

Ramsey County

Employee Insurance Benefit Plans

Reference Guide

2012

Retiree Benefits

Retiree benefits are addressed in a separate Retiree Benefit Plan Reference Guide that is available on RamseyNet. These benefits are subject to change each year.

Please keep this guide for future reference

Contents

Eligibility	Page 1
Medical	Page 5
Dental	Page 9
Life	Page 12
Disability	Page 15
Benefit Reps	Page 18
Premium Rates	Page 19

Enrollment Restrictions

Please Note: There are restrictions on enrolling or changing medical or dental coverage during the plan year if you pay your premiums on a pre-tax basis. If you are paying premiums on a pre-tax basis, you may not cancel coverage during the year unless you have a qualifying change in status (see page 3) and notify the County within 31 days. Please refer to the Ramsey County Cafeteria Plan Reference Guide (available on RamseyNet or you may obtain a copy from your Benefit Representative.) Check with your Benefit Representative if you have any questions.

Special Enrollment Due to Change in Eligibility for Medicaid or SCHIP

If you or a dependent lose eligibility or become eligible for Medicaid or coverage under a State Children’s Health Insurance Program, you have up to 60 days after the change in eligibility to request special enrollment in the Ramsey County medical or dental plan. If you think you or any of your dependents might be eligible for either of these programs, call 1-877-KIDS NOW to discuss your options.

Eligibility for Insurance

Who is eligible?

- Permanent, probationary, provisional and unclassified employees who work at least 40 hours per pay period on a regular basis.

Who is not eligible?

- Temporary, seasonal, and intermittent employees.
- Employees who work less than 40 hours per pay period on a regular basis.

Who is an eligible dependent?¹

For medical and dental insurance:

- Your spouse (as defined by the State of Minnesota). If your spouse is a Ramsey County employee, neither you nor your spouse may be enrolled as both an employee and dependent, and you may not double cover your children. Divorced spouses are **not** eligible dependents. If you are getting divorced and carry family coverage, you must contact Diane Leyde at 651-266-2734 concerning state and federal laws regarding continuation of coverage.
- Your children to age 26, including adopted children, stepchildren, and children under your or your spouse’s legal guardianship, regardless of student status, marital status, or financial dependency. Grandchildren may be covered under the medical and dental plans up to age 26 if they are dependent upon you for the majority of financial support.
- Children of any age who are both (a) incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicaps; and, (b) dependent upon a covered person for the majority of their support and maintenance. This disability must have come into existence prior to losing dependent status.

For optional life insurance and long term care insurance:

- Domestic partners are eligible for the same benefits as spouses.
- Spouses or domestic partners, and children from 14 days up to age 19 (up to age 25 if full time students) are eligible for coverage under Optional Dependent Life insurance.

¹ Employees are responsible for notifying the County within 31 days of the date a dependent is no longer eligible for coverage. Failure to do so may result in retroactive charges for claims and may also impact your ability to switch from family to single coverage. Coverage of the dependent ends at the end of the month in which they lose eligibility. However, state and federal laws provide for continuation of coverage for certain events, provided you notify the County within 60 days of the day coverage would otherwise end.

When can employees enroll or change coverage?

Medical and Dental:

Without evidence of insurability:

1. Current eligible employees may enroll or change coverage during designated open enrollment periods.
2. Eligible new employees may enroll within the first 31 days of their employment.
3. Employees who become eligible for coverage due to an increase in their work hours may enroll within 31 days of becoming eligible for coverage.
4. All employees may be permitted to enroll or change medical or dental coverage within 31 days of a qualifying change in status. (See Qualifying Change in Status on Page 3. Contact your Benefits Representative to verify your eligibility to make a change.)

Also, see Special Enrollment Period for Medical Insurance and Late Enrollment for Medical Insurance on this page.

Short-Term Disability, Optional Long-Term Disability and Dependent Life:

Without evidence of insurability:

1. Current eligible employees may enroll or change coverage during designated open enrollment periods.
2. Eligible new employees may enroll within the first 31 days of their employment.
3. Employees who become eligible for coverage due to an increase in their work hours may enroll within 31 days of becoming eligible for coverage.
4. For Short-Term Disability, you can change to a longer elimination period at any time during the year.

With evidence of insurability:

1. Employees can enroll in Short-Term Disability, Optional Long-Term Disability or Dependent Life, or change to a shorter elimination period for Short-Term Disability at any other time, if they provide evidence of insurability and are approved by the insurance carrier.

Optional Employee Life and Spouse Life:

Employees may enroll or increase coverage **at any time**, if they provide evidence of insurability and are approved as required by the carrier. (See page 12 concerning opportunity to add coverage without evidence of insurability through “guarantee issue.”)

Special Enrollment Period for Medical Insurance

If you are declining enrollment in the Ramsey County Employee Benefit Plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days of losing your 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, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Please contact your Benefits Representative if you have questions.

Late Enrollment for Medical Insurance

If you do not enroll yourself or any eligible dependents within 31 days of the date that you or your dependents first become eligible, you may enroll yourself and any eligible dependents at any time, if you or your dependents have maintained continuous and qualifying coverage within 63 days prior to your application for coverage, subject to pre-existing condition limitations.

Newborn Enrollment

If you elect coverage, newborn infants (and newly-adopted children) the effective date of coverage will be the date of birth (or adoption) regardless of when notice is provided.

Qualifying Changes in Status may include, but are not limited to:

- Marriage
- Birth/Adoption
- Death of your spouse or dependent
- Divorce
- Termination or commencement of spouse's employment
- Change of your or your spouse's employment from full-time to part-time or part-time to full-time
- You or your spouse going on or returning from an unpaid leave of absence
- Significant change in your or your spouse's health coverage attributable to the spouse's employment
- Dependent no longer qualifying under the County's health insurance program due to age
- Court order requiring you to assume liability for medical expenses of a dependent child

Other changes may be considered as qualifying events depending on individual circumstances.

Note: Generally, qualifying changes must impact eligibility, and changes in coverage must be on account of and consistent with the qualifying change in status. You must notify your Department Benefits Representative within 31 days of the change.

**When can employees enroll or change coverage?
(continued)**

Optional Accidental Death and Dismemberment (AD&D):

Eligible employees may enroll at any time without evidence of insurability. You must have optional employee life or spouse life in order to purchase optional AD&D.

Basic Life and Basic Long-Term Disability (LTD)

Employees who are eligible for a County contribution for insurance are automatically enrolled in Basic Life and Basic Long-Term Disability.

When is coverage effective?

The effective date of coverage will vary based on plan type and individual circumstances. In general, coverage is effective for new employees the first of the month following 30 days of employment. For most other situations, if you enroll on or before the date you are first eligible to participate, coverage is effective the first day of eligibility. If you enroll after the first day of eligibility, coverage is effective the first of the month following enrollment. (For information on eligibility for County contribution, see "Waiting Period for County Contribution to Insurance" on next page.)

Consult with your Benefits Representative about when your coverage will be effective for your specific situation. Late return of the enrollment form could result in delay of coverage or loss of eligibility to enroll.

What happens to coverage during an unpaid leave of absence?

The types of coverage you may continue, the length of time for continuation, and the length of time you will receive a County contribution, vary depending on the type of leave. For most unpaid leaves of absence, the County contribution continues for the month you are last on paid status, plus the next month. This may vary if your leave qualifies under the Family and Medical Leave Act. Contact your Department Benefits Representative for more detailed information about unpaid leaves, and to obtain an Unpaid Leave of Absence Coverage Form.

When can eligible employees cancel their coverage?

Medical Coverage: This coverage may be canceled at any time if you are not participating in Pre-Tax Premium Program (PTPP) and pay your premiums on an after tax basis. If you are participating in the PTPP, and your premiums are paid on a pre-tax basis, you can only cancel medical coverage during an open enrollment period, or if there is a qualifying change in status. (See explanation at left.)

Dental Coverage: If you are not participating in the PTPP, and pay your premiums on an after tax basis, you may cancel dental coverage at any time subject to restrictions listed in the section on "Dental Coverage" in this Reference Guide. If you are participating in the PTPP, your premiums are paid on a pre-tax basis, and you can only cancel dental coverage during an open enrollment period, or if there is a qualifying change in status (see explanation on Page 3), subject to the restrictions listed in the section on "Dental Coverage" in this Reference Guide.

Life Insurance and Disability coverage may be canceled at any time.

Effective Dates: When eligible employees cancel any of the above coverages, the cancellation is effective at the end of the month in which they provide cancellation notice.

What are the County Contributions?

Basic Life and Basic Long-Term Disability:

The County pays the full premium for Basic Life and Basic LTD for employees who are eligible for the County contribution. (See Appendix B for rates.)

Optional Employee and Spouse Life, Optional AD&D, Dependent Life and Optional Long-Term and Short-Term Disability:

The employee pays the full premium. (See Appendix B for rates.)

Medical and/or Dental Coverage: (See Appendix B for rates.)

If you work:

64 to 80 hours/pay period
40 to 63 hours/pay period

You will receive:

100% of the County contribution
2/3 of the County contribution

If your position is designated as *less than 64 hours* per pay period, your eligibility and contribution will be determined in one of two ways:

1. For employees in Local 8—General Unit; Local 1935-Parks and Recreation; Local 151-Community Human Services; Job Training; Licensed Practical Nurses; Local 1076-Ramsey Nursing Home; Local 707-Lake Owasso Residence; and Local 2599-Public Health RNs, eligibility for insurance and the County contribution will be based on the average hours worked over a six-month period. Average hours worked between pay periods 15-1 will determine eligibility and contribution beginning February 1st; and average hours worked between pay periods 2-14 will determine eligibility and contribution beginning August 1st. For new employees in these bargaining units, or current employees becoming eligible due to a change in employment status, the contribution will be based on the position's assigned standard hours until the next average hours calculation is run.
2. For all other employees, eligibility and the County contribution will be based solely on the position's assigned standard hours.

Waiting Period for County Contribution to Insurance

New employees are eligible for a County contribution the first of the month following 30 days of employment.

New employees may enroll in insurance plans before the County contribution is effective; however, they must pay the full premium until they are eligible for the County contribution.

Current employees, who become eligible for coverage based on the terms of their union contract or Personnel Rules/Benefits Policies due to an increase in hours, will be immediately eligible for a County Contribution provided they have worked for the County as a permanent, provisional, probationary or intermittent employee, for the length of the waiting period for new employees. (For effective date of coverage, see "When is Coverage Effective" on Page 3.)

**HealthPartners
Information**

Member Services:
952-883-5000 or
1-800-883-2177
www.healthpartners.com

Provider Information

The most current provider information is available at www.healthpartners.com or contact Members Services for provider information or to request a directory.

Note: HealthPartners contracts with CIGNA Healthcare to provide services outside of the HealthPartners service area. CIGNA is a national network of over 700,000 providers. When members use the CIGNA network outside of the HealthPartners service area, their claim will be processed as an in-network, Benefit Level Two claim. If you need help finding a CIGNA provider, call 952-883-5000 or 1-800-883-2177, or www.healthpartners.com.

Waiver of Deductible for Dependent Children

The out-of-network deductible (\$750) is waived for dependent children residing outside the HealthPartners network of participating providers. You must complete a "Waiver of Out-of-Network Deductible" form each year in order to receive the deductible waiver. Forms are available from your Department Benefits Representative or on RamseyNet.

Medical Coverage

HealthPartners Distinctions (Group #12900)

Medical coverage is available to you, or to you and your family through the HealthPartners Distinctions plan. Dependent children may be covered up to age 26 regardless of student status, place of residence, or marital status.

This plan provides in-network and out-of-network coverage. To obtain in-network benefits, you may obtain services from any network provider. The large, open-access network is split into two benefit levels based on provider cost and quality. You generally have richer benefits when you use providers in Benefit Level One than when you use providers in Benefit Level Two.

In-network benefits: There is an annual in-network deductible (not applicable to preventive care or prescriptions) of \$25 per person/\$75 per family. Preventive health care is covered at 100% in both Benefit Level One and Two. *If you (and your spouse if carrying family coverage) complete the HealthPartners Healthy Benefits program, your office visit co-pay to see a Benefit Level One provider for illness or injury is \$20; to see a Benefit Level Two provider is \$35. Your co-pay if you visit a convenience clinic is \$10. If you (or your spouse if carrying family coverage) do not complete the HealthPartners Healthy Benefits program, your office visit co-pay to see a Benefit Level One provider for injury or illness is \$40; to see a Benefit Level Two provider is \$55. Your co-pay if you visit a convenience clinic is \$20.* Urgent care is covered at the Benefit Level Two cost; emergency care is covered at 100% after \$75 co-pay. You will have access to Virtuwell, HealthPartners 24/7 on-line clinic, for 3 free visits. Additional visits are covered at the convenience clinic co-pay level.

The inpatient hospital care co-pay for a Benefit Level One provider is \$100 per admit; for a Benefit Level Two provider, the co-pay is \$250 per admit. The Outpatient co-pay for a Benefit Level One provider is \$100 per year; for a Benefit Level Two provider, the co-pay is \$250 per year. There is an annual medical out-of-pocket maximum of \$900 per person/\$1,800 per family and a separate annual prescription drug out-of-pocket maximum of \$900 per person/\$1,800 per family. The co-pay for formulary prescriptions for a one month supply is \$12 for generic and \$35 for brand. The mail order pharmacy benefit is available to obtain a three month supply of prescription drugs for two co-pays.

Out-of-network benefits: Emergency or urgently needed care is covered at 100% after a \$75 co-pay. For non-emergency care, inpatient and outpatient care are generally covered at 65% (of the usual and customary charges recognized by HealthPartners) after you have met your deductible of \$750 per person or \$2,100 per family. Costs incurred in excess of the usual and customary level are the responsibility of the member (balance billing) and do not count toward the out-of-pocket maximum. The out-of-pocket maximum for eligible out-of-network medical expenses is \$3,500 per person/\$8,500 per family.



The following is an overview of your HealthPartners coverage. For exact coverage terms, and conditions, consult your plan materials, or call Member Services at (952) 883-5000 or 1-800-883-2177.

Plan highlights	In-network	Out-of-network
Partial listing of covered services	Care from a network provider	Care from an out-of-network provider
Deductible and Out-of-Pocket		
Lifetime maximum	Unlimited	\$1,000,000
Calendar year deductible	\$25 per person;\$75 per family	\$750 per person; \$2,100 per family
Calendar year medical out-of-pocket maximum	\$900 per person; \$1,800 per family	\$3,500 per person; \$8,500 per family
Calendar year prescription out-of-pocket maximum	\$900 per person; \$1,800 per family, combined for in-network and out-of-network	
Preventive Health Care		
Routine physical & eye examinations, well-child care	100% coverage	No Coverage
Prenatal and postnatal care	100% coverage	You pay 35% after deductible
Immunizations	100% coverage	No Coverage
Office Visits		
Illness or injury	<u>Healthy Benefits:</u> - \$20 Benefit Level 1 - \$35 Benefit Level 2 <u>No Healthy Benefits:</u> - \$40 Benefit Level 1 - \$55 Benefit Level 2	You pay 35% after deductible
Allergy Injections	100% coverage	You pay 35% after deductible
Physical, occupational and speech therapy	<u>Healthy Benefits:</u> - \$20 Benefit Level 1 - \$35 Benefit Level 2 <u>No Healthy Benefits:</u> - \$40 Benefit Level 1 - \$55 Benefit Level 2	You pay 35% e after deductible
Chiropractic care (neuromusculo-skeletal conditions only)	Healthy Benefits: \$35 No Healthy Benefits: \$55	You pay 35% after deductible 20 visits per calendar year
Mental health care	Healthy Benefits: \$20 No Healthy Benefits: \$40	You pay 35% after deductible
Chemical health care	Healthy Benefits: \$20 No Healthy Benefits: \$40	You pay 35% after deductible
Convenience Care		
Convenience clinics (retail clinics), eVisits; if using Virtuwel the first three visits free	Healthy Benefits: \$10 No Healthy Benefits: \$20	You pay 35% after deductible
Outpatient Care		
Scheduled outpatient procedure	Benefit Level 1 - \$100 per year Benefit Level 2 - \$250 per year	You pay 35% after deductible
Outpatient MRI and CT Scan	You pay 20% after deductible	You pay 35% after deductible
Emergency Care		
Urgently needed care at an urgent care clinic or medical center	Healthy Benefits: \$35 No Healthy Benefits: \$55	HealthPartners in-network benefit
Emergency care at a hospital ER	\$75 co-payment per visit after deductible	HealthPartners in-network benefit
Ambulance	You pay 20% after deductible	HealthPartners in-network benefit

Plan highlights	In-network	Out-of-network
	Care from a network provider	Care from an out-of-network provider
Inpatient Hospital Care		
Illness or injury, mental and chemical health care	\$100 for Benefit Level 1 per admit \$250 for Benefit Level 2 per admit	You pay 35% after deductible
Durable Medical Equipment		
Durable medical equipment and prosthetic devices	You pay 20% after deductible	You pay 35% after deductible
Home Health Care		
Physical, speech, occupational and respiratory therapy and home health aides	Healthy Benefits: \$35 No Healthy Benefits: \$55	You pay 35% after deductible 60 visits per calendar year
Prescription Drugs (30-day supply; 1 cycle of oral contraceptives; 90-day supply for mail order)	HealthPartners Participating Pharmacy Benefit	Non Participating Pharmacy Benefit
Retail Pharmacy Co-payment for one-month supply		
- Generic Preferred	\$12 co-payment	75% coverage after deductible
- Brand Preferred	\$35 co-payment	75% coverage after deductible
HealthPartners Mail Order Pharmacy Co-payment for three-month supply		
- Generic Preferred	\$24 co-payment	N/A
- Brand Preferred	\$70 co-payment	N/A
Specialty Drugs	You pay 20% up to \$200 maximum per prescription per month	You pay 35% after deductible
Note: There is a \$3,000 annual maximum for Infertility Drugs (Plan covers up to \$3,000 worth of charges)		
Benefit Level Coinsurance		
Coinsurance means you pay a portion of the bill for services. The facility you use will decide the format of your bill. Some facilities bill for ALL services provided during your visit (or hospital stay). When you receive one total bill, you will be charged at the facility Benefit Level. For facilities that do not bill for all services in one total bill, you will receive separate bills from each professional who provided services. The individual provider Benefit Level determines the amount you pay.		
Summary of Utilization Management Programs		
<p>HealthPartners utilization management programs help ensure effective, accessible and high quality health care. These programs are based on the most up-to-date medical evidence to evaluate appropriate levels of care and establish guidelines for medical practices. Our programs include activities to reduce the underuse, overuse and misuse of health services. These programs include:</p> <ul style="list-style-type: none"> - Inpatient concurrent review and care coordination to support timely care and ensure a safe and timely transition from the hospital - “Best practice” care guidelines for selected kinds of care - Outpatient case management to provide care coordination - The CareCheck® program to coordinate out-of-network hospitalizations and certain services. <p>We require prior approval for a small number of services and procedures. For a complete list, go to healthpartners.com or call Member Services. You must call CareCheck® at (952) 883-5800 or 1-800-942-4872 to receive maximum benefits when using out-of-network providers for in-patient hospital stays; same-day surgery; new or experimental or reconstructive outpatient technologies or procedures; durable medical equipment or prosthetics costing more than \$3,000; home health services after your visits exceed 30; and skilled nursing facility stays. We will review your proposed treatment plan, determine length of stay, approve additional days when needed and review the quality and appropriateness of the care you receive. Benefits will be reduced by 20 percent if CareCheck® is not notified.</p>		

Our approach to protecting personal information

HealthPartners complies with federal and state laws regarding the confidentiality of medical records and personal information about our members and former members. Our policies and procedures help ensure that the collection, use and disclosure of information complies with the law. When needed, we get consent or authorization from our members (or an approved member representative when the member is unable to give consent or authorization) for release of personal information. We give members access to their own information consistent with applicable law and standards. Our policies and practices support appropriate and effective use of information, internally and externally, and enable us to serve and improve the health of our members, our patients and the community, while being sensitive to privacy. For a copy of our privacy notice, please visit healthpartners.com or call Member Services at 952-883-5000 or 1-800-883-2177. Please contact your provider for a copy of the HealthPartners privacy notice.

Appropriate use and coverage of prescription medications

We provide our members with coverage for high quality, safe and cost-effective medications. To help us do this, we use:

- * A preferred list of prescription drugs that has been reviewed and approved for coverage based on quality, safety, effectiveness and value.
- * A special program that helps members who use many different medications avoid unintended drug interactions.

The preferred drug list is available on healthpartners.com, along with information on how drugs are reviewed, the criteria used to determine which drugs are added to the list, and more. You may also get this information from Member Services.

Services not covered

After you enroll, you will receive a Group Membership Contract or Summary Plan Description that explain exact coverage terms and conditions. *This plan does not cover all health care expenses.* In general, services not provided or directed by a licensed physician are not covered. The following is a *summary* of excluded or limited items:

- * Treatment, services, or procedures which are experimental, investigative or are not medically necessary
- * Dental care or oral surgery†
- * Non-rehabilitative chiropractic services
- * Eyeglasses, contact lenses, hearing aids and their fittings
- * Private-duty nursing; rest, respite and custodial care†
- * Cosmetic surgery†
- * Vocational rehabilitation; recreational or educational therapy
- * Sterilization reversal and artificial conception processes†
- * Physical, mental or substance-abuse examinations done for, or ordered by third parties†
- * Out-of-network coverage may also exclude preventive health care services

† *except as specifically described in your Group Membership Contract or Summary Plan Description.*

**THIS PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES.
READ YOUR GROUP MEMBERSHIP CONTRACT OR SUMMARY PLAN DESCRIPTION
CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED.**

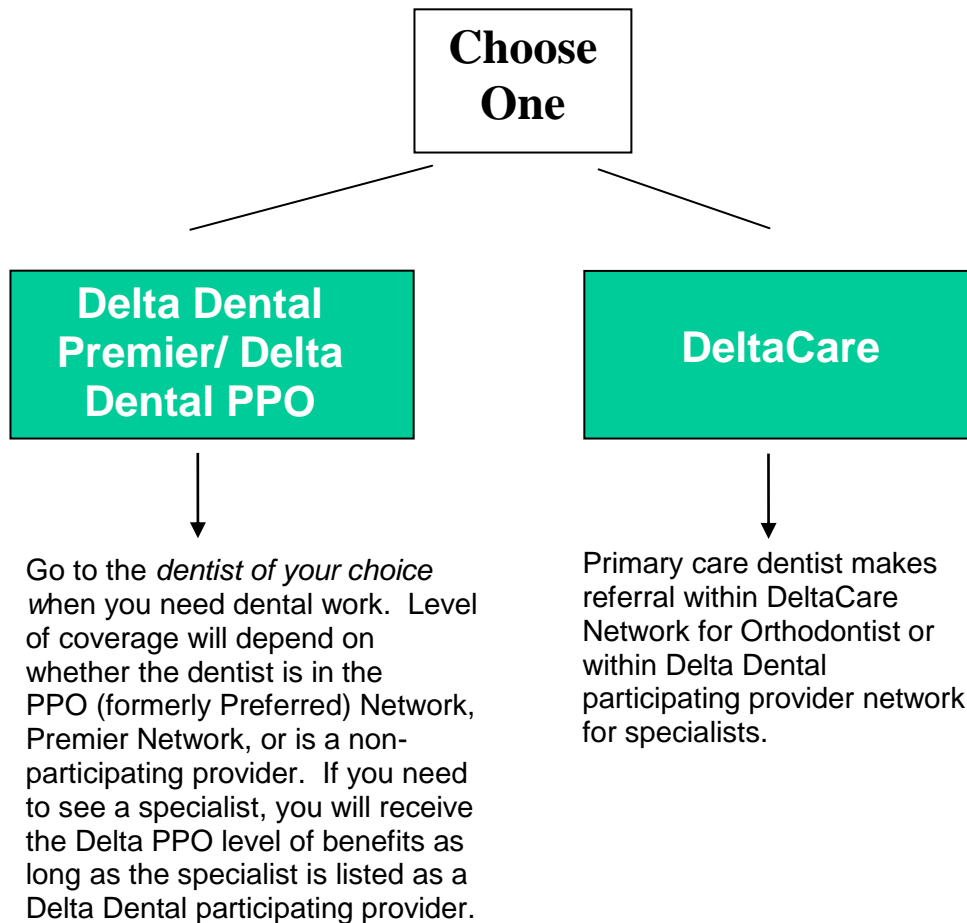
For details about benefits and services, call Member Services at (952) 883-5000 or 1-800-883-2177.

Our mission is to improve the health of our members, our patients and the community.

Dental Coverage

Choices for Employee and Family

- The employee must be enrolled in dental in order to cover dependents.
- Dental insurance is provided by Delta Dental Plan of Minnesota.
- Choose between Delta Dental Premier/Delta Dental PPO or DeltaCare. Each family member must participate in the same plan as the employee. After you make your selection at open enrollment, you may not switch to the other plan until the next open enrollment.



Dental Insurance Rates

Rates are the same for Delta Premier/PPO or DeltaCare. 2012 rates are listed in Appendix B.

Enrollment Restrictions

Once you have enrolled in either Delta Dental plan, you must remain in Delta for 12 months. If coverage is terminated, there is a three year waiting period before an employee can re-enroll. Employees may re-enroll for coverage during the next open enrollment period following the three year waiting period. If you have a qualifying change in status, these restrictions may be waived. These restrictions apply to both single and family coverage.

Retiree Dental

Employees who retire are only permitted to continue the same level of dental coverage they are carrying as an employee: single or family.

Delta Dental Plan and Provider Information

Delta Premier/Delta PPO
Customer Service:
(651) 406-5916

DeltaCare Information:
Customer Service:
(651) 406-5903

www.deltadentalmn.org

Delta Premier/Delta PPO

If you choose this option, you can see any dentist throughout the plan year. However, in order to verify that the dentist you select is currently a Delta PPO or Delta Premier provider, ask the dentist's office at the time you schedule an appointment, or call Delta Dental Customer Service.

DeltaCare

If you choose DeltaCare at open enrollment, you must remain in the plan for the entire plan year.

For dental emergencies when traveling out of area, DeltaCare will pay \$50 per occurrence for emergency treatment for relief of pain from a non-DeltaCare provider.

Delta Dental Premier/Delta Dental PPO (Group #138)

By choosing this plan, you get access to two networks of dentists – Delta Dental Premier and Delta Dental PPO. During open enrollment, you do not need to make a selection between Delta Dental Premier and Delta Dental PPO dentists. Each time you make an appointment, you or your family member select either a **Delta Dental Premier** or **Delta Dental PPO** dentist. If your dentist (Premier or PPO) refers you to a specialist, you will receive the PPO level of benefits if your specialist is a Delta Dental participating dentist.

- **Delta Dental Premier** network includes 80% of the dentists (2,671 dentists in 4,698 separate locations) throughout the state.
- **Delta Dental PPO** network offers a greater level of benefits for some services, but services must be provided by dentists in the **PPO** network. Delta Dental PPO has a network of approximately 1,639 participating dentists in 3,291 separate locations throughout the state.
- **Non-participating dentist** –You can also choose to receive services from a dentist who does not participate in Delta Dental. However, you pay your coinsurance as well as the difference between what the dentist charges and Delta Dental's allowable fee, which may result in significant out-of-pocket expenses. It is advisable to submit a pre-estimate from your dentist to Delta Dental in order to identify costs prior to receiving service.

DeltaCare (Group #84053)

DeltaCare has no annual maximum benefit, no deductible and 50% orthodontic coverage for children up to age 19, up to a \$1,000 lifetime maximum per child.

If you elect DeltaCare, you may visit any participating DeltaCare provider. If you receive treatment from a non-DeltaCare dentist, services will not be covered.

Your DeltaCare clinic will coordinate all your dental needs. When necessary, you may be referred to a specialist. To receive coverage, services must be provided by a Delta Dental participating provider. Orthodontic care must be provided by an OrthoCare Orthodontist listed in the back of the DeltaCare Provider directory, or at www.deltadentalmn.org.

DeltaCare has a limited network that includes 789 participating dentists and 1,715 separate locations throughout the state.

Delta Dental Plan of Minnesota Benefits *

<u>Dental Service</u>	<u>Delta PPO</u>	<u>Delta Premier</u>	<u>DeltaCare</u>
Diagnostic & Preventive Care	100% coverage <ul style="list-style-type: none"> - Dental Prophylaxis (cleaning of teeth) twice per calendar year. - Two oral exams of any type (including emergency exams and specialist exams) per calendar year. - Fluoride applications every 12 months - Bitewing x-rays every 12 months - Full mouth x-rays every three (3) years 	100% coverage	100% coverage As prescribed by the dentist As prescribed by the dentist For under age 19 only. Bitewing x-rays every 24 months (18 & over); every 12 months (under 18) Full mouth x-rays every five (5) years
Basic & Restorative Services	100% coverage <ul style="list-style-type: none"> - Fillings (may vary for amalgam & white resin) - Emergency treatment for relief of pain (minor procedures) - Oral surgery - Root canals - Periodontal/gum disease treatment 	80% coverage	100% coverage Same
Major Restorative Services	80% coverage <ul style="list-style-type: none"> - Crowns, Inlays and Onlays 	60% coverage	60% coverage Same
Prosthetics	50% coverage <ul style="list-style-type: none"> - Bridges, full & partial dentures - Repair and adjustment - Dental implants 	50% coverage	60% coverage Same Same No coverage
Orthodontics	0% coverage	0% coverage	50% coverage up to \$1,000 lifetime maximum per child
Annual Deductible	\$25 individual/\$75 maximum per family		No deductible
Annual Maximum Benefit	\$1200 per person		No maximum

*** This is a summary of benefits only. Please refer to your Dental Benefit Plan Summary Booklet for a complete list of covered services and limitations/exclusions.**

Life Insurance Information:

Ochs, Inc.
651-665-3789

Eligibility:

Current employees becoming eligible for insurance due to an increase in hours will be immediately eligible for a County contribution for Basic Life provided they have worked for the County as a permanent, provisional, probationary or intermittent employee for the length of the waiting period for new employees.

Disability Provision:

If, prior to age 60, you become totally disabled for at least 9 months while insured under Ramsey County's Group Life Insurance Policy with Minnesota Life, you may be eligible to continue your coverage until age 65 if you continue to pay the premium during the nine month waiting period. Please call Dena Kujawa at 266-2733 if you become disabled and think you may be eligible.

Life Insurance (Minnesota Life)

Basic Employee Life Insurance

Basic Life coverage provides life insurance in an amount equal to your annual salary. Your salary is rounded up to the next \$1,000 (e.g., if your salary is \$28,452, you would get \$29,000 Basic Life Insurance). Basic Life has a minimum of \$10,000 and a maximum of \$50,000 coverage. Basic Life includes Accidental Death and Dismemberment (AD&D).

- Employees are provided with County paid Basic Employee Life insurance when eligible for the County contribution.
- Eligible new employees may enroll in Basic Employee Life coverage during their first 31 days of employment, at their own expense until the effective date of the County contribution. Coverage will be effective the date of employment (if enrolled on or before the first day of employment), or the first of the month following the date of enrollment.
- Basic Life Insurance is adjusted annually - based on salary - at the beginning of the calendar year.

If you are enrolled in Basic Life, you may also apply for the Optional Life coverages listed below at any time during the year.

Optional Employee Life Insurance

- Coverage is available in increments of \$1,000.
- The amount cannot exceed **5** times your salary or \$300,000, **whichever is greater**. In no case may an employee's life coverage (Basic + Optional) exceed \$500,000.
- **New employees, or employees eligible for insurance for the first time, are offered a one-time opportunity to purchase up to \$40,000 in optional life coverage without evidence of insurability (Guarantee Issue) provided they do so within 31 days of eligibility. Amounts above \$40,000 will require evidence of insurability.**
- Except during Guarantee Issue periods, employees who choose to add optional coverage must provide *evidence of insurability*. Evidence of insurability forms will be sent to you by Human Resources after you submit the insurance enrollment application form. Coverage will be effective on the date it is approved by Minnesota Life.

Optional Spouse Life Insurance

- Coverage is available in increments of \$1,000.
- The amount cannot exceed **four** times your salary or \$250,000, whichever is greater, but can never exceed \$500,000.
- Optional Spouse Life is available to qualified domestic partners. Contact your Department Benefits Representative for further information.
- Optional Spouse Life cannot be purchased if your spouse or domestic partner is a Ramsey County employee eligible for benefits.
- Evidence of insurability is always required. Coverage will be effective on the date it is approved by Minnesota Life.

Optional Accidental Death & Dismemberment Insurance

- Provides an additional death benefit to the beneficiary in the amount of the life insurance if the death is a result of an accident, and provides coverage for specific types of injuries up to the value of the life insurance.
- If you elect AD&D coverage, it must be included with both your Optional Spouse Life coverage and Optional Employee Life coverage.
- Evidence of insurability is not required for AD&D.
- If you already have Optional Life, AD&D coverage will be effective the first of the month following the date of application. If you are adding AD&D at the same time as Optional Life, coverage will be effective on the date the Optional Life is approved by Minnesota Life.

Optional Dependent Life Insurance

- Optional Dependent Life Insurance provides \$10,000 of coverage for each of your dependents (including your spouse or domestic partner) no matter how many dependents you have.
- Optional Dependent Life does not cover your spouse or domestic partner if he/she is also a Ramsey County employee eligible for benefits, and you may not double-cover the same children.
- Dependents younger than 14 days old are not covered.
- Evidence of insurability is not required during open enrollment or if enrolling as a new employee. At all other times, evidence of insurability is required. If evidence of insurability is required, coverage will be effective on the date it is approved by Minnesota Life.
- Dependents do not need to be identified. Dependents are automatically covered if they meet the eligibility requirements.

Rates for Optional Life Insurances:

Employee and Spouse Optional rates are based on age. See Appendix B for all 2012 rates.

Optional Accidental Death and Dismemberment (AD&D) Insurance:

You must have Optional Employee Life or Spouse Life in order to purchase Optional AD&D. See Appendix B for 2012 rates.

Beneficiary Designation:

You may designate a beneficiary or beneficiaries for Basic Life and/or Optional Employee Life Insurance.

Minnesota Life is responsible for life insurance beneficiary management services. When first enrolled in basic and/or optional life insurance, employees will receive a letter from Minnesota Life that provides them with instructions on how to designate beneficiaries.

Employees may add or change beneficiary information by logging on to www.lifebenefits.com. Paper forms are available as an option.

For assistance, contact Minnesota Life at 1-866-293-6047.

In the absence of a beneficiary designation, payment of benefits will be made in the following order of priority: 1) your surviving spouse; 2) your surviving children in equal shares; 3) your surviving parents in equal shares; 4) the duly appointed legal representative of your estate. The employee is the beneficiary for Optional Spouse Life and Dependent Life Insurance.

Life Benefits Extra

Beneficiary Financial Counseling

Beneficiaries who receive at least \$25,000 in policy benefits may choose to use independent beneficiary counseling services from PricewaterhouseCoopers LLP (PwC), one of the world's leading professional services firms. The counseling services are designed to help families make sound financial decisions at a difficult time. PwC advisors do not sell insurance or investment products, and no information will be given to PwC without your beneficiary's written consent. There is no additional cost for this service.

Will Preparation

Employees may take advantage of will preparation services through Ceridian LifeWorks. The program gives employees and their dependents telephone access to a national network of 22,000 attorneys for consultation on simple wills and testamentary trusts and simple power-of-attorney and health directives. Document review and drafting also is available.

For more information on the will preparation program, please call Ceridian LifeWorks at 1-877-849-6034 or visit www.lifeworks.com:

Username: *will* Password: *preparation*

Travel Assistance

Provided by Europ Assistance USA, coverage provides 24-hour emergency travel service for U.S. group life insurance plan participants and their families when they are traveling for business or pleasure more than 100 miles from home. The service includes assistance in locating and accessing physicians, dentists, medical facilities and pharmacies, arranging and paying for medical evacuation or returning mortal remains, providing interpreters or relaying messages to friends and family and offering a wide range of travel information. There is no additional cost for this service.

For more information on the travel assistance program, please call Europ Assistance USA at 1-877-708-6992, or visit: www.lifebenefits.com/travelassistance.

Disability Insurance (Madison National Life)

The County offers employees both long-term and short-term disability insurance. Disability insurance is designed to protect your income in the event you are unable to work due to a disability.

Types of Disability Insurance

Basic Long-Term Disability Insurance

Basic Long-Term Disability (LTD) insurance provides a benefit of 40% of your gross pre-disability income, subject to a maximum benefit of \$5000 per month, if you become disabled for more than six months. This is a taxable benefit.

- Insurance-eligible employees are provided with Basic LTD coverage which is fully paid by the County and is effective the first of the month following 30 days of employment.
- The amount of coverage is updated monthly, based on your salary.
- Current employees becoming eligible for insurance due to an increase in work hours will be immediately eligible for Basic Long-Term Disability insurance, provided they have worked for the County as a permanent, provisional, probationary or intermittent employee for the length of the waiting period for new employees.
- Eligible new employees may enroll in Basic Long-Term Disability during their first 31 days of employment, at their own expense until the effective date of the County contribution. Coverage will be effective the date of employment (if enrolled on or before the first day of employment), or the first of the month following the date of enrollment.

Optional Long-Term Disability Insurance

If you are enrolled in Basic Long-Term Disability, you may choose to add an additional 20% income replacement at your own cost for a total of 60% of your gross pre-disability income, subject to a maximum benefit of \$7,500 per month. Because the premium you pay is taxed, the additional 20% above the basic coverage is not taxed at the time you receive the benefit.

As a new employee or during open enrollment, you may add the 20% optional coverage without providing evidence of insurability. Evidence of insurability is required at all other times. If evidence of insurability is required, coverage will be effective on the date it is approved by the carrier.

What is a Disability?

You are defined as disabled if you are unable to engage in the “material and substantial” duties of *your* occupation during the first two years that benefits are payable. Thereafter, disability means your inability to perform *any* occupation for which you are qualified by education, training or experience. The short and long-term disability plans also include partial disability provisions.

Disability includes: pregnancy, childbirth and related medical conditions. It also includes mental or emotional illness and alcohol and drug-related disorders*. However, all disabilities must be under the regular care of a physician.

To Submit a Claim:

To obtain a short-term or long-term disability insurance claim form, or if you have questions about how to submit a claim, contact Dena Kujawa at 266-2733.

*For mental or emotional disorders or substance abuse, benefit payments for long-term disability will be limited to a 2-year period unless claimant is hospital-confined at the end of that period for the same condition.

Information Contacts for Short and Long Term Disability Benefits:

For more information about the long-term or short-term disability policies, call our plan administrator, National Insurance Services at 952-941-7372.

If you have questions about the status of a claim or the payment of benefits, call Madison National Life at 1-800-356-9601.

Pre-Existing Condition Limitation for Short and Long-Term Disability Insurance:

You will not be covered for any disability which begins in the first 12 months after your effective date if it is caused by, contributed to, or resulting from a pre-existing condition. A pre-existing condition is defined as a sickness or injury for which you received medical treatment, consultation, care or services, including diagnostic measures in the three months prior to your effective date.

Rates for Long Term and Short Term Disability Insurance: 2012 rates are listed in Appendix B.

Long-Term Disability Coverage Information

If you become disabled, you are eligible for this monthly benefit following the completion of a six month elimination period. Benefits will continue while you remain disabled according to the following table:

Maximum Benefit Duration* For A Period Of Your Disability

<u>Your Age on Date Disability Begins</u>	<u>Your Maximum Benefit Duration</u>
Under age 61	To your normal retirement age,** but not less than 60 months.
Age 61	To your normal retirement age,** but not less than 48 months.
Age 62	To your normal retirement age,** but not less than 42 months.
Age 63	To your normal retirement age,** but not less than 36 months.
Age 64	To your normal retirement age,** but not less than 30 months.
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69+	12 months

* For mental or emotional disorders or substance abuse, benefit payments will be limited to a 2-year period unless claimant is hospital-confined at the end of that period for the same condition.

** Your normal retirement age is your retirement age under the Social Security Act where retirement age depends on your year of birth, as follows:

<u>Year of Birth</u>	<u>Social Security Retirement Age</u>
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

Short-Term Disability Insurance

Short-Term Disability Insurance is designed to temporarily replace your income in the event you are unable to work due to a disability. The disability may be caused by injury or illness, and does not need to be work-related. If you are unable to work due to a disability, you are eligible to receive 60% of your gross pre-disability income after satisfying the elimination period (waiting period) you have selected.

The minimum monthly benefit is \$50 and the maximum is \$7,500. If your disability ends in mid-month, your benefits will be pro-rated. Your actual disability payment will be offset by income you receive from other sources, including Workers' Compensation, PERA Disability, Social Security and paid sick or vacation. (You are not required to use paid vacation either before or after satisfying the elimination period.) Benefits are not taxable and no other payroll deductions are taken from your check.

The short-term disability insurance benefit terminates 26 weeks from the date of the onset of your disability. If you are still unable to work due to the disability at that time, you may then be eligible to receive a long-term disability insurance benefit.

Eligible new employees may enroll in short-term disability insurance without evidence of insurability during their first 31 days of employment. Employees may also enroll in short-term disability, or change to a shorter elimination period, without evidence of insurability during open enrollment. Coverage will be effective the date of employment (if enrolled on or before the first day of employment), or the first of the month following the date of enrollment. Employees may change to a longer elimination period at any time.

Short-Term Disability Insurance Elimination Period

Employees must choose whether they want a 30, 60, or 90 day elimination period. Benefits are payable after you have satisfied the elimination period. The elimination period runs simultaneously with the use of your sick leave, so the size of your sick leave bank may help you determine the appropriate elimination period.

The elimination period is based on calendar days, not work days.

30 calendar days = approximately 21 work days or 168 hours.

60 calendar days = approximately 43 work days or 344 hours.

90 calendar days = approximately 65 work days or 520 hours.

Monthly Benefit Examples:

Monthly Salary = \$2,353 (\$28,236 annual/12) times .6 = \$1,411.80

Monthly Salary = \$3,467 (\$41,600 annual/12) times .6 = \$2,080.20

Monthly Premium Rate Example:

Multiply your Monthly Salary=\$2,353 (\$28,236 annual/12) by rate:

30 day-- .00515 = \$12.12 Monthly Premium

60 day-- .00395 = \$ 9.29 Monthly Premium

90 day-- .00240 = \$ 5.65 Monthly Premium

Offsets to Disability Insurance Payments for Short-Term and Long-Term Disability Insurance:

Your monthly benefit will be determined by deducting other income from your monthly disability benefit amount. Examples include:

- Disability retirement
- Worker's Compensation
- No-fault automobile policy
- Sick leave
- Vacation leave
- Social Security

(In no event will this plan pay less than a \$50 monthly benefit.)

Use of Sick Leave Prior to Unpaid Leave of Absence for Short-Term and Long-Term Disability Insurance:

The County requires that employees use their available sick leave prior to beginning an unpaid medical leave. **However, if the disability insurance elimination period has been satisfied, the employee may elect to retain up to 40 hours of their remaining sick leave for use upon return to work.** If the employee does not return to work, this sick leave bank will be forfeited.

Appendix A – Department Benefits Representatives

Department Fax #	Address	Name	Phone #	
Attorney	315 RCGC-West	Stephanie Plote	266-3145	266-3010
Attorney-Child Support & Collections	4500 Metro Square Building	Mary O'Malley	266-3024	266-3032
Board of Commissioners	220 Courthouse	Jim Grieman	266-2930	266-2934
Budgeting & Accounting	Central Payroll 2100 Metro Square Building	Nick Ganas	266-1060	266-1078
City Hall/Courthouse	120 Courthouse	Red Garfield	266-8400	266-8480
Community Corrections	650RCGC-W	Kathy Graven	266-2392	266-2293
Community Human Services	9800 RCGC-East	Yvonne Schneider Drong Yang	266-4064 266-4065	266-4439
County Manager	250 Courthouse	Jim Grieman	266-2930	266-2934
Courts	1700 Courthouse	Linda White Jenine DeGraw	266-8267 266-9266	266-8278
Emergency Communications	388 13 th Street, St. Paul	Tania Mulvaney	266-7714	266-7711
Human Resources	2100 Metro Square Building	Diane Leyde	266-2734	266-2934
Information Services	2301 Metro Square Building	Sandy Vilendrer	266-3433	266-3442
Lake Owasso Residence	210 N. Owasso Blvd.	Julie Anderson	765-7708	765-7722
Law Library	1815 Courthouse	Sara Galligan Diane Leyde	266-8391 266-2734	266-2934
Library	4570 N. Victoria St.	Lee Ann Lause	486-2205	486-2220
Medical Examiner	300 University Ave. E.	Sue Swanson	224-7627	266-1720
Parks & Recreation	2015 N. Van Dyke St.	Becky Hagle	748-2500 Ext. 323	748-2505
Property Management - East	4690 RCGC-East	Lynda Clausen	266-4483	266-3720
Property Management - West	660 RCGC-West	Shelly Frahm	266-2253	266-2204
Property Records & Revenue	90 W. Plato Blvd.	Chris Kuefler	266-2195	266-2199
Public Defender	101 E. 5 th St., Suite 1808	Annette Lofgren	757-1622	215-0673
Public Health	90 W. Plato Blvd., Suite 200	Sue Krinke	266-2406	266-2593
Public Works	1425 Paul Kirkwold Drive	Pam Thompson	266-7101	266-7110
Ramsey Care Center	2000 White Bear Ave.	Barb Ruza Ryan Engle	251-2407 251-2408	777-1426
Regional Rail Authority	50 W. Kellogg, Suite 6560	Linda Danielson	266-2923	296-2934
Sheriff	425 Grove St.	Deb Boldt	266-9370	266-9390
Soil and Water Conservation District	1425 Paul Kirkwold Drive	Ann White Eagle	266-7271	266-7276
Veterans Service	90 W. Plato Blvd., Suite 210	Sue Krinke	266-2406	266-2593
Workforce Solutions	2098 11th Ave. E., No. St. Paul	Amber Kempe	779-5318	779-5090

Appendix B 2012 Monthly Insurance Premiums and Contributions

The County contributions for insurance listed below are for 2011. Contributions for 2012 are subject to change based on bargaining unit contracts and County Board Resolution.

MEDICAL INSURANCE

HealthPartners

	Full-Time Contribution			Part-Time 2/3 Contribution		
	Total <u>Premium</u>	Employee <u>Cost*</u>	County <u>Cost*</u>		Employee <u>Cost*</u>	County <u>Cost*</u>
Single	\$ 740.40	\$ 31.00	\$ 709.40	Single	\$ 265.60	\$ 474.80
Family	\$ 1,764.56	\$ 455.10	\$ 1,309.46	Family	\$ 887.72	\$ 876.84
Family Biweekly deduction:		\$ 227.55	\$ 654.73	Biweekly	\$ 443.86	\$ 438.42

DENTAL INSURANCE – Delta Dental

Full-Time Contribution

Part-Time 2/3 Contribution

	Full-Time Contribution			Part-Time 2/3 Contribution	
	Total <u>Premium</u>	Employee <u>Cost*</u>	County <u>Cost*</u>	Employee <u>Cost*</u>	County <u>Cost*</u>
Single	\$ 44.45	\$ 16.18	\$ 28.27	\$ 25.51	\$ 18.94
Family	\$ 99.00	\$ 43.43	\$ 55.57	\$ 61.77	\$ 37.23

LIFE INSURANCE - Minnesota Life

Basic Life/AD&D (County paid)	<u>Monthly Premium</u>	\$.155/\$1000 annual salary
Optional Life (Employee Paid)	Age	
	29 or less	\$0.04 per \$1,000
	30 - 34	\$0.05
	35-39	\$0.06
	40-44	\$0.10
	45-49	\$0.14
	50-54	\$0.22
	55-59	\$0.38
	60-64	\$0.52
	65-69	\$0.81
	70+	\$0.90
Accidental Death/ and Dismemberment		\$0.025 per \$1,000
Dependent Life (Employee Paid)	Coverage	
	\$10,000	\$1.90 per month

LONG TERM DISABILITY – National Insurance Services

40% Income replacement (County paid)

	<u>Monthly Premium</u>
All ages	\$ 0.102 /\$100 monthly salary

Optional 20% Buy up (Employee paid)

39 or less	\$ 0.082 /\$100 monthly salary
40-49	\$ 0.214 /\$100 monthly salary
50 or over	\$ 0.255 /\$100 monthly salary

SHORT TERM DISABILITY – National Insurance Services

	<u>Monthly Premium</u>
Option 1 – 30 day elimination period	.515% of monthly salary
Option 2 – 60 day elimination period	.395% of monthly salary
Option 3 – 90 day elimination period	.240% of monthly salary