Cochise Combined Trust

2017-2018
OPEN ENROLLMENT BENEFIT GUIDE

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Who is Eligible?

All active employees in accordance with the established policy of Cochise County and the Cochise Combined Trust are eligible for benefits provided they occupy an authorized budgeted position as defined by the County, and are performing all of the duties of their employment. For a list of eligible dependents, please refer to the Summary Plan Document.

Enrollment/Change Deadline

This year's open enrollment period is from **April 3, 2017** to **April 28, 2017**. This is the time period set aside for you to make changes to your benefit elections. The benefit changes you elect during open enrollment will become effective July 1, 2017.

Qualified Changes in Status

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. For a list of qualifying change of status situations, please refer to the Summary Plan Document.

What's New for **2017-18?**

Medical

We are pleased to announcement that for the first time, employees will be able to choose between different medical benefit plans.

Option 1:
Traditional (EPO)

The following changes to the Medical benefits will be effective for the upcoming plan year beginning **July 01, 2017** ***for the EPO Plan*****:**

- Add a National Wrap Network – You will now have access to the PHCS Healthy Directions Network outside of Arizona.
- Coverage added for Diagnostic 3D Mammograms
- Increase the single max out-of-pocket maximum from $3,000 to $3,500 and the family max out-of-pocket maximum from $13,700 to $14,300 inclusive of deductibles and co-pays as required by the Affordable Care Act;
- Increase the deductible from $350/$1,050 to $500/$1,500
- Sleep Studies and Advanced Imaging now require pre-certification
- An additional EPO option has been added - $250/$750 deductible and $2,000/$4,000 maximum out-of-pocket. All other plan provisions remain the same. There is an additional premium to participate in this plan.

When you enroll in the EPO, benefits are payable only to contracted Blue Cross Blue Shield of Arizona (BCBSAZ) providers or PHCS Healthy Directions Providers outside of Arizona, except in the case of a life-threatening emergency. Members will pay a set copayment for services as outlined in the summary plan document, such as doctor's office visits ($25 Primary Care Physician or $35 Specialist) and prescriptions. Before the plan's benefits take effect, you must meet the plan year deductible of $500 per individual and $1,500 for family ($250/$750 EPO Buy-up). *Copayments do not apply to the deductible.*

Coinsurance is the percentage of eligible expenses that members and the plan share when care is received. The plan pays 80% and you as the member pay 20% *after the individual or family deductible has been met*. You are responsible for your share of coinsurance until reaching the plan year out-of-pocket maximum. The out-of-pocket maximum is the most you will pay for eligible services during the plan year. When you reach the maximum, the plan pays 100% for eligible major medical services for the remainder of the plan year. The out-of-pocket maximum is $3,500 per individual and $14,300 for a family ($2,000/$4,000 EPO Buy-up). Your deductible and medical co-payments accumulate toward the maximum out-of-pocket. Please see prescription drugs section for information on prescription co-pays and prescription out-of-pocket maximums

To obtain Pre-certification and Verification of Benefits, members should call AmeriBen at 800-388-3193. ***If a plan participant fails to comply with the pre-certification requirements, it will result in a three hundred-dollar ($300) penalty***. Please refer to your summary plan document to see what services require pre-certification.

Option 2:

HealthCare Savings Account (HCSA)

Under the HCSA, members must meet the plan year deductible before the plan benefits kick in. You may use your Health Savings Account (HSA) funds to pay for any qualified medical expenses, including those incurred while meeting your deductible. If you exhaust your HSA funds, you pay any additional expenses required to meet your deductible out of your own pocket. Medical care and prescriptions are both subject to the deductible in this plan. The in-network deductible is $3,000 for an individual and $6,000 for a family and the *separate* out-of-network deductible is $5,000 for an individual and $10,000 for a family. ***Please note that if you have elected employee only coverage, the $3,000 individual deductible must be met before the plan will begin to pay for ANY benefits except preventive care. If you elect family coverage, once any one member reaches $3,000 in eligible expenses, the plan will begin to pay for their covered expenses; any combination of family members can meet the family deductible of $6,000.*** Once you have met *the applicable in network or out of network* deductible, your care is covered through the plan's coinsurance as outlined in the summary plan document. The plan pays 100% of eligible charges for services provided in-network and 50% of eligible charges for services provided out-of-network.

If you select the **HCSA additional option,** the in-network deductible is $1,300 for an individual and $2,600 for a family and the *separate* out-of-network deductible is $5,000 for an individual and $10,000 for a family. ***Please note that if you have elected employee only coverage, the $1,300 individual deductible must be met before the plan will begin to pay for ANY benefits except preventive care. If you elect family coverage, the plan will begin to pay for covered expenses once the $2,600 family deductible has been met.*** Once you have met *the applicable in-network or out-of-network* deductible, your care is covered through the plan's coinsurance as outlined in the summary plan document. The plan pays 90% of eligible charges for services provided in-network and 50% of eligible charges for services provided out-of-network until you reach the maximum out-of-pocket.

You are responsible for your share of coinsurance until reaching the plan's out-of-pocket maximum. The out-of-pocket maximum is the most you will pay for eligible services during the plan year. Once you reach the maximum, the plan will pay 100% of eligible charges. The out-of-pocket maximum for in-network services is $3,000 for an individual and $6,000 for a family; out-of-network is $5,000 individual and $10,000 family. The out-of-pocket maximums include the deductible and coinsurance.

Participants in the HCSA are eligible to contribute to a health savings account. The County will also contribute $500 annually to the employee's health savings account.

Health Savings Account (HSA)

What is an HSA?

An HSA is an individual savings account that can be used to pay for qualified medical expenses. The HCSA option allows you to open an HSA and take advantage of terrific tax savings. The money in your account accumulates on a tax-deferred basis and can be rolled over from year to year. You can save your money for future medical expenses, and as long as you use the money for a qualified medical expense, your funds are never taxed. This account is only available if you select the Health-Care Savings Account (HCSA). A participant cannot contribute to an HSA if they are covered on any

other non-qualified plan, are covered as a dependent on another person's tax return (excluding spouses), are enrolled in an FSA, or are enrolled in Medicare.

How Does an HSA Work?

A HealthCare Savings Account offers a lower monthly premium in exchange for a higher deductible. The money you would normally spend on monthly premiums can now be contributed on a pre-tax basis to your HSA account. You will receive a debit card to use for qualified medical expenses, which will draw from your HSA. Distributions from your HSA are tax-free when used to pay for qualified medical expenses. The 2017 maximum combined contribution for single coverage is $3,400, and family is $6,750. HSA participants who are 55 or older can contribute an additional $1,000. There is a $2.95 per month fee for your HSA Account.

Prescription Drugs

CCT is implementing the following changes to the prescription medication program effective July 1, 2017 for the EPO plan:

- Decrease the prescription maximum out-of-pocket of $3,850 to $3,650 for an individual.
- The family maximum out-of-pocket is $14,300 and includes both medical and prescription.

The health care savings account (HCSA) prescription drug benefit is subject to the plan year deductible of $3,000 for an individual and $6,000 for a family. There are no copayments, coinsurance or separate deductible for prescription drugs**.** The HCSA additional option prescription drug benefit is subject to the plan year deductible of $1,300 for an individual and $2,600 for a family. After the deductible, there is 90/10 coinsurance until the maximum out-of-pocket has been met. There are no copayments or separate deductibles for prescription drugs**.**

You can find additional information about your prescription drug plan at www.navitus.com, or contact Navitus Customer Service at (866) 333-2757. Both resources are available 24 hours a day, 7 days a week.

Dental Insurance

- Coverage for Orthodontia has been increased from $1,000 lifetime to $2,500 lifetime.

Unmarried dependents age 19 but less than 24 who are a full time student (12 credit hours per semester) at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and primarily dependent on the Member or the Member's Spouse for support and maintenance are eligible.

Voluntary Vision Insurance

- Allowance for Elective Contacts has been increased from $135 to $150
- Allowance for Eyeglass Frames has been increased from 120 to $150

Unmarried dependents age 19 but less than 24 who are a full time student (12 credit hours per semester) at an accredited school or college, which includes a vocational, technical, vocational-

technical, trade school or institute; and primarily dependent on the Member or the Member's Spouse for support and maintenance are eligible.

Employee Premium Contributions

Employee Health Benefit Rate Schedule FY 17-18
Rates and plans effective July 1, 2017 – June 30, 2018

	Traditional Plan (EPO)			
	Employee Only	Employee/Spouse	Employee/Child	Employee/Family
Monthly Premium	$574.19	$1,004.63	$836.91	$1,222.17
County Contribution	$524.19			
Employee Cost Per pay Period*	$25.00	$135.00	$85.00	$185.00
Employee Cost Per Pay Period* for Lower Deductible/OOP Max	$37.50	$180.00	$121.00	$254.00

	Healthcare Savings Account (HDHP)			
	Employee Only	Employee/Spouse	Employee/Child	Employee/Family
Monthly Premium	$529.79	$922.39	$765.91	$1,124.43
County Contribution to Premium	$529.79			
Annual County Contribution to Employee's HSA	$500.00	$500.00	$500.00	$500.00
Employee Cost Per Pay Period*	$0	$67.50	$42.50	$92.50
Employee Cost Per Pay Period* for Lower Deductible/OOP Max	$50.00	$184.00	$121.00	$261.00

	Dental & Vision Rates			
	Employee Only	Employee/Spouse	Employee/Child	Employee/Family
Dental Premium	$26.31			$74.60
County Contribution	$2.76			$8.78
Employee Cost Per pay Period*	$11.78			$32.91
Vision Premium	$3.20	$6.08	$6.40	$9.31

Employee Assistance Program (EAP)

Cochise Combined Trust has selected a new Employee Assistance Program vendor. The County now provides an Employee Assistance Program through Alliance Work Partners (AWP). The EAP provides up to three (3) free counseling sessions each plan year (July 1 through June 30) for each type of problem you or your household members may encounter, along with work-life assistance for financial and/or legal problems. To make a confidential appointment, please call 800-343-3822. You can also access a variety of information on their website at www.awpnow.com. Brochures and more information are available in Human Resources.

Voluntary Life Insurance

There are no changes to the voluntary life *insurance* benefit for the 2017-18 plan year. *However, premium rates are adjusted on 7-1-2017 for the employee and spouses that move into a new age band. If you, your spouse or children are not enrolled or if you wish to increase amounts you may complete an application; however, evidence of insurability will be required.* For benefits and rate information, please refer to the handout provided separately or call Human Resources. **Open Enrollment is an excellent time to review your beneficiary designation to determine if any changes should be made.**

Teladoc

The County provides access to Teladoc for quick and convenient consultations with a physician. **E*ach plan participant in the EPO plan will receive two (2) consultations at a $0 consultation fee.*** Due to IRS regulations HCSA cannot receive the $0 consultations but are still encouraged to utilize Teladoc with the $45 fee for convenience. HCSA plan participants can receive reimbursement for consultations after meeting their deductible. Visit **www.teladoc.com** or call **1-800-Teladoc (835-2362)** to set up your account and talk to a doctor.

Wellness Program

Cochise Combined Trust is going back to basics for the 2017-18 Wellness programming. The HumanaVitality (Go365) program will be discontinued effective June 30, 2017 so be sure to cash in your rewards.

On-site Screenings will continue to be offered and a new and improved Health and Wellness quarterly newsletter will be coming your way.

Participation is the key to a successful Wellness Program and the key to a better quality of life for those who participate. Take the time to check out the Wellness Program being offered to you and your dependents as CCT participants. It is good for your health!

Calendar of events will be published at a later date.

Retirement Contributions FY 17-18

Effective July 01, 2017, retirement system contribution rates are as follows:

2017-2018 Retirement Contributions

Retirement	Current Employee Contribution	New Employee Contribution	% Change Employee	Current Employer Contribution	New Employer Contribution	% Change Employer
Arizona State	11.48%	11.50%	+0.02	11.50%	11.50%	+0.02%
Public Safety	11.65%%	11.65%	0%	50.98%%	54.96%	+3.98%
CORP - AOC	8.41%	8.41%	0%	20.88%	23.34%	+2.46%
CORP	8.41%	8.41%	0%	19.53%	19.90%	+.37%
EORP	13.00%	13.00%	0%	23.50%	23.50%	0%

Flexible Spending Accounts(FSA)

Under Section 125 of the IRS code, your employer sponsors a pre-tax cafeteria plan known as a Flexible Spending Account (FSA). This plan provides you with a convenient way to pay for certain expenses with pre-tax dollars' savings from FICA, federal, and sometimes even state taxes. Through the plan, you set aside a portion of your earnings to pay for medical/dental/vision/ prescription expenses such as co-pays that are not covered by insurance. The plan also allows for earned income to be set aside for child daycare expenses.

Dependent Daycare eligible expenses are for children under the age of 13 and dependents of any age who are physically or mentally unable to care for themselves. By enrolling in this plan, you save money on child daycare expenses incurred so that you (and your spouse, if married) can work, look for work, or attend school on a full-time basis.

The County offers you the opportunity to participate in the following flexible spending accounts:

1. **Unreimbursed Medical (URM) Account** – Employees may elect to participate in the unreimbursed medical account, which is a cost-effective way to pay for predictable, eligible health care expenses that comply with the rules defined by the IRS. Such expenses typically are items not covered by health care insurance, such as co-payments for doctor visits and prescriptions. By paying for these expenses through an FSA before federal, social security, and state taxes are taken out, your taxable income is reduced.
   The maximum medical reimbursement amount allowable in FY 2017-18 is $2,600. Cochise County has chosen to provide you with the $500.00 Carryover option for your Flexible Benefit Plan. This allows you to carry over up to $500.00 of unused funds at the end of the Plan Year into the next Plan Year. Any funds in excess of $500.00 must be claimed by the end of the run-out period or they will be forfeited under the "use-it-or-lose-it" rule. Your plan also includes an FSA debit card to facilitate the use of your FSA contributions by allowing participants to pay for services at point of sale, without having to send in a request for reimbursement. **This does not mean that you will not have to submit documentation for any expenses paid for with the card.**

2. **Dependent Day Care (DDC) Account** - Employees may also elect to participate in the dependent day care account which allows them to pay for dependent care expenses with tax-free dollars for eligible dependents. Maximum amount is $5,000 or $2,500 if married or filing separate.

As a reminder, you must re-enroll in the medical reimbursement or dependent care plan each year.
The funds elected can only be used for expenses incurred during the plan year.
Contact Wendy De La Cruz for the appropriate enrollment forms.

Important Notices

Women's Health and Cancer Rights Act (WHCRA)

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

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

This coverage is subject to the same *deductibles* and *co-payments* consistent with those established for other benefits under this *Plan*.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444- EBSA (3272).

If you live in the following State, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.

State	Website	Phone
Arizona • CHIP	http://www.azahcccs.gov/applicants	(Outside of Maricopa Co.): 1-877-764-5437 (Maricopa Co.): 1-602-417-5437

To research the availability of, and your eligibility for, premium assistance in other states, 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 & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Compliance with HIPAA Privacy Standards

HIPAA stands for the *Health Insurance Portability and Accountability Act of 1996*.

Certain members of the ***employer's*** workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the *Privacy Standards*), these *employees* are permitted to have such access subject to the following:

1. **General.** The *Plan* shall not disclose Protected Health Information to any member of the ***employer's*** workforce unless each of the conditions set out in this Compliance with *HIPAA Privacy Standards* section is met. Protected Health Information shall have the same definition as set out in the *Privacy Standards* but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the ***employer's*** workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The ***Plan's*** administrative functions shall include all *Plan* payment and health care operations. The terms payment and health care operations shall have the same definitions as set out in the *Privacy Standards*, but the term payment generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill *Plan* responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. Health care operations generally shall mean activities on behalf of the *Plan* that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. *Genetic information* will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the ***employer's*** workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this Compliance with *HIPAA Privacy Standards* section, members of the ***employer's*** workforce shall refer to all *employees* and other persons under the control of the *employer*.
    a. Updates Required. The *employer* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    b. Use and Disclosure Restricted. An authorized member of the ***employer's*** workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the *Plan*.
    c. Resolution of Issues of Noncompliance. In the event that any member of the ***employer's*** workforce uses or discloses Protected Health Information other than as permitted by the *Privacy Standards*, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
        i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised

ii. applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment

iii. mitigating any harm caused by the breach, to the extent practicable

iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages

4. **Certification of Employer.** The *employer* must provide certification to the *Plan* that it agrees to:

   a. Not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law.

   b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the *Plan*, agrees to the same restrictions and conditions that apply to the *employer* with respect to such information.

   c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *employer*.

   d. Report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

   e. Make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the *Privacy Standards*.

   f. Make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the *Privacy Standards*.

   g. Make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the *Privacy Standards*.

   h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *Privacy Standards*.

   i. If feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible.

   j. Ensure the adequate separation between the *Plan* and member of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the *Privacy Standards*.

5. The following members of the Cochise Combined Trust are designated as authorized to receive Protected Health Information from the Cochise Combined Trust (the *Plan*) in order to perform their duties with respect to the *Plan*:

   a. Account Manager (brokerage firm)

   b. Group Benefits Analyst (brokerage firm)

   c. Assistant Vice President – Human Resources

   d. Human Resources Director

   e. Benefits Coordinator

Compliance with HIPAA Electronic Security Standards

Under the *Security Standards* for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the *Security Standards*), the *employer* agrees to the following:

1. The *employer* agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the *employer* creates, maintains or transmits on behalf of the *Plan*. Electronic Protected Health Information shall have the same definition as set out in the *Security Standards*, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

The *employer* shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Authorized Employees and Certification of Employers provisions, described above.

Mental Health Parity

Under a Federal law known as the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is self-funded by the *employer*, rather than provided through a health insurance policy. The Cochise Combined Trust (CCT) has elected exemption from the following requirement:

Parity in the Application of Certain Limits to Mental Health Benefits

Group health plans [of employers that employ more than fifty (50) employees] that provide both medical and surgical benefit and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the *Plan*.
The exemption from this Federal requirement will be in effect for the plan year beginning July 1, 2017 and ending June 30, 2018. This election may be renewed for subsequent plan years.
If you have any questions regarding CCT's election to exempt the Trust from the requirements of mental health parity, please feel free to contact the Pool Administrator, Stephanie Moore with Erin P. Collins & Associates, Inc., at (928) 753-4700 ext. 303.

Reminder: Completed forms are required this year to request a change to your current benefit elections by April 28, 2017.

If you have any questions, please contact Wendy De La Cruz at wdelacruz@cochise.az.gov or call (520) 432-9706

The text contained in the Open Enrollment Benefit Guide was taken from the summary plan document and benefit information. While every effort was take to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this guide and the actual plan documents, the actual documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about open enrollment, please contact your Benefits Representative.