling the deductible amount have been incurred.

For example, let's say Mary and her son are enrolled in the Platinum Plan with a \$2,000 individual deductible and a \$4,000 family deductible. Jack takes a fall at recess and must have a procedure that costs \$2,000 and is applied to his deductible. A few weeks later Mary sees a doctor about her sinus infection and pays \$100 for the doctor visit. So, between Jack and Mary, \$2,100 has been applied to the \$4,000 deductible. Mary and Jack will continue to pay out-of-pocket for care until they have applied an additional \$1,900 towards the family deductible. At that point, the insurance company would begin paying 80% of covered expenses.

[Refer to the benefit summary or certificate of coverage for more information](#)

Employee Contributions – Bi-Weekly

	Employee Only	Employee + Spouse	Employee + Children	Employee + Family	Annual HSA Contributions
Healthcare					
Platinum Plan @ 20%	\$80.44	\$167.32	\$149.62	\$244.55	\$1,000 Single \$2,000 Family
Gold Plan @ 30%	\$89.86	\$186.91	\$167.14	\$273.17	\$3,000 Single \$6,000 Family
Gold Plan @ 25%	\$74.88	\$155.76	\$139.28	\$227.64	\$2,600 Single \$5,200 Family
Gold Plan @ 20%	\$59.90	\$124.61	\$111.42	\$182.12	\$2,000 Single \$4,000 Family
Gold Plan @ 15%	\$44.92	\$93.46	\$83.57	\$136.59	\$1,500 Single \$3,000 Family
Gold Plan @ 10%	\$29.95	\$62.30	\$55.71	\$91.05	\$1,000 Single \$2,000 Family
Gold Plan @ 5%	\$14.97	\$31.15	\$27.86	\$45.52	\$500 Single \$1,000 Family
Gold Plan @ 0%	\$0	\$0	\$0	\$0	\$250 Single \$500 Family
Dental					
The Preferred Plan	\$2.65	\$8.38	\$8.38	\$8.38	
Vision					
Vision Plan	\$.53	\$1.07	\$1.09	\$1.62	

Health Savings Accounts



Colerain Township offers HSA compatible health plans and as such you may need to know the following about Health Savings Accounts:

An HSA is a tax-exempt custodial bank account created exclusively to pay for qualified medical expenses of the account holder/employee and his/her spouse or tax dependents. An HSA is offered only in conjunction with a Qualified High Deductible Health Plan (HDHP).

Eligibility:

- You are enrolled in a High Deductible Health Plan (also called an HDHP).
- You are not enrolled in Medicare.
- You are not a dependent on someone else’s tax return.
- You have no other coverage (such as being covered under your spouse’s plan, or other individual coverage). That also means that you can’t be covered under a separate prescription drug plan. You can, however, be covered under dental, vision or long-term care coverage, or coverage that pays a fixed dollar amount for a disease or for a period of hospitalization, and still enroll in a HSA.
- There are no income limits for HSAs, your income is never a determining factor in whether you can establish an HSA.
- Members with coverage with a Non-Qualified HDHP plan are not permitted to contribute to a HSA banking account.

Here is how the HSA works:

- You have a choice to set up a tax-free bank account. Colerain Township utilizes Northside Bank & Trust.
- On August 1st, Colerain Township will make contributions to the HSA based on your plan selection.
- In addition to the funds received from Colerain Township, you may set aside pre-tax dollars from your check to your HSA account. The 2020 IRS maximums are \$3,550 for individual coverage, and \$7,100 for family coverage. If you are age 55 or older, you are eligible to make an additional \$1,000 “catch-up contribution”. Employee contributions are deposited with each regular payroll cycle. For more information on Health Savings eligible expenses, please go to <http://www.irs.gov/pub/irs-pdf/p502.pdf>.
- The amounts an employee has in his/her HSA can be withdrawn tax-free for qualified medical expenses including dental, vision, chiropractic care, eyeglasses and hearing aids among other items.
- The best part of the HSA is that any money you don’t spend rolls over from year to year (unlike money in a flexible spending account). This way, you can start building up a reserve for future medical expenses that you and your family may incur.
- The next best part of the HSA is that generally everything is tax-free to you. If you pay via payroll deduction, your contributions are pre-tax. Your interest and investment earnings are tax-free. And your reimbursements for any qualified medical expenses are tax-free. **But remember:** if you use the money for anything other than qualified medical expenses, you will owe a 20% penalty plus ordinary income tax on the funds used. (Note: if you are age 65 or older there is no 20% penalty on funds you withdraw to pay for non-qualified expenses).

Plan	Annualized 2020 Employer Contributions	
	Employee	Employee + Dependent(s)
Platinum	\$1,000	\$2,000
Gold	Varies	Varies
IRS Maximum Contributions		
Single	\$3,550	These contributions include employer and employee contributions.
Family	\$7,100	
Catch Up (over 55)	\$1,000	

** Colerain Township contributions will be prorated for New Hires based on the date of hire.

Dental Insurance

Colerain Township offers a Dental PPO plan through Anthem Blue Cross Blue Shield for all employees. With the Dental PPO you have the ability to obtain dental care services from the dentist of your choice (contracted or not). However, the dental plan provides a higher level of benefit if you choose to use an in-network provider.

Please Note: It is recommended that when a course of treatment is expected to cost \$300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.



Benefit Description	Anthem Blue Cross Blue Shield Dental	
	In-Network	Out-of-Network ¹
Annual Deductible <i>per member / family</i>	\$25 / \$50	\$25 / \$50
Waived for Preventive Care?	Yes	Yes
Annual maximum dental benefit	\$1,000	\$1,000
Preventive Care Services	100%	100%
Basic Services	80%	80%
Major Services	80%	80%
Orthodontic Benefit (Dependent Children Only)	60% \$1,500 lifetime maximum	60% \$1,500 lifetime maximum
	Cost per Pay Period:	
Employee	\$2.65	
Family	\$8.38	

*Coinsurance percentages shown in the above plan descriptions represent the percentages paid by the dental plan.*¹ You can receive care from any licensed dentist, anywhere in the United States. If you choose a non-participating dentist, you will be responsible for the coinsurance amount listed above, as well as any charges above Anthem’s maximum allowable charge for covered services

Vision Insurance

Are you really seeing your best? Or are you simply used to the view? With good vision, your experiences are clearer, sharper and brighter.

Vision examinations not only determine the need for corrective eye wear but also may help detect other general health problems such as glaucoma, cataracts, and diabetes. Plus, eye exams for children can help detect problems that can impact learning and development.

Dollar for dollar, you get the best value from your vision care plan when you visit an Anthem Blue Cross and Blue Shield network doctor. If you decide not to see an Anthem provider, the Out-of-Network plan copays will apply. The choice is yours—either way, your vision benefits are a tremendous part of your overall benefits package.



Benefit Description	Anthem Blue Cross Blue Shield Vision	
	<i>In Network</i>	<i>Out-of-Network</i>
Copay (per person)	Examination - \$10 copay Materials - \$10 copay	Examination - \$42 reimbursement max Materials – see reimbursements below
Frequency Limits	Exams - 12 months Lenses - 12 months Contacts - 12 months Frames - 24 months	Same as In Network Benefits
Exams	\$10 copay	\$42 reimbursement max
Single Vision Lenses	\$10 copay	\$40 reimbursement max
Bifocal Lenses	\$10 copay	\$60 reimbursement max
Trifocal Lenses	\$10 copay	\$80 reimbursement max
Frames	\$130 allowance (20% off balance)	\$45 reimbursement max
Contact Lenses (instead of prescription glasses)	\$130 allowance (15% off balance)	\$105 reimbursement max
Cost per Pay Period:		
Employee	\$0.53	
Employee & Spouse	\$1.07	
Employee & Child(ren)	\$1.09	
Family	\$1.62	

Life Insurance



Basic (Employer Paid) Life and AD&D Insurance

Colerain Township provides a Basic Life and AD&D benefit to eligible employees through Anthem Blue Cross Blue Shield at no cost to the employee. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.



Life & AD&D	
Life (employee)	\$50,000
AD&D (employee)	\$50,000
Benefit Reduction Schedule	Age 65 – 69 65% of original benefit
	Age 70 – 74 40% of original benefit
	Age 75 or Over 20% of original benefit

Voluntary (Employee Paid) Life and AD&D Insurance

Employees have an opportunity to purchase additional voluntary life and AD&D coverage. This includes additional coverage for yourself, your spouse and/or your dependent child(ren). You must elect additional coverage for yourself in order to cover your spouse and/or child(ren).

You can choose to elect the below amounts.

Voluntary Life & AD&D	
Employee	Available in \$10,000 increments
Maximum Amount	5x Salary or \$500,000 Subject to Reduction Schedule Based on Age
Guarantee Issue	\$150,000
Spouse	Available in \$5,000 increments
Maximum Amount	\$250,000 not to exceed 50% of the employee's benefit amount. Subject to Reduction Schedule Based on Age
Guarantee Issue	\$30,000
Child(ren)	Available in \$5,000 increments
Maximum Amount	\$15,000
Guarantee Issue	\$15,000

Remember – The guarantee issue amounts only apply when you are initially eligible for the Vol Life coverage as a new hire. If you apply for this coverage after initial eligibility, you must complete an Evidence of Insurability (EOI) or medical questionnaire to be considered for this coverage. Coverage is not guaranteed.

Voluntary Life/AD&D

Rate and Premium Summary

Basic Coverage	Number of Lives	Monthly Rate	Volume	Monthly Premium
Basic Group Term Life	174	\$0.10 per \$1000	\$8,652,500.00	\$865.25
AD&D	174	\$0.020 per \$1000	\$8,652,500.00	\$173.05
Total Monthly Group Premium				\$1,038.30
Total Annual Group Premium				\$12,459.60

Voluntary Coverage	Number of Lives	Monthly Premium	Volume	Annual Premium
Optional Supplemental Life - Employee	76	\$1,894.68	\$11,080,000.00	\$22,736.16
Optional Supplemental Life - Spouse	32	\$354.20	\$1,610,000.00	\$4,250.40
Optional Supplemental AD&D - Employee	76	\$387.80	\$11,080,000.00	\$4,653.60
Optional Supplemental AD&D - Spouse	32	\$56.35	\$1,610,000.00	\$676.20
Optional Supplemental Life - Dependent Child	37 (units)	\$89.60	\$560,000.00	\$1,075.20
Total Monthly Group Premium				\$2,782.63
Total Annual Group Premium				\$33,391.56

The number of lives, volume and premiums displayed are based on assumptions. Actual number of lives, volume and premium totals may vary at enrollment.

Optional Supplemental Group Term Life, Accidental Death and Dismemberment, Dependent Life Rates*

Coverage	Age bands	Monthly Rate per \$1,000
Optional Supplemental Life Employee and Spouse (based on employee age)	Under 25	\$0.060
	25-29	\$0.060
	30-34	\$0.070
	35-39	\$0.090
	40-44	\$0.139
	45-49	\$0.220
	50-54	\$0.350
	55-59	\$0.528
	60-64	\$0.688
	65-69	\$1.148
	70-74	\$2.508
	Over 74	\$5.268
Optional Supplemental AD&D (employee)		\$0.035 per \$1000
Optional Supplemental AD&D (spouse)		\$0.035 per \$1000
Optional Supplemental Dependent Child(ren) (covers all dependent children)		\$0.160 per \$1000

Accident/Critical Illness

Voluntary Accident Insurance

Accident coverage is a great way to supplement your major medical insurance. The accident plan offers two flexible options that feature very different payment levels. Below is a highlight of the benefits, for more details please reach out Human Resources.

Base Benefit	Low Off Job	High Off Job
Life and Dismemberment Losses		
Catastrophic Loss – both arms and both hands, both legs or both feet, one hand and one foot or one arm and one leg	\$7,500	\$15,000
One hand, one foot, one leg, one arm	\$3,750	\$7,500
Loss of sight of one eye or loss of one eye	\$3,750	\$7,500
Two or more fingers or toes	\$750	\$1,500
One finger or one toe	\$375	\$750
Dislocations		
Hip	\$2,000	\$4,000
Knee, ankle, or bones of the foot	\$1,000	\$2,000
Elbow or wrist, lower jaw	\$400	\$800
Shoulder	\$500	\$1,000
Collarbone or bones of the hand	\$800	\$1,600
Finger(s) or toe(s)	\$100	\$200
Fractures		
Hip or thigh	\$2,000	\$4,000
Skull-depressed	\$3,000	\$6,000
Skull-simple	\$1,500	\$3,000
Vertebral processes, bones of the face, nose	\$350	\$700
Leg	\$1,000	\$2,000
Vertebrae, Sternum, Pelvis	\$800	\$1,600
Upper jaw or upper arm	\$375	\$750
Lower jaw, collarbone, shoulder, forearm, hand, wrist, foot, ankle, kneecap, elbow, heel	\$325	\$650
Rib, finger, toe, coccyx	\$175	\$350
Multiple ribs	\$500	\$1,000

For a full list of coverages, please refer to the policy.

Critical Illness/Cancer

Critical Illness/Cancer policies offer specialized benefits to supplement medical coverage at a time when you and your family may experience a difficult diagnosis. The plan would pay a benefit after receiving a diagnosis for what would qualify as a critical illness. In addition to coverage for the condition, the plan also pays a \$50 wellness reward per preventive visit after the policy is in force.

A qualified critical illness could include:

- Loss of sight, speech, or hearing
- Cancer
- Stroke
- Transplant, as a result of heart failure
- Heart Attack
- End Stage Renal Failure



Benefit Resource Center

The Benefit Resource Center is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00AM to 5:00PM Eastern & Central Standard Time via phone 855-874-6699 or via e-mail BRCMidwest@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

For other escalated benefit questions, please contact:

USI Benefit Resource Center (BRC)

Phone: 855-874-6699

BRCMidwest@usi.com

Monday – Friday 8AM to 5 PM EST & CST



Contact Information

Have Questions? Need Help?

Colerain Township is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.



Member Service Information

Policy	Carrier Name	Group Number	Telephone	Website
<u>Medical Plans</u>				
Gold Plan	Anthem Blue Cross Blue Shield	00247956	888-224-4902	www.anthem.com
Platinum Plan	Anthem Blue Cross Blue Shield	00247956	888-224-4902	www.anthem.com
Dental Plan	Anthem Blue Cross Blue Shield	00247956	855-769-1464	www.anthem.com
Vision Plan	Anthem Blue Cross Blue Shield	00247956	888-884-8461	www.anthem.com
Basic Life Plan	Anthem Blue Cross Blue Shield	00247956	888-224-4902	www.anthem.com
Voluntary Life Plan	Anthem Blue Cross Blue Shield	00247956	888-224-4902	www.anthem.com
Critical Illness/Accident	Sun Life Financial	913540	800-451-2513	www.sunlife.com
Health Savings Account	Northside Bank-Amber Newman		513-448-4889	amberlyn@nsbt.net
Deferred Compensation	Ohio Deferred Compensation	0749000	877-654-6457	www.Ohio457.org
Employee Assistance	Health Advocate		877-240-6863	www.healthadvocate.com/members
Deferred Compensation	AXA-Equitable		513-550-0163	

This brochure summarizes the benefit plans that are available to Colerain Township eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

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

NEWBORNS ACT DISCLOSURE - FEDERAL

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).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called “fiduciaries” of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$152 per day (up to a \$1,527 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

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Questions regarding any of this information can be directed to:

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