Larimer County

2012 New Employee Benefits Summary

LARIMER COUNTY
COMMITTED TO EXCELLENCE

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2012 Human Resources Staff

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2012 Benefits Orientation Schedule

This orientation is designed to have all new benefited Larimer County employees come in to have questions answered and to sign up for their appropriate benefits. Two hours have been set aside to explain all of Larimer County's benefits and to complete the necessary forms. Please remember to bring your Benefits Booklet to the Benefits Orientation.

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

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

Date (Sessions are every other Wednesday)	*Time*	*Location*
November 16, 2011	All Benefits Orientations are held from 8:30 – 10:30 am	200 W. Oak (Lake Loveland Room)
November 30, 2011		200 W. Oak (Lake Loveland Room)
December 14, 2011		200 W. Oak (Carter Lake Room)
December 28, 2011		200 W. Oak (Jewell Lake Room)
January 11, 2012		200 W. Oak (Jewell Lake Room)
January 25, 2012		200 W. Oak (Jewell Lake Room)
February 8, 2012		200 W. Oak (Jewell Lake Room)
February 22, 2012		200 W. Oak (Jewell Lake Room)
March 7, 2012		200 W. Oak (Jewell Lake Room)
March 21, 2012		200 W. Oak (Jewell Lake Room)

2012 Benefit Plan Overview for New Employees

Welcome to Larimer County!! The County-provided plans are designed to help you in the event of illness, injury, disability, or death, as well as to help you plan and save for retirement. The following pages give a brief description of the benefit plans offered to you as a Larimer County employee. If you need more specific information on any of the plans, please see the appropriate certificate or plan description document in your New Employee Orientation materials, or contact the Human Resources Department.

The Human Resources staff is available to answer any questions you may have about your benefits, or any other aspect of your employment with Larimer County. Please let us know how we can help you!!

LARIMER COUNTY
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Benefits Overview

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

We offer you <u>three</u> ways to complete all your benefit enrollment forms:

√ Forms may be completed before Benefits Orientation and submitted to Pam Stultz at the meeting.
√ Forms may be completed during the Benefits Orientation and submitted to Pam Stultz.
√ Forms may be taken home to review with family and brought back to the Human Resources Department at 200 W. Oak Street, Ste. 3200, by the specified date.

Note that the following descriptions are intended to be accurate and any errors are inadvertent. If we find any errors, we'll correct them in the next update of this outline.

2012 Benefit Eligibility Dates and Information

When will my benefits become effective?

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

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

Flexible Spending Account (FSA)

The FSA participation date will be the same as the insurance effective date. The contribution amount will be deducted starting with the first paycheck after the benefits effective date.

Retirement Plan (401a)

Upon hire, employees will immediately become participants in the retirement plan.
Contributions will begin with the first paycheck.

When will my benefits terminate if I leave employment?

Insurance Benefits

Benefits coverage will terminate at the end of the month in which the employee separates from employment.

FSA (Flexible Spending Account)

Flexible Spending Account participation will continue through the last day of employment, with deductions coming out of the final paycheck.

Covering Dependents

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

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

Special Enrollment Options (In compliance with federal law)

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

Annual Open Enrollment

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

2012 Benefit Cost Summaries

Schedule for Full-Time Employees

Larimer County Benefit Cost Summary *(Effective January 1, 2012)*

	TOTAL COST *(monthly)*	COUNTY PAYS *(monthly)**	YOU PAY *(monthly)*	YOU PAY *(semi-monthly)***
Standard PPO Plan – Admin. by UMR				
Employee Only	$ 629.24	$ 586.00	$ 43.24	$ 21.62
Employee and Spouse or Domestic Partner	$ 1,204.82	$ 902.08	$ 302.74	$ 151.37
Employee and One Child	$ 865.20	$ 647.36	$ 217.84	$ 108.92
Employee and Children	$ 1,112.18	$ 832.60	$ 279.58	$ 139.79
Employee and Family	$ 1,550.38	$ 1,161.24	$ 389.14	$ 194.57
Choice PPO Plan - Admin. by UMR				
Employee Only	$ 663.10	$ 586.00	$ 77.10	$ 38.55
Employee and Spouse or Domestic Partner	$ 1,345.62	$ 902.08	$ 443.54	$ 221.77
Employee and One Child	$ 966.70	$ 647.36	$ 319.34	$ 159.67
Employee and Children	$ 1,242.22	$ 832.60	$ 409.62	$ 204.81
Employee and Family	$ 1,728.00	$ 1,161.24	$ 566.76	$ 283.38
Dental Plan - MetLife				
Employee Only	$ 32.76	$ 32.76	$ -	$ -
Employee and One Dependent	$ 63.76	$ 32.76	$ 31.00	$ 15.50
Employee and Family	$ 92.26	$ 32.76	$ 59.50	$ 29.75
Vision Insurance - Vision Service Plan				
Employee Only	$ 8.82	$	$ 8.82	$ 4.41
Employee and One Dependent	$ 16.68	$	$ 16.68	$ 8.34
Employee and Family	$ 24.38	$	$ 24.38	$ 12.19
Life Insurance – Hartford				
Employee Only	varies	$ .125/1000 of salary	$ -	$ -
Employee and Family	varies	$ -	$ 0.76	Monthly deduction
Long Term Disability – Hartford				
Salary, up to $8333 per month	varies	.23% of salary	$ -	$ -
Other Voluntary Policies				

The costs for the Supplemental Term Life Insurance, Voluntary Accidental Death and Dismemberment, and the AFLAC supplemental plans are based on the coverage selected. See the individual brochures for current premiums.

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

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

Schedule of Proportional Benefits

Health Insurance:

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

Standard PPO – *Employee's Cost Per Paycheck*

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

Choice PPO – *Employee's Cost Per Paycheck*

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

Dental Insurance:

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

Employee's Cost Per Paycheck:

# Hours Worked Per Week	Employee Only	Employee + 1 Dependent	Employee and Family
20 – 29	$4.10	$19.60	$33.85
30 – 39	$2.05	$17.55	$31.80
Full Time	$0.00	$15.50	$29.75

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

2012 Medical Insurance

PPO Option

As a Preferred Provider Organization (PPO) member:

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

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

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

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

Medical Insurance Definitions

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

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

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

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

2012 Larimer County Medical Plans

Administered By UMR

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

Continued…….

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

2012 Larimer County Dental Plan

Administered by MetLife Dental

The County offers a comprehensive dental program. Our Claims Administrator is MetLife Dental.

Note that the dental plan does *not* cover orthodontics.

MetLife participating dentists have agreed to collect only the portion of your charges for which you are ultimately responsible (i.e., deductible and coinsurance). You will not be charged the entire fee at the time services are rendered unless the service you receive is not covered by your plan. Should you elect to receive treatment from a dentist who has not enrolled with MetLife as a participating dentist (i.e., a non-participating dentist), you will be responsible for any amount over the maximum plan allowance. By going to a non-participating dentist, you may have additional out-of-pocket expenses.

If you anticipate dental services which would exceed $300, your dentist can submit the treatment plan to MetLife for review before any work is actually done. Predetermination of benefits allows both you and your dentist to know exactly what is covered and what your plan will pay.

MAXIMUM
Calendar Year: $1,500

DEDUCTIBLE: $50 calendar year deductible, applies to only to basic and major services; limited to three per family.

DIAGNOSTIC and PREVENTATIVE SERVICES - COVERED AT 100%

- **Oral Exam** - 2 exams every 12 months
- **Bitewing X-Rays** - 1 set every 12 months
- **Full Mouth X-Rays** - 1 set every 3 years
- **Routine Cleaning** - 1 routine cleaning every 6 months
- **Space Maintainers** - Up to age 14
- **Fluoride Treatments** - 1 treatment every 12 months up to age 18
- **Sealants** - Up to age 15 on unrestored, noncarious permanent molars, but no more than once in a 36-month period.

BASIC SERVICES - COVERED AT 80%

Restorative Services:

- Amalgam Fillings
- Resin, Composite Fillings (anterior teeth only)
- Treatment Fillings
- Local Anesthesia

Oral Surgery:

- Simple Extractions
- Surgical Extractions
- General Anethesia

Periodontics

- Periodontal Surgery (including gingivectomy)
- Scaling and Root Planning
- Gingival Curettage

Endodontics:

- Root Canal Therapy
- Pulpal Therapy
- Pulp Capping

MAJOR SERVICES - COVERED AT 50%

Major Restorative:

- Crowns, Inlays, and Onlays - When teeth cannot be restored with regular fillings

Prosthodontics:

- Dentures, Partials
- Fixed Bridges and Crowns - when part of the bridge

Prosthodontic Maintenance:

- Bridge or Denture Repair
- Rebase or Reline of Dentures
- Replacement of Crowns, Inlays, and Onlays

- **Temporomandibular Joint Care** - $1,000 lifetime maximum per person. Diagnostic services, occlusal adjustment, orthotic applicance, and orthognathic surgery - services **must be** preauthorized.

WHAT IS NOT COVERED

 Services covered by Worker's Compensation or Employer Liability Laws Services provided by any governmental agency Services begun before the effective date of coverage General anesthesia unless administered by dentist during oral surgery Speech therapy, replacement of lost or stolen appliances Charges for completion of forms Charges for hospitalization or hospital visits Experimental treatment for which the prognosis is not good Charges which the covered person would not be required to pay in the absence of this coverage Correction of congenital, developmental, or acquired malformations Procedures are necessary to alter or correct occlusion or vertical dimension or restoration of tooth structure lost through attrition Associated sedative procedures (Relative Analgesia, Hypnosis, Pre-medication) Treatment solely for cosmetic reasons Plaque control programs Orthodontic services

2012 Vision Insurance

Administered by Vision Service Plan (VSP)

The County offers a comprehensive Vision program. Our Claims Administrator is Vision Service Plan (VSP).

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

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

Vision Service Plan (VSP)

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

Your Coverage with a VSP Doctor

WellVision Exam®
focuses on your eye health and overall wellness

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

Prescription Glasses

- $15.00 copay

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

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

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

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

~OR~

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

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

Your Coverage with Other Providers

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

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

2012 Basic Life / Accidental Death & Dismemberment and Long Term Disability

Underwritten by Hartford Life Insurance Co

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

Basic Life & Accidental Death & Dismemberment

The Hartford

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

Long Term Disability

The Hartford

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

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

2012 Employee Paid Benefits

Voluntary Term Life
The Hartford

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

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

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

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

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

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

SUPPLEMENTAL LIFE RATE CHART

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

How To Use This Chart

To determine your monthly premium:

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

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

Personal Health Application

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

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

Voluntary Accidental Death and Dismemberment

The Hartford

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

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

Rate Chart - Employee and

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

Rate Chart - Child(ren)

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

2012 Employee Paid Benefits

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

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

Plus, there's no preauthorization or strings attached.

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

Aflac Associates for Larimer County

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Mitchell-Zuber Insurance Agency
383 W. Drake Road, Ste. 202
Fort Collins, CO 80526

Phone: 970-207-0600
Fax: 970-207-0640

2012 Employee Paid Benefits

Rate Sheets

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

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

AGE	INDIVIDUAL		HUSBand WIFE		ONE PARENT FAMILY		TWO PARENT FAMILY	
	Premium	Total	Premium	Total	Premium	Total	Premium	Total
18-49	$21.71	$21.71	$28.99	$28.99	$32.76	$32.76	$41.21	$41.21
50-70	$21.71	$21.71	$28.99	$28.99	$32.76	$32.76	$41.21	$41.21

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

AGE	INDIVIDUAL		HUSBand WIFE		ONE PARENT FAMILY		TWO PARENT FAMILY	
	Premium	Total	Premium	Total	Premium	Total	Premium	Total
18-49	$26.52	$26.52	$35.36	$35.36	$39.91	$39.91	$50.31	$50.31
50-70	$26.52	$26.52	$35.36	$35.36	$39.91	$39.91	$50.31	$50.31

DISABILITY INCOME PROTECTION ADVANTAGE - Series A-57500

Elimination Period Accident/Sickness - 0/7 DAYS

Annual Income		$25,000	$27,000	$29,000	$32,000	$34,000	$36,000	$39,000	$41,000	$43,000	$45,000
Benefit Period	Age	$1,100	$1,200	$1,300	$1,400	$1,500	$1,600	$1,700	$1,800	$1,900	$2,000
3 MONTHS	18-49	$34.32	$37.44	$40.56	$43.68	$46.80	$49.92	$53.04	$56.16	$59.28	$62.40
	50-64	$40.04	$43.68	$47.32	$50.96	$54.60	$58.24	$61.88	$65.52	$69.16	$72.80

DISABILITY INCOME PROTECTION ADVANTAGE - Series A-57500

Elimination Period Accident/Sickness - 0/14 DAYS

Annual Income		$25,000	$27,000	$29,000	$32,000	$34,000	$36,000	$39,000	$41,000	$43,000	$45,000
Benefit Period	**Age**	$1,100	$1,200	$1,300	$1,400	$1,500	$1,600	$1,700	$1,800	$1,900	$2,000
3 MONTHS	18-49	$25.74	$28.08	$30.42	$32.76	$35.10	$37.44	$39.78	$42.12	$44.46	$46.80
	50-64	$31.46	$34.32	$37.18	$40.04	$42.90	$45.76	$48.62	$51.48	$54.34	$57.20

MAXIMUM DIFFERENCE CANCER PLAN LEVEL ONE - Series A-76100

AGE	INDIVIDUAL		HUSBand WIFE		ONE PARENT FAMILY		TWO PARENT FAMILY	
	Premium	Total	Premium	Total	Premium	Total	Premium	Total
18-35	$16.12	$16.12	$29.90	$29.90	$16.12	$16.12	$29.90	$29.90
36-45	$23.40	$23.40	$42.12	$42.12	$23.40	$23.40	$42.12	$42.12
46-55	$33.02	$33.02	$61.75	$61.75	$33.02	$33.02	$61.75	$61.75
56-70	$43.55	$43.55	$85.67	$85.67	$43.55	$43.55	$85.67	$85.67

Rate Sheets

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

CRITICAL CARE and RECOVERY LEVEL ONE - Series A71100

AGE	INDIVIDUAL		ONE PARENT FAMILY		INSURED/SPOUSE		TWO PARENT FAMILY	
	Premium	Total	Premium	Total	Premium	Total	Premium	Total
18-35	$9.10	$9.10	$10.14	$10.14	$13.00	$13.00	$15.08	$15.08
36-45	$14.17	$14.17	$14.69	$14.69	$21.71	$21.71	$23.92	$23.92
46-55	$19.63	$19.63	$20.28	$20.28	$32.50	$32.50	$35.36	$35.36
56-70	$26.52	$26.52	$27.17	$27.17	$47.71	$47.71	$50.96	$50.96

CRITICAL CARE and RECOVERY LEVEL TWO - Series A71200

AGE	INDIVIDUAL		ONE PARENT FAMILY		INSURED/SPOUSE		TWO PARENT FAMILY	
	Premium	Total	Premium	Total	Premium	Total	Premium	Total
18-35	$16.38	$16.38	$28.08	$28.08	$31.59	$31.59	$35.88	$35.88
36-45	$23.40	$23.40	$33.02	$33.02	$41.08	$41.08	$45.50	$45.50
46-55	$31.85	$31.85	$42.51	$42.51	$55.25	$55.25	$60.84	$60.84
56-70	$41.08	$41.08	$55.90	$55.90	$76.96	$76.96	$83.59	$83.59

HOSPITAL PROTECTION PLAN ONE - Series 46100

AGE	INDIVIDUAL		ONE PARENT FAMILY		INSURED/SPOUSE		TWO PARENT FAMILY	
	Premium	Total	Premium	Total	Premium	Total	Premium	Total
18-39	$26.39	$26.39	$37.44	$37.44	$47.97	$47.97	$54.34	$54.34
40-49	$31.07	$31.07	$40.30	$40.30	$51.74	$51.74	$56.16	$56.16
50-59	$40.43	$40.43	$47.84	$47.84	$68.64	$68.64	$75.14	$75.14
60-70	$50.96	$50.96	$64.74	$64.74	$84.76	$84.76	$93.99	$93.99

PERSONAL SICKNESS INDEMNITY LEVEL ONE – Series A-45100

AGE	INDIVIDUAL			ONE PARENT FAMILY			INSURED/SPOUSE			TWO PARENT FAMILY		
	Premium	Rider*	Total	Premium	Rider*	Total	Premium	Rider*	Total	Premium	Rider*	Total
18-39	$19.90	$9.60	$29.50	$32.30	$14.40	$46.70	$36.30	$19.20	$55.50	$39.90	$23.70	$63.60
40-49	$22.60	$11.10	$33.70	$33.80	$15.00	$48.80	$39.40	$21.30	$60.70	$44.10	$25.20	$69.30
50-59	$28.10	$15.60	$43.70	$37.90	$17.10	$55.00	$49.60	$29.10	$78.70	$53.80	$30.60	$84.40
60-64	$39.10	$23.10	$62.20	$46.10	$24.30	$70.40	$67.90	$45.90	$113.80	$70.10	$47.10	$117.20

* 3 units of Optional Hospital Rider A46050 ($250 per unit) selected

2012 S.125 Flexible Spending Plan

The County has been administering a S.125 Flexible Benefits Plan for many years. Internal Revenue Code Sections 125 and 129 govern this plan, as well as the plan document. This plan allows you to pay for certain payroll-deducted insurance premiums with pre-tax dollars and establish pre-tax Health Care and Dependent Care Flexible Spending Accounts (FSA).

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

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

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

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

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

Qualified status changes include:

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

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

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

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

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

2012 Flexible Spending Accounts

Administered by Wageworks

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

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

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

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

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

"Use It or Lose It" Rule

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

More Information

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

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

2012 Flexible Spending Accounts

Administered by Wageworks

Flexible Spending Accounts

WageWorks

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

What can a WageWorks Flexible Spending Account do for Me?

Save between 25% and 40% on everyday expenses.

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

How does it work?

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

What is the take care®Card?

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

Is it hard to use my FSA?

Using your FSA is easy.

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

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

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

2012 Flexible Spending Accounts - Cont'd

Administered by Wageworks

WageWorks

Qualifying Expenses For Your Take Care Plan

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

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

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

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

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

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

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

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

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

2012 Flexible Spending Accounts - Cont'd

Administered by Wageworks

Accepted Over-the-Counter (OTC) items*

Antiseptics

Prescription (Rx) required beginning 1/1/2011.

- Antiseptic wash or ointment for cuts or scrapes (Rx)
- Antiseptic mouthwash (Rx)
- Benzocaine swabs (Rx)
- Boric acid powder (Rx)
- First aid wipes (Rx)
- Hydrogen peroxide (Rx)
- Iodine tincture (Rx)
- Rubbing alcohol (Rx)
- Sublimed sulfur powder (Rx)

Cold, Flu, Asthma, & Allergy Medications

Prescription (Rx) required beginning 1/1/2011.

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

Diabetes

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

Ear/Eye Care

Letter of Medical Necessity required from a physician (LOMN).
Prescription (Rx) required beginning 1/1/2011.

- Airplane ear protection (LOMN)
- Ear drops for swimmers (Rx)
- Ear water-drying aid (Rx)
- Earwax removal drops (Rx)
- Homeopathic earache tablets (Rx)
- Contact lens solutions

Health Aids

Prescription (Rx) required beginning 1/1/2011.

- Anti-fungal treatments (Rx)
- Denture adhesives
- Diuretics and water pills (Rx)
- Hemorrhoid relief (Rx)
- Lice control
- Medicated bandages
- Motion sickness tablets (Rx)
- Respiratory stimulant ammonia (Rx)
- Sleeping aids (Rx)

Pain Relief

Prescription (Rx) required beginning 1/1/2011.

- Arthritis pain reliever (Rx)
- Bunion and blister treatments (Rx)
- Itch relief (Rx)
- Orajel® (Rx)
- Pain relievers, aspirin and non-aspirin (Rx)
- Throat pain medications (Rx)

Personal Test Kits

- Cholesterol tests
- Colorectal cancer screening tests
- Home drug tests
- Ovulation indicators
- Pregnancy tests

Skin Care

Prescription (Rx) required beginning 1/1/2011.

- Acne medications (Rx)
- Anti-itch lotion (Rx)
- Bunion and blister treatments (Rx)
- Cold sore and fever blister medications (Rx)
- Corn and callus removal medications (Rx)
- Diaper rash ointment (Rx)
- Eczema cream (Rx)
- Medicated bath products (Rx)

Stomach Care

Prescription (Rx) required beginning 1/1/2011.

- Acid reducing gum, liquid, and tablets (Rx)
- Anti-diarrhea medications (Rx)
- Gas prevention (liquid, tablets, or drops) (Rx)
- Ipecac syrup (Rx)
- Laxatives (Rx)
- Pinworm treatment (Rx)
- Prilosec® (Rx)
- Upset stomach medications (Rx)

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

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

OTC not acceptable *

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

2012 Flexible Spending Accounts - Cont'd

Administered by Wageworks

take care® OF YOURSELF WORKSHEET

Visit takecareWageWorks.com for the complete list of covered items

Take a moment to fill out this worksheet to determine how much money you'll save annually by participating in your employer's flex benefit plan. Simply check off the items you wish to save for and budget how much you'll spend in the upcoming year on those products and services. Fill in the estimate in the space next to each item. Then add up each category and place those totals in the corresponding section below the checklist. Then enroll in your plan.

Use the easy calculator at takecareWageWorks.com

HEALTH CARE EXPENSES (estimated) FOR EXPENSES NOT PAID BY INSURANCE

PRESCRIPTIONS & CO-PAYS

- ☐ Prescription drugs & co-pays $ ________
- ☐ Diabetic supplies & insulin $ ________

DOCTOR FEES & CO-PAYS

- ☐ Doctor co-pays $ ________
- ☐ Office visits & checkups $ ________
- ☐ Psychologist & psychiatrist fees $ ________
- ☐ Obstetrics & fertility $ ________
- ☐ Lab tests & body scans $ ________
- ☐ Chiropractic & podiatrist fees $ ________
- ☐ Reconstructive surgery (birth defect, disease) $ ________

OVER-THE-COUNTER

Medicines & supplies $ ________

(Effective January 1, 2011, reimbursement requests for OTC drugs and medicines must be accompanied by a physician's prescription in order to be reimbursed by your plan.)

DENTAL SERVICES & SUPPLIES

- ☐ Dental cleanings, fillings & x-rays $ ________
- ☐ Sealants, crowns, bridges & dentures $ ________
- ☐ Braces, spacers & retainers $ ________
- ☐ Wisdom teeth, implants & oral surgery $ ________

VISION SERVICES & SUPPLIES

- ☐ Prescribed sunglasses & eyeglasses $ ________
- ☐ Contact lenses, solutions & supplies $ ________
- ☐ Eye exams, surgery & LASIK $ ________

HEALTH IMPROVEMENT PROGRAMS

- ☐ Physical & speech therapy $ ________
- ☐ Weight-loss program (prescribed by doctor) $ ________
- ☐ Quit-smoking program & medications $ ________
- ☐ Alcoholism & drug treatment $ ________

HEALTH-RELATED EXPENSES

Generally, these items require a doctor's prescription to qualify

- ☐ Hearing aids, batteries & exams $ ________
- ☐ Artificial limbs & braces $ ________
- ☐ Arches & orthopedic shoes $ ________
- ☐ Walkers, canes & wheelchairs $ ________
- ☐ Medical alert bracelet & fees $ ________
- ☐ Wigs for hair loss caused by disease $ ________
- ☐ Travel & mileage to doctor or hospital $ ________

TOTAL HEALTH CARE 1 $ ________

DEPENDENT CARE EXPENSES (estimated) SO YOU CAN WORK

- ☐ Nanny & babysitter thru age 12 $ ________
- ☐ Pre-K or nursery school $ ________
- ☐ Before & after-school care thru age 12 $ ________
- ☐ Day camp thru age 12 $ ________
- ☐ Day care for a disabled adult or child $ ________
- ☐ Elder day care for parent or dependent $ ________

TOTAL DEPENDENT CARE 2 $ ________

INSURANCE PREMIUMS (estimated) DEDUCTED FROM YOUR PAYCHECK

- ☐ Health insurance (your share only) $ ________
- ☐ Other (your share only) $ ________

TOTAL INSURANCE PREMIUMS 3 $ ________

ESTIMATED ANNUAL EXPENSES AND TAX SAVINGS

1 ________ + 2 ________ + 3 ________ = $ ________

Save between 25% and 40% on FICA, federal & state income tax (in applicable states). x 36%

Based on national averages, you'll save 25% if your annual household earnings are less than $30,000, 36% if you earn $30,000 to $60,000, or 40% if you earn more than $60,000. Federal and/or plan limits apply to all options. See your summary plan description for plan limits.

YOU SAVE $ ________

IMPORTANT INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

take care®
by WageWorks

takecareWageWorks.com

TCWW_3622_TCPLB1 (Sep 2010)

2012 Retirement Plan 401(a)

Administered by Principal

Principal Life Insurance Company
Des Moines, Iowa 50306-9394

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Account Information
You may obtain account information through:

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

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

you choose.

When You Receive Benefits
Benefits are payable at:

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

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

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

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

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

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

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

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

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

To find out more information about The Principal Financial Group ® , visit our homepage at www.principal.com.

2012 Retired Public Safety Officer Notice

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

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

Who is an eligible public safety officer?

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

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

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

Who is not eligible?

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

How can eligible public safety officers get started?

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

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

Nationwide Retirement Solutions
(877) 677-3678

The Hartford
(800) 528-9009

2012 Deferred Compensation Plans

Voluntary Retirement Savings

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

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

Frequently Asked Questions:

1. **Do my contributions affect my Social Security Benefits?**
   No. Your total wages remain the same for Social Security purposes. Furthermore, amounts you receive from deferred compensation when you retire will not reduce your Social Security benefits.

2. **Is there a maximum amount I can invest each year?**
   Yes. The dollar limits on contributions in 2012 is $16,500. Special "catch-up" rules apply for participants age 50 and older, allowing you to make an additional "bonus" contribution. The upper limit of this extra amount in 2010 is $5,500. There is also a pre-retirement catch-up, which allows you to defer up to twice the standard limit. The pre-retirement catch-up period runs for the three consecutive taxable years ending with the year before you reach our plan's normal retirement age.

3. **How does the amount I contribute affect my income taxes?**
   Your taxable income is reduced by the amount of money you defer. For example, if your annual salary is $24,000 and you contribute $2,000 to the 457 plan, your annual taxable income will show as $22,000 on your W-2 form. These adjustments are automatically made through the County's payroll system.

4. **When do I pay taxes on my account?**
   Under current law, income tax is due on amounts paid to you (contributions and earning) as you receive them. If your account balance is distributed over time, you only pay taxes each year on the amount you receive during that year.

5. **When can I stop contributing and may I restart later?**
   You may stop contributing at any time. Also, you may start your contributions at any time.

6. **Can I change the contribution amount?**
   Yes. You may increase or decrease your contribution amount as often as you like.

7. **What happens if I terminate my employment prior to retirement?**
   You may leave funds in the account; transfer them to another 457 plan; or roll them over tax-free to 401(k) and other tax-qualified plans, 403(b) annuities, other types of eligible plans that accept rollovers, or an IRA.

6\. **When can I receive the money?**
   Generally at retirement, termination of employment, death, or in the event of an unforeseen, severe financial emergency. At the very latest, you begin receiving your account values no later than April 1st of the calendar year following the calendar year in which you attain age 70 ½ , unless you are still employed.

6\. **What is an unforeseen, severe financial emergency?**
   The tax rules under Section 457 define a financial emergency as a real, unforeseen event which occurs for reasons beyond your control, such as unexpected unreimbursed medical expenses. Transportation, education, housing, or other expenses that can be "planned for" will not qualify for a hardship withdrawal request.

10\. **Is there a 10% penalty tax imposed by the IRS on early withdrawals?**
   No. Under current law, the IRS does not impose the 10% tax penalty on early withdrawals made from a 457 plan.

2012 Deferred Compensation Plans
Voluntary Retirement Savings

Nationwide

Nationwide Retirement Solutions

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

~ The Smart Choice ~

457 Deferred Compensation Plan.

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

When you contribute this portion of your income, up to a maximum of $16,500 annually, you reduce the amount that's taxable now. So you're not only investing for tomorrow, you're reducing your federal taxable income today.

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

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

See the Possibilities with The Hartford

457 Deferred Compensation Plan.

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

The Hartford

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

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

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

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

For additional information contact our local representative , Ryan Fletcher, at (720)535-6146.
Or visit our web site at: http://retire.hartfordlife.com

2012 Employee Assistance Program (EAP)

Administered by ComPsych

Call ComPsych® GuidanceResources® anytime for confidential assistance.

Call: **800.272.7255** TDD: **800.697.0353**

Go online: **guidanceresources.com** Your company Web ID: **COM589**

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

Confidential Counseling

Someone to talk to.

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

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

Financial Information and Resources

Discover your best options.

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

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

Legal Support and Resources

Expert info when you need it.

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

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

Work-Life Solutions

Delegate your "to-do" list.

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

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

GuidanceResources® Online

Knowledge at your fingertips.

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

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

2012 Provider Contact Info

Insurance Type	Provider	Group Number	Contact Number	Website
Basic Life Insurance	Hartford Life Insurance	GL-677800	800-523-2233	www.thehartfordatwork.com
Deferred Compensation	Hartford		Ryan Fletcher 720-535-6146 ------------------ Service Center 800-528-9009	www.retire.hartfordlife.com
Deferred Compensation	Nationwide	606017	Joe Pugliese 970-214-7462 ------------------ Participant Services 877-677-3678	http://www.nrsservicecenter.com/
Dental Insurance	MetLife Dental	304098	800-942-0854	https://mybenefits.metlife.com
Employee Assistance Program	ComPsych	COM589	800-272-7255	https://www.guidanceresources.com
Flexible Spending Accounts	WageWorks		800-950-0105	http://www.takecareWageWorks..com
Hearing Services Plan	EPIC Hearing Healthcare		866-956-5400	www.epichearing.com
Long-Term Disability	Hartford Life Insurance	GLT-677800	800-523-2233	www.thehartfordatwork.com
Medical Insurance	UMR	76-411073	800-320-3206	www.umr.com
Prescription Plan	Kroger Prescription Plans (KPP)		800-482-1285	http://www.kpp-rx.com
Retirement Plan (401a)	Principal Financial	801183	Service Center 800-547-7754	https://www.principal.com
Supplemental Insurance Policies	Aflac		Robin Mitchell or Jean Zuber 970-207-0600	https://www.aflac.com
Vision Insurance	Vision Service Plan	12065186	800-877-7195	https://www.vsp.com/
Voluntary Accidental Death and Dismember-ment	Hartford Life Insurance	ADD-507329	800-523-2233	www.thehartfordatwork.com
Supplemental Life Insurance	Hartford Life Insurance	GL-677800	800-523-2233	www.thehartfordatwork.com

2012 Holiday Schedule

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

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

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

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

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

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

2012 Accrual Charts

Vacation and Sick Leave

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

Accrual and Usage

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

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

Hours Worked Per Week	**Sick Leave Hours Accrued**	**Vacation Leave Hours Accrued**			
		0 to < 5 Years	5 to < 10 Years	10 to < 15 Years	15+ Years
20 - 24	1.85	1.85	2.31	2.77	3.24
25 - 29	2.31	2.31	2.89	3.47	4.04
30 - 34	2.77	2.77	3.47	4.16	4.85
35 - 39	3.24	3.24	4.04	4.85	5.66
Full Time	3.70	3.70	4.62	5.54	6.47

Appointed Officials:					
Hours Worked Per Week	**Sick Leave Hours Accrued**	**Vacation Leave Hours Accrued**			
		0 to < 4 Years	5 to < 9 Years	10 to < 14 Years	15+ Years
20 - 24	1.85	2.31	2.77	3.24	3.70
25 - 29	2.31	2.89	3.47	4.04	4.62
30 - 34	2.77	3.47	4.16	4.85	5.54
35 - 39	3.24	4.04	4.85	5.66	6.47
Full Time	3.70	4.62	5.54	6.47	7.39

2012 Bi-Weekly Pay Schedule

Pay Period	Start Date	End Date
1 2	Dec 15, 2011 Dec 29, 2011	Dec 28, 2011 Jan 11, 2012
3 4	Jan 12, 2012 Jan 26, 2012	Jan 25, 2012 Feb 08, 2012
5 6	Feb 09, 2012 Feb 23, 2012	Feb 22, 2012 Mar 07, 2012
7 8	Mar 08, 2012 Mar 22, 2012	Mar 21, 2012 Apr 04, 2012
9 10	Apr 05, 2012 Apr 19, 2012	Apr 18, 2012 May 02, 2012
11 12	May 03, 2012 May 17, 2012	May 16, 2012 May 30, 2012
13 14	May 31, 2012 Jun 14, 2012	Jun 13, 2012 Jun 27, 2012
15 16	Jun 28, 2012 Jul 12, 2012	Jul 11, 2012 Jul 25, 2012
17 18	Jul 26, 2012 Aug 09, 2012	Aug 08, 2012 Aug 22, 2012
19 20	Aug 23, 2012 Sep 06, 2012	Sep 05, 2012 Sep 19, 2012
21 22	Sep 20, 2012 Oct 04, 2012	Oct 03, 2012 Oct 17, 2012
23 24	Oct 18, 2012 Nov 01, 2012	Oct 31, 2012 Nov 14, 2012
25 26	Nov 15, 2012 Nov 29, 2012	Nov 28, 2012 Dec 12, 2012

Pay Date	
Jan 06, 2012 Jan 20, 2012	January
Feb 03, 2012 Feb 17, 2012	February
Mar 02, 2012 Mar 16, 2012 Mar 30, 2012	March
Apr 13, 2012 Apr 27, 2012	April
May 11, 2012 May 25, 2012	May
Jun 08, 2012 Jun 22, 2012	June
Jul 06, 2012 Jul 20, 2012	July
Aug 03, 2012 Aug 17, 2012 Aug 31, 2012	August
Sep 14, 2012 Sep 28, 2012	September
Oct 12, 2012 Oct 26, 2012	October
Nov 09, 2012 Nov 23, 2012	November
Dec 07, 2012 Dec 21, 2012	December

2012 Annual Notices

Notice of Information Practices for Larimer County's Group Health Plan, Group Vision Plan, Employee Assistance Program Group Dental Plan, and Flexible Spending Account

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Effective Date of Notice: April 14, 2003

Larimer County's Group Health Plan, its Group Vision Plan, its Employee Assistance Program, its Group Dental Plan, and its Flexible Spending Account ("Plans"), and designated health care components, are required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plans' uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plans' duties with respect to your PHI;
- your right to file a complaint with the Plans and to the Secretary of the US Department of Health and Human Services; and
- the person or office to contact for further information about the Plans' privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plans, regardless of form (oral, written, electronic).

Section I. Notice of PHI Uses and Disclosures
Required PHI Uses and Disclosures:

Upon your request, the Plans are required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plans' compliance with the privacy regulations.

A. Uses and disclosures to carry out treatment, payment, and health care operations

The Plans and their business associates will use PHI without your consent, authorization, or opportunity to agree or object to carry out the treatment, payment, and health care operations. The Plans also will disclose PHI to the Plan Sponsor, Larimer County, for purposes related to treatment, payment, and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plans may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity, and appropriateness of care and utilization review and preauthorizations).

For example, the Plans may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plans.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning, and development, business management, and general administrative activities.

For example, the Plans may use information about your claims to refer you to a disease management program; project future benefit costs or audit the accuracy of its claim processing functions.

B. Uses and disclosures that require your written authorization
Your written authorization generally will be obtain before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plans may use and disclose such notes when needed by the Plans to defend against litigation filed by you.

C. Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives, and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

D. Uses and disclosures for which consent authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization, or request under the following circumstances:

1. When required by law.
2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease, or are at risk of spreading a disease or condition, if authorized by law.
3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plans will promptly inform you that such a disclosure has been, or will be made, unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been, or will be, made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. The Plans may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5. The Plans may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plans that the requesting party has made a good faith effort to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. When required for law enforcement purposes (for example, to report certain types of wounds).
7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. Also, when disclosing information about you if you are suspected to be a victim of a crime but only if you agree to the disclosure or the Plan is unable to obtain your agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against you, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain your agreement and disclosure is in the best interest of you, as determined by the exercise of the Plans' best judgment.
8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
9. The Plans may use or disclose PHI for research, subject to conditions.
10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses, and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Section II. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plans to restrict uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to restrict uses and disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, the Plans are not required to agree to your request.

The Plans will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You, or your personal representative, will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the following office: Larimer County Benefits Specialist, Human Resources; (970) 498-5983; 200 W. Oak Street, Ste. 3200, Fort Collins, CO 80521.

B. Right to Inspect and Copy of PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set", for as long as the Plans maintain the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plans, regardless of form.

"Designated Record Set" includes the medical records and billing records about you maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the Plans to make decisions about you. Information used for qualify control or peer review analyses and not used to make decisions about you is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offside. A single 30-day extension is allowed if the Plans is unable to comply with the deadline.

You, or your personal representative, will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following office: Larimer County Benefits Specialist, Human Resources; (970) 498-5983; 2555 Midpoint Drive, Suite A, Fort Collins, Colorado 80525.

If access is denied, you, or your personal representative, will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the US Department of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Plans to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plans have 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plans are unable to comply with the deadline. If the request is denied in whole or in part, the Plans must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the following office: Larimer County Benefits Specialist, Human Resources; (970) 498-5983; 200 W. Oak Street, Ste. 3200 Fort Collins, CO 80521.

You, or your personal representative, will be required to complete a form to request amendment of the PHI in your designated record set. The written request must clearly describe the reason(s) which support(s) the requested amendment.

D. The Right to Receive an Accounting of PHI Disclosures

At your request, the Plans will also provide you with an accounting of disclosures by the Plans of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment, or health care operations; (2) to you about your own PHI; or (3) prior to the compliance date. The Plans are not required to provide an accounting of any disclosures that may have occurred before April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed and the Plans will give you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plans will charge a reasonable, cost-based fee for each subsequent accounting. The Plans will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

E. The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact the following office: Larimer County Benefits Specialist, Human Resources; (970) 498-5983; 200 W. Oak Street, Ste. 3200, Fort Collins, CO 80521.

F. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section III. The Plans' Duties

The Plans are required by law to maintain the privacy of PHI and to provide you and beneficiaries with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2003 and the Plans are required to comply with the terms of this notice. However, the Plans reserve the right to change their privacy practices and to apply the changes to any PHI received or maintained by the Plans prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to accord with applicable law to all past and present participants and beneficiaries for whom the Plans still maintain PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plans, or other privacy practices stated in this notice.

A. Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plans will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purposes of the use, disclosure, or request, taking into consideration practical and technological limitations.

- However, the minimum necessary standard will not apply in the following situations:
- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to you;
- disclosures made to the Secretary of the US Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plans' compliance with legal resolutions.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify you and with respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plans may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan, which summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section IV. Your Right to File a Complaint With the Plans or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plans in care of the following office: Larimer County Privacy Officer, Human Resources; 200 W. Oak Street, Ste. 3200 Fort Collins, CO 80521;
(970) 498-5983; or privacyofficer@larimer.org

You may file a complaint with the Secretary of the US Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plans will not retaliate against you for filing a complaint.

Section V. Whom to Contact at the Plans for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following office: Larimer County Privacy Officer, Human Resources; 200 W. Oak Street, Ste. 3200 Fort Collins, CO 80521; (970) 498-5983; or privacyofficer@larimer.org

Conclusion

PHI use and disclosure by the Plans is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules as 45 Code of Federal Regulations Part 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

2012 Annual Notices

Important Notice from Larimer County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Larimer County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to joing a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. Larimer County has determined that the prescription drug coverage offered by the Larimer County Medical Insurance Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Larimer County coverage will not be affected. If you enroll in a Medicare prescription drug plan and retain the Larimer County coverage, you and your other eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Larimer County coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (Penalty) to join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Larimer County and didn't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information or call UMR at 800-826-9781.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Larimer County changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare and You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare and You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-4227). TTY users should call 1-877486-2048.

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).

Contact—Position/Office:	Larimer County
	Human Resources/Benefits Administrator
Address:	PO Box 1190
	Fort Collins, CO 80522-1190
Number:	970-498-5983

2012 Annual Notices

Children’s Health Insurance Program Notice

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.
If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268

2012 Annual Notices (Cont.)

GEORGIA – Medicaid	**MISSOURI** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	
MASSACHUSETTS – Medicaid and CHIP	**NEW MEXICO –** Medicaid and CHIP
Medicaid and CHIP Website: http://www.mass.gov/MassHealth Medicaid and CHIP Phone: 1-800-462-1120	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	
NEW YORK – Medicaid	**TEXAS** – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493

2012 Annual Notices (Cont.)

NORTH CAROLINA – Medicaid	**UTAH** – Medicaid
Website: http://www.nc.gov Phone: 919-855-4100	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	**VERMONT**– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm _Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	**WASHINGTON** – Medicaid
Medicaid and CHIP Website: http://www.oregonhealthykids.gov Medicaid and CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLand – Medicaid	**WISCONSIN** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

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

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

OMB Control Number 1210-0137 (expires 09/30/2013)

Annual Healthcare Notices

Availability of HIPAA Privacy Notice

The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) provides certain protections with respect to the confidentiality of your health information. Larimer County 's Group Health Plans maintain a Notice of Privacy practices that provides information to individuals whose protected health information will be used or maintained by the Plans. As a participant in the Plans, you have the right to obtain this notice upon request. The Notice of Privacy Practices is available on the Human Resources Bulletin Board page.

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 31 days after your or your dependents' other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 498-5970.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call UMR, the plan administrator, for more information.

Right to Request a Certificate of Creditable Coverage

You are entitled to request a certificate of creditable coverage upon termination of your group health plan coverage. This certificate can be used to prove prior coverage and reduce your pre-existing condition exclusion period with future health plans.

To obtain a certificate of creditable coverage, please contact UMR at 800-826-9781, or the Larimer County Benefits Administrator at 970-498-5983.