



Steuben County, NY

2022 EMPLOYEE BENEFITS





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BENEFITS OVERVIEW

Steuben County is proud to offer a comprehensive benefits package to eligible employees. The complete benefits package is briefly summarized in this booklet. Upon request, you will receive plan booklets, which give you more detailed information about each of these programs.

BENEFIT PLANS OFFERED

- Medical
- Health Savings Account
- Dental
- Vision

**Open Enrollment for 2022 Plan Year:
November 1st — November 30th**

This document is an outline of coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.





ELIGIBILITY

Full-time employees and your dependents are eligible for Steuben County's benefits on the first of the month following date of hire.

Eligible dependents are your spouse, children under age 26 or disabled dependents of any age.

Elections made now will remain in effect until the next open enrollment period unless you or your family members experience a qualifying event. **If you experience a qualifying event, you must contact the finance office within 30 days.**

Class	Date of Eligibility– Medical, Dental, Vision
Management	The first day of the month following date of hire, Permanent Full and Part time employees; No hourly requirement
Retirees	Upon retirement at age 55 or older and / or retired due to disability; No years of service requirement
CSEA	The first day of the month following date of hire; Permanent Full and Part time employees; Minimum of 20 hours or more per week
Deputies Association	The first day of the month following date of hire; Permanent Full and Part time employees; Minimum of 20 hours or more per week
Correctional Officers, Dispatchers and Court Security Officers	The first day of the month following date of hire; Permanent Full and Part time employees; Minimum of 20 hours or more per week

BENEFITS WELLNESS ACTION PLAN

COMPLETERS: employees who undergo biometric screening

NON-COMPLETERS: employees who **did not** undergo biometric screening



CHANGES TO YOUR BENEFIT ELECTIONS

Employees may only make changes to their benefits during Open Enrollment; however, mid-year changes can be made if you experience an IRS qualifying change in status. Examples include:

- ◆ Marriage
- ◆ Birth or adoption of a child
- ◆ Death of an employee or dependent
- ◆ Divorce
- ◆ Change in employment status that affects benefit eligibility for you or your spouse
- ◆ Change of eligibility status for a dependent (ex: your child reaches the age limit of a benefit plan)

Benefit changes must take place within 30 days of the qualifying change in status OR during Open Enrollment

COBRA BENEFITS– ELIGIBILITY

COBRA Qualified Beneficiaries are individuals covered by a group health plan on the day before a COBRA qualifying event who are an employee, employee's spouse or an employee's dependent child.

COBRA Qualifying Events noted here are certain events that would cause an employee, their covered spouse and dependents to lose health coverage:

- ◆ Death of the employee / parent
- ◆ The employee / parent's employment ends
- ◆ The employee / parent's hours of employment are reduced
- ◆ The employee / parent becomes entitled to Medicare benefits
- ◆ The employee / parent divorces or is legally separated
- ◆ The child is no longer eligible for coverage under the plan



MEDICAL BENEFITS

Administered by Excellus

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large issues. By identifying the problems early, often they can be treated easily and at little cost. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Steuben County.

	Copay Plan	Lower Premium Plan
	In-Network	In-Network
Lifetime Benefit Maximum	Unlimited	Unlimited
Annual Deductible	\$0 single \$0 family	\$1,500 single \$3,000 family
Annual Out-of-Pocket Maximum (includes deductible)	\$1,250 single \$2,500 family	\$4,000 single \$8,000 family
Coinsurance	0%	20%
DOCTOR'S OFFICE		
Primary Care Office Visit	\$15 copay	20% coinsurance subject to deductible
Specialist Office Visit (including Urgent Care)	\$25 copay	20% coinsurance subject to deductible
Wellness Care (routine exams, x-rays/tests, immunizations, well child care and mammograms)	Covered in full	Covered in full
PRESCRIPTION DRUGS		
Retail—Generic Drug (30-day supply)	\$5 copay \$0 generics for kids to age 19	\$5 copay subject to deductible \$0 generics for kids to age 19
Retail—Formulary Drug (30-day supply)	\$20 copay	\$20 copay subject to deductible
Retail—Nonformulary Drug (30-day supply)	\$40 copay	\$40 copay subject to deductible
Mail Order—Generic Drug (90-day supply)	\$5 copay	\$10 copay subject to deductible
Mail Order—Formulary Drug (90-day supply)	\$20 copay	\$40 copay subject to deductible
Mail Order—Nonformulary Drug (90-day supply)	\$40 copay	\$80 copay subject to deductible



	Copay Plan	Lower Premium Plan
	In-Network	In-Network
HOSPITAL SERVICES		
Emergency Room	\$100 copay	20% coinsurance subject to deductible
Physician / Surgeon	Covered in full	20% coinsurance subject to deductible
Urgent Care Centers	\$25 copay	20% coinsurance subject to deductible
MENTAL HEALTH SERVICES		
Inpatient Services	\$100 copay	20% coinsurance subject to deductible
Outpatient Services	\$15 copay	20% coinsurance subject to deductible
SUBSTANCE ABUSE SERVICES		
Inpatient Services	\$100 copay	20% coinsurance subject to deductible
Outpatient Services	\$15 copay	20% coinsurance subject to deductible
OTHER SERVICES		
Maternity Services (All Subsequent Prenatal Visits, Postnatal visits and Physician's Delivery Charges)	Covered in full	20% coinsurance subject to deductible
Diagnostic Test (x-ray, blood work)	X-ray: \$15 copay Lab Services: Covered in Full	20% coinsurance subject to deductible
Diagnostic Imaging (CT / PET scans / MRI)	\$15 copay	20% coinsurance subject to deductible



HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account, also known as an HSA, is a tax-advantaged medical savings account available to participants who are enrolled in an IRS qualified High Deductible Health Plan. HSA funds may be used to pay for qualified medical expenses (including dental and vision) without federal tax liability or penalty.

If you enroll in Steuben County's Low Premium Plan, the County will make a contribution per pay period into your Health Savings Account (**\$650 annual contribution for employee only coverage or \$1,300 annual contribution for family coverage**) to help pay for out-of-pocket expenses.

Eligibility

- Must be covered under an IRS qualified High Deductible Health Plan
- You cannot be covered under any other health plan (Medicare, Medicaid, dual coverage through a spouse)
- You cannot be claimed as a dependent on someone else's tax return

2022 Contribution Limits

- **Individual Contribution Limit: \$3,650**
- **Family Contribution Limit: \$7,300**
- The annual contribution limit is a combination of both employer and employee funds
- Participants of a Health Savings Account who are age 55 and older may contribute an extra \$1,000 of "catch up" contributions into their HSA annually

Steuben County Health Savings Account Information

Any Steuben County employee who elects the High Deductible Health Plan will automatically be eligible for a contribution into a Health Savings Account. The County will contribute a pre-determined amount every pay period and you may choose to contribute additional funds on a pre-tax basis through payroll deductions. For 2022 the County will contribute \$25 per pay period for individual coverage or \$50 per pay period for family coverage.

*****The Health Savings Account will be available through *Community Bank, NA* and you must open a Health Savings Account with them in order to receive the County's contribution.*****



DENTAL BENEFITS

Administered by CSEA Employee Benefits Fund

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with Steuben County's dental benefit plan.

Service Type	Schedule of Allowances	
	CSEA Sunrise Dental	COCSEA Horizon Dental
Annual Deductible	N/A	N/A
Annual Benefit Maximum	\$2,850	\$3,000
Preventive Dental Services (cleanings, exams, x-rays)	Cleanings / X-rays: \$75 / \$85 Oral Exams / Sealants: \$34 / \$24 Emergency Treatment: Variable based on services rendered	Cleanings / X-rays: \$80 / \$85 Oral Exams / Sealants: \$42 / \$25 Emergency Treatment: Variable based on services rendered
Basic Dental Services (fillings, root canal therapy, oral surgery)	Fillings: \$88 (one surface filling) Oral Surgery: \$80 to \$375 (one tooth per lifetime)	Fillings: \$94 (one surface filling) Oral Surgery: \$90 to \$400 (one tooth per lifetime)
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	Implants: \$575 to \$725 Inlays / Onlays: \$243 (one surface) Prosthetic Removable: \$200 to \$900	Implants: \$625 to \$750 Inlays / Onlays: \$250 (one surface) Prosthetic Removable: \$220 to \$925
Orthodontia Services (covered to age 19)	Appliance Insertion: \$950 Limited/Appliance Therapy: \$500 Periodic Ortho Treatment: \$135 (For 24 active monthly treatment visits)	Appliance Insertion: \$975 Limited/Appliance Therapy: \$500 Periodic Ortho Treatment: \$150 (For 24 active monthly treatment visits)
Dependent Coverage	Covered to age 26	Covered to age 26





DENTAL BENEFITS (CONTINUED)

Administered by Excellus- Management, Deputies Association and Retiree

Service Type	Coverage
Annual Deductible	N/A
Annual Benefit Maximum	\$2,500
Preventive Dental Services (cleanings, exams, x-rays)	Covered at 100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	Covered at 80%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	Covered at 50%
Orthodontia Services (covered to age 19)	\$2,100 lifetime maximum
Dependent Coverage	To age 26



VISION INSURANCE

Regular eye examinations cannot only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Administered by EyeMed– Management and Retirees

	In-Network	Out-of-Network
Eye Exam — once every 12 months	\$0 copay	Up to \$40
Lenses — once every 12 months		
Single Vision Lenses	\$0 copay	Up to \$32
Lined Bifocal Lenses	\$0 copay	Up to \$46
Lined Trifocal Lenses	\$0 copay	Up to \$60
Lenticular Lenses	\$0 copay	Up to \$90
Frames — once every 12 months	\$0 copay; \$130 allowance; 20% off price over \$130	Up to \$91
Contact Lenses — Conventional	\$0 copay; \$130 allowance 15% off price over \$130	Up to \$115
Contact Lenses — Disposable	\$0 copay; \$130 allowance	Up to \$115

Administered by CSEA– CSEA and COCSEA

	In-Network	Out-of-Network
Eye Exam — once every 12 months	Covered if Panel Provider	\$16
Lenses — once every 12 months		
Single Vision Lenses	Covered if Panel Provider	\$14
Lined Bifocal Lenses	Covered if Panel Provider	\$23
Lined Trifocal Lenses	Covered if Panel Provider	\$32
Frames — once every 12 months	Only the frame collection	\$11
Contact Lenses — Conventional	Covered if Panel Provider	\$125 for Non Plan Contact Lenses
Contact Lenses — Disposable	Covered if Panel Provider	\$125 for Non Plan Contact Lenses

Administered by VSP– Deputies Association

	In-Network	Out-of-Network
Eye Exam — once every 24 months	\$0 copay	Up to \$40
Lenses — once every 24 months		
Single Vision Lenses	\$0 copay	Up to \$35
Lined Bifocal Lenses	\$0 copay	Up to \$52
Lined Trifocal Lenses	\$0 copay	Up to \$65
Frames — once every 24 months	\$130 allowance; 20% savings on the amount over your allowance	Up to \$52
Contact Lenses — Conventional	\$130 allowance , copay does not apply. Covered every 24 months	Up to \$105
Contact Lenses — Disposable	\$130 allowance , copay does not apply. Covered every 24 months	Up to \$105





2022 Medical Premiums Per Pay Period

	Copay Plan		Low Premium Plan	
	With Wellness	No Wellness	With Wellness	No Wellness
CSEA– Steuben County Employee Unit				
Hired Before 1/1/1998	Single: \$44.15 Family: \$132.16	Single: \$59.92 Family: \$179.35	Single: \$7 Family: \$60	Single: \$20 Family: \$100
Hired After 1/1/1998	Single: \$50.46 Family: \$151.04	Single: \$63.08 Family: \$188.79	Single: \$7 Family: \$60	Single: \$20 Family: \$100
CSEA– Correction Officers, Dispatchers & Court Security Unit				
Hired Before 9/1/2008	Single: \$47.31 Family: \$141.60	Single: \$59.92 Family: \$179.35	Single: \$7 Family: \$60	Single: \$20 Family: \$100
Hired After 9/1/2008	Single: \$50.46 Family: \$151.04	Single: \$63.08 Family: \$188.79	Single: \$7 Family: \$60	Single: \$20 Family: \$100
Deputies Association				
	Single: \$47.31 Family: \$141.60	Single: \$59.92 Family: \$179.35	Single: \$7 Family: \$60	Single: \$20 Family: \$100
Management				
	Single: \$44.15 Family: \$132.16	Single: \$59.92 Family: \$179.35	Single: \$7 Family: \$60	Single: \$20 Family: \$100



2022 Dental/Vision Premiums Per Pay Period

CSEA
Composite Rate: \$60.66
CSEA- CO
Composite Rate: \$67.69
Deputies Association
Single: \$18.05
Family: \$47.37
Management
Single: \$22.00
Family: \$57.31



APPENDIX– ANNUAL COMPLIANCE NOTICES

The following are notices that Steuben County is required to provide to employees on an annual basis.

Credible Coverage Disclosure Notice

Important Notice from Steuben 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 your employer about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join 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 to 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 by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered by Excellus Blue/Cross Blue/Shield 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 to 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, and drop your current group plan with your employer, coverage may be affected and you may not be able to get it back. Please contact us for further information.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the person listed below for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may 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 & 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 or call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).



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COBRA Rights

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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



APPENDIX– ANNUAL COMPLIANCE NOTICES

The following are notices that Steuben County is required to provide to employees on an annual basis

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

Keep your Plan informed of address changes

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

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within "30 days" after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Personnel Office.



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Reminder of Availability of HIPAA Privacy Notice

The Plan Sponsor maintains the HIPAA Notice of Privacy Practices for the Plan, which describes how health information about you may be used and disclosed. You may obtain a copy of our HIPAA Notice of Privacy Practices by contacting the Plan Sponsor or Privacy Officer by writing to your employer.

Newborn's and Mother's Health Protection Act

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

Women's Health and Cancer Rights Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 1-800-724-5032 or visit the Excellus website for more information <https://www.excellusbcbcs.com>.

Women's Health and Cancer Rights Act Annual Notice

Do you know that 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 lymph edema? Contact Excellus Customer Service at 1-800-724-5032 or visit the Excellus website for more information <https://www.excellusbcbcs.com>.

Women's Preventive Benefits as part of Patient Protection and Affordable Care Act (PPACA) Summary

The Patient Protection and Affordable Care Act (PPACA) requires health plans to cover designated women's preventive services without cost sharing for the member. Cost sharing includes deductibles, copayments and coinsurance. Some of the benefits and services outlined in the women's preventive guidelines are already included within the existing PPACA preventive services requirements. Many of the screenings/services included in this provision would be provided at the time of the annual well-women visit. The following preventive services must be covered with no cost sharing:

- a) Well woman visits: Including coverage for prenatal visits that are billed separately from the delivery and postpartum care.
- b) Gestational Diabetes Screening*
- c) Human Papillomavirus (HPV) Testing*
- d) Counseling for Sexually Transmitted Diseases
- e) HIV Testing and Counseling*
- f) Contraceptive Methods and Counseling
- g) Breastfeeding Support, Supplies and Counseling



APPENDIX– ANNUAL COMPLIANCE NOTICES

The following are notices that Steuben County is required to provide to employees on an annual basis

Women’s Preventive Benefits as part of Patient Protection and Affordable Care Act (PPACA) Summary CONTINUED

(* laboratory services associated with the screening are covered at no cost□share)

The existing PPACA preventive benefits had age, gender and frequency restrictions.

Does the women’s preventive services provision contain any restrictions?

Yes, there are certain benefits and services that contain frequency restrictions. Some services/benefits are provided to pregnant women only or for women who are sexually active. For a full list of restrictions and guidelines, visit: <http://www.hrsa.gov/womensguidelines/>

Lifetime/Annual Dollar Limits Summary and Essential Health Benefits per the Patient Protection and Affordable Care Act (PPACA)

Law prohibits imposing annual limits on “Essential Health Benefits” and any lifetime dollar limits. The services covered in the medical plan will not change but any service designated as “essential” will no longer have an annual and/or lifetime dollar limit. These “essential services” as defined by the federal mandate include: Ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative care, laboratory services, preventative and wellness service and chronic disease management, pediatric services, including oral and vision care. Essential Health Benefits as required by Health Care Reform are included in your medical plan. Please visit www.excellusbcbs.com for a full listing of covered benefits. This list is subject to change based on additions and deletions from regulatory agencies.

Medicaid – CHIP Notice

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –



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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, 2019. Contact your State for more information on eligibility –

<p style="text-align: center;">ALABAMA – Medicaid</p> <p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p style="text-align: center;">FLORIDA – Medicaid</p> <p>Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268</p>
<p style="text-align: center;">ALASKA – Medicaid</p> <p>The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp x</p>	<p style="text-align: center;">GEORGIA – Medicaid</p> <p>Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131</p>
<p style="text-align: center;">ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p style="text-align: center;">INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864</p>
<p style="text-align: center;">COLORADO – Health First Colorado</p> <p style="text-align: center;">(Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)</p> <p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711</p>	<p style="text-align: center;">IOWA – Medicaid</p> <p>Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563</p>
<p style="text-align: center;">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512</p>	<p style="text-align: center;">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p style="text-align: center;">KENTUCKY – Medicaid</p> <p>Website: https://chfs.ky.gov Phone: 1-800-635-2570</p>	<p style="text-align: center;">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>



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<p style="text-align: center;">LOUISIANA – Medicaid</p> <p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447</p>	<p style="text-align: center;">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p style="text-align: center;">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public_assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711</p>	<p style="text-align: center;">NORTH CAROLINA – Medicaid</p> <p>Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100</p>
<p style="text-align: center;">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p style="text-align: center;">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825</p>
<p style="text-align: center;">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p style="text-align: center;">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p style="text-align: center;">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p style="text-align: center;">OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>
<p style="text-align: center;">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>	<p style="text-align: center;">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462</p>
<p style="text-align: center;">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178</p>	<p style="text-align: center;">RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>
<p style="text-align: center;">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p style="text-align: center;">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>
<p style="text-align: center;">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p style="text-align: center;">WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473</p>



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<p style="text-align: center;">TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>	<p style="text-align: center;">WEST VIRGINIA – Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p style="text-align: center;">UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>	<p style="text-align: center;">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</p>
<p style="text-align: center;">VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>	<p style="text-align: center;">WYOMING – Medicaid</p> <p>Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531</p>
<p style="text-align: center;">VIRGINIA – Medicaid and CHIP</p> <p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance CHIP Phone: 1-855-242-8282</p>	



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To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

LEGAL DISCLAIMER

STEBEN COUNTY attempted to ensure all information in this handbook is clear and accurate. Each benefit plan available through STEUBEN COUNTY is governed by the individual Summary Plan Description and/or the Plan Document.

This document is not meant to describe STEUBEN COUNTY benefits in detail, and is not a Summary Plan Document. This is merely a summary of available benefits and is subject to change at any time. Open Enrollment for these programs will occur annually. Eligibility requirements apply.



APPENDIX– ANNUAL COMPLIANCE NOTICES

Marketplace Coverage Notice

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment- based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Steuben County		4. Employer Identification Number (EIN)	
5. Employer Address 3 East Pulteney Square		6. Employer phone number	
7. City Bath		8. State New York	9. ZIP code 14810
10. Who can we contact at this job? Personnel Department			
11. Phone number (if different from above)		8. Email address	



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Here is some basic information about your health coverage offered by this employer: As our employer, we offer a health plan to:

Employees who regularly scheduled to work at least 30 hours per week.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [healthcare.gov](https://www.healthcare.gov) will guide you through the process.

QUESTIONS?

If you have any questions regarding these notices, please contact the Personnel Office.