Boone County

Important Information regarding your Employer Sponsored Health Benefits

Deductible Year

Deductible runs from January 1 to December 31 of each year.

Enrollment Periods

- New Hire – Coverage is effective on the first day of employment. Enrollment forms must be completed, signed and returned to your employer within 31 days of your effective date of coverage.

- Timely Enrollment - Enrollment forms must be completed, signed and returned to your employer within 31 days of your effective date of coverage.

- Special Enrollment/Qualifying Event - If you or your dependents experience a life event during the year such as marriage, birth, adoption or involuntary loss of coverage (spouse changing jobs, reaching dependent age limit on parents plan, divorce, etc), you have 31 days from the life event date to enroll in benefits. Date of coverage due to a special enrollment/qualifying event will begin on the date of the event. Enrollment forms must be completed, signed and returned to your employer within 31 days of the life event. Failure to provide signed forms in a timely manner will result in benefits not being effective until open enrollment.

- Annual Open Enrollment Period - If you previously waived coverage and/or enrolled more than 31 days following your initial enrollment period or a special enrollment/qualifying event then you can come on at open enrollment. The open enrollment period is the 30 days prior to your group's renewal date. An enrollment form must be completed, signed and returned to your employer prior to the renewal date.

Eligible Dependents

An eligible dependent would include your legally married spouse, dependent children of you or your spouse or dependent children for which you or your spouse have legal guardianship of. Refer to each benefit on the following pages to determine dependent age limit for each benefit.

Coordination of Benefits – insured under more than one insurance plan

If you, your spouse and/or your children will be electing medical coverage AND will be enrolled by another insurance plan (spouse's employers plan, individual plan, Medicaid, Medicare due to age, Medicare due to disability, Tri-Care, VA Benefits, etc), it is your responsibility to notify both insurance plans about the other coverage to determine appropriate coordination of benefits. Each plan has certain coordination of benefits rules it must follow. If you have questions about who pays primary and who pays secondary per family member, please review your plan document available on the carrier websites or by contacting member services (number on the back of your ID cards). If the other enrollment is Medicare or Medicaid, please contact your local Social Security office with questions. If your other coverage changes at anytime, it is your responsibility to notify both plans of this change. Failure to do so will result in delayed or denied claims.

Life Insurance Portability & Conversion Rights

If you terminate employment you can elect to continue the Life policy by contacting Guardian within 30 days of your termination. For additional details about portability and conversion rights please refer to your Guardian Policy that can be found by logging into www.guardiananytime.com or you may contact Guardian at 1-888-600-1600.

Women's Health and Cancer Rights Act

Did 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 lymphedema)? For more information on this coverage, contact member services (number on the back of your ID card).

Newborn 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).