



County of Cumberland Employee Benefits

Aaron Smith


Department of Personnel & Human Resources

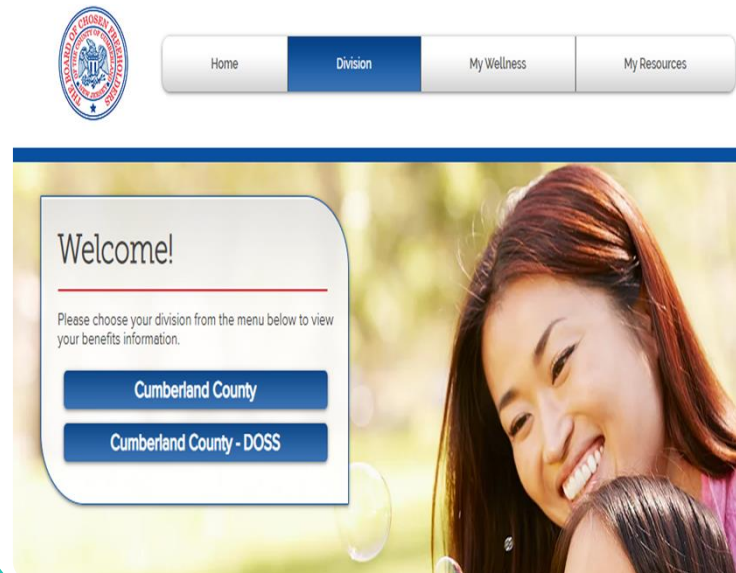
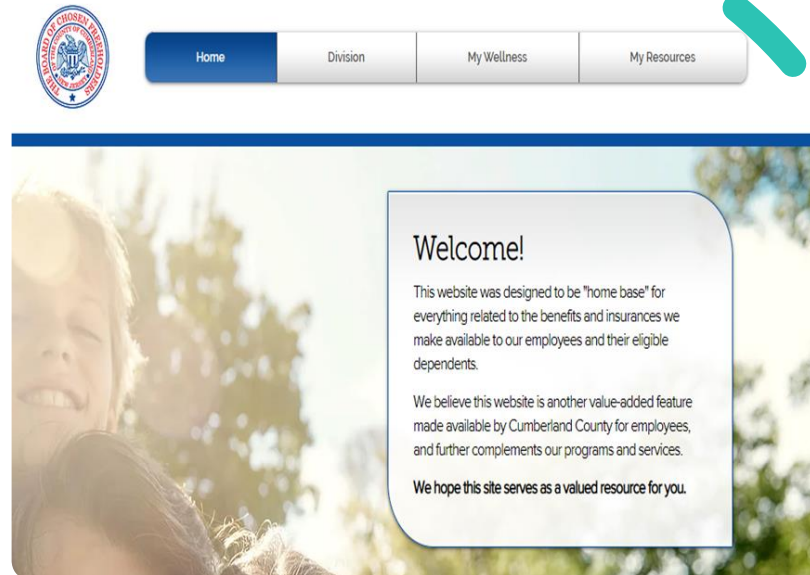
Employee Benefits Clerk

County Intranet

Link: Cumberland
County Intranet –
One Stop shop for
your employee
information

The Intranet is a useful website for accessing multiple resources within the County:

- Employee Self Service Portal: Paycheck History, W2, W4 forms, Vac/Pers/Sick Time
 - County Policy and Union Contracts
 - Forms & Misc. Guidelines
- 



Employee BenePortal “One Stop Shop for all your *Benefit Information*” www.cumberlandcountybenefits.com

- The BenePortal will contain various pieces of important information such as:
 - Benefit Forms
 - Announcements
 - Discounts and Perks through our providers
 - Benefits Member Advocacy Center
 - So Much More!

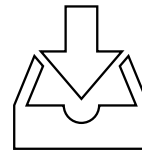
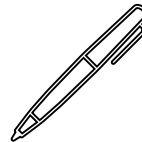
Employee Beneportal

*“All employee forms are right at
your fingertips”*

Insurance Plan Summaries
Contribution Calculators
Opt Out Forms
Personnel Information Change Forms
Tuition Reimbursement Applications

Cumberland County
Password: county123

Cumberland County DOSS
Password: DOSS987



Full-Time Employee Benefits

All Full-Time Employee Benefits are available on the 1st of the month following 60 days from your date of hire.

(i.e.: DOH: 09/16, benefit eligible on 12/01)

- ✓ Medical/RX
- ✓ Dental
- ✓ Vision
- ✓ Life Insurance (No Cost)
- ✓ Voluntary Benefits through American Fidelity

Open Enrollment:
Usually held in Fall for
Medical/RX, Dental
and Vision

MEDICAL CARRIER



COUNTY BASE PLAN:

AETNA HEALTH NETWORK ONLY (HNO) OPEN ACCESS PLAN

UPCHARGE PLANS:

AETNA QPOS

AETNA CHOICE POS II

*AETNA EPO H.S.A (HIGH DEDUCTIBLE PLAN)

*EPO/HAS PLANS ONLY AVAILABLE
FOR ASAP, PBA396, PBA396S

NON-UNION, MANAGEMENT
EMPLOYEES – BASE PLAN ONLY

PRESCRIPTION CARRIER



Generic -
\$10.00

Non-
Preferred/Name
Brand - \$25

Formulary -
\$50

2023 OPT OUT STIPEND

Single - \$625

Parent/Child - \$1,300

2Adult - \$1,435

Family - \$2,000

Will need to opt out every year.

Please read the Opt Out Form to see if you are eligible.

Set of actual enrollment forms are still needed - select "waive" option

Available to any employee that waives the medical and prescription insurance

May still enroll in dental, vision and other voluntary benefits

Opt Out Form (notarized) and proof of outside insurance is required (letter, plan ID card)

DENTAL & VISION PLANS

Dental - Horizon BCBS

- **County of Cumberland**
Employees: Horizon Dental PPO
- **DOSS Employees**: Horizon
Dental Choice or Dental Option



Vision - National Vision Administrators

- One Provider for all County and DOSS Employees.



Eligible Dependents

I. Spouse

II. Civil Union Partner

III. Legal Dependent Children

DOCUMENTS REQUIRED FOR ENROLLMENT

Spouse/Civil Union Partner:

- ✓ Marriage or civil union license
- ✓ Social Security card

Legal dependent child(ren)

- ✓ Birth certificate
- ✓ Social Security card
- ✓ Court Documents (if guardianship was court ordered)



Symetra Life Insurance Policy

Automatic Enrollment and only required form is the Reliance Standard Life Insurance Beneficiary Form

Provided at NO COST to all full-time employees

COVERAGE AMOUNT

- \$7,500 (County and DOSS Employees)
- \$15,000 (Dept. Heads and Unions PBA 396, PBA396S)

Clear
Save
Print

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | TTY/TDD 1-800-833-6388

CHANGE OF BENEFICIARY DESIGNATION

Please attach to original enrollment form

POLICY # 0102065800

EMPLOYER/POLICYHOLDER NAME County of Cumberland

EMPLOYEE INFORMATION

NAME _____ PHONE NUMBER _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PRIMARY BENEFICIARY(IES):

NAME	DATE OF BIRTH
ADDRESS	
RELATIONSHIP	BENEFIT PERCENT

NAME _____ DATE OF BIRTH _____

ADDRESS _____

RELATIONSHIP _____ BENEFIT PERCENT _____

CONTINGENT BENEFICIARY(IES):

NAME	DATE OF BIRTH
ADDRESS	
RELATIONSHIP	BENEFIT PERCENT

NAME _____ DATE OF BIRTH _____

ADDRESS _____

RELATIONSHIP _____ BENEFIT PERCENT _____

DEFINITIONS

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

EMPLOYEE SIGNATURE _____ DATE SIGNED _____

LC-12008 3/17 Symetra® is a registered service mark of Symetra Life Insurance Company.

Cumberland County 2023-2024 Plan Year Enrollment Form / Payroll Authorization



EMPLOYEE INFORMATION			Please provide all requested information.			
Last name:	First Name:	M.I.:	Social Security Number	Marital Status:		
			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed			
Address:			Date of Birth:	Gender:	Date of Hire:	
City:	State:	Zip:	Home Phone Number:			
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire _____			<input type="checkbox"/> Change in Qualified Life Event (QLE)* _____			
<p>* PLEASE NOTE: If you have a QLE you <u>must</u> re-enroll in <u>ALL</u> plans for you and your family. For example, if you are adding dental but want to remain in medical/prescription and vision you must check off the boxes for dental, medical/prescription and vision for yourself and any family member.</p>						
<small>Circle Your Current Unit - IMPORTANT:</small> UAW2327 UAWLIB UAWOET PBA231 PBA 299 PBA299S CWA1036 CWA1036M FOP194 UPSEU						

COVERAGE OPTIONS		YOU MUST CHECK ONE BOX (✓) ON EACH LINE.				
Benefit and Plan Name <small>(CHOOSE ONLY ONE Aetna MEDICAL/Benecard RX PLAN)</small>	Single	Parent/Child	EE + Spouse	Family	Waive	
MEDICAL/RX – Aetna HNO \$5/\$15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL/RX – Aetna POS II \$20 ER \$50 (Upcharge)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL/RX – Aetna POS II \$20 ER/\$100 (Upcharge)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PLEASE NOTE: WHEN YOU ELECT MEDICAL COVERAGE YOU WILL AUTOMATICALLY BE ENROLLED IN PRESCRIPTION DRUG COVERAGE.						
DENTAL Horizon BCBS of NJ Dental Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VISION NVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) American Fidelity		Please contact: Renee Callahan, Account Manager (302) 245-6857 (Mobile) 1-800-654-8489 ext. 2455 (Work) Renee.callahan@americanfidelity.com				



DEPENDENT INFORMATION **								Please provide all requested information and check (✓) all boxes that apply.		
Dependent's Last Name, First Name & Middle Initial	Relationship <small>SP = Spouse CU = Civil Union C = Child</small>	Date of Birth (MM/DD/YY)	Social Security Number	Gender (M/F)	Medical/Rx	Vision	Dental			
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

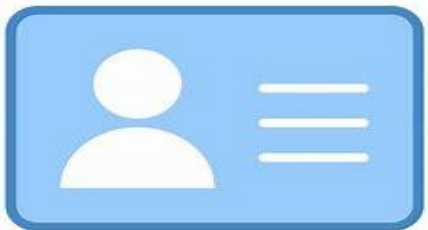
** If enrolling more than five (5) dependents for coverage, please write all information on additional sheet of paper.



Health Insurance ID Cards

Any member that enrolls into coverage should expect to receive their ID cards 5-7 days before the coverage is in effect.

It is encouraged that your member account is created, so that you can have your ID card electronically.



Qualifying Life Events

You have 30 days from an event to notify HR of benefit changes. If you do not notify HR timely, you will need to wait until open enrollment to make any changes.

Qualifying Status Includes:

- Marriage
- Divorce
- Birth/adoption of child
- Change in child's dependent status
- Death of spouse/child/qualified dependent
- Change in residence due to employment transfer
- Commencement or termination of adoption
- Change in spouses benefits or employment status

QUALIFYING LIFE EVENTS

CUMBERLAND COUNTY WOULD LIKE TO REMIND EMPLOYEES OF THEIR RESPONSIBILITY TO NOTIFY HUMAN RESOURCES OF ANY CHANGES RELATED TO A QUALIFIED LIFE EVENT WITHIN 30 DAYS OF THE QUALIFYING LIFE EVENT.

IRS §125 prohibits you from changing your enrollment during the Plan Year unless you experience a qualifying life event (QLE). Qualified status changes include: marriage, divorce, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in your spouse's benefits or employment status. **You must notify the Benefits Department within 30 days of experiencing a qualified status change.**

DENTAL AND VISION - Children are eligible until the end of the calendar year in which age 19 is attained or age 23 if attending an accredited school, college or university on a full-time basis (12 credits or more).

MEDICAL AND PRESCRIPTION - Children are eligible until the end of the calendar year in which they turn 26 years old.

Benefit Contributions

**Bi-weekly through
paycheck**

**24 contributions
(two paychecks
are free rides)**

**Based on coverage
type and salary
(Chapter 78 scale)**

**A calculation
worksheet is
available on the
Employee
BenePortal.**



www.cumberlandcountybenefits.com

2023 COUNTY OF CUMBERLAND HEALTH INSURANCE OPTIONS

PLAN NAME	SINGLE	PARENT/CHILD	2 Adult	FAMILY
Medical Insurance:				
Aetna Open Access HNO	\$7,548	\$14,940	\$17,353	\$27,336
Aetna Choice POS II (\$100 ER)	\$11,868	\$23,508	\$27,288	\$42,984
Aetna Choice POS II (\$50 ER)	\$12,660	\$25,080	\$29,124	\$45,864
Rx Insurance:				
Aetna HNO Benecard 10/25/50	\$2,280	\$3,314	\$5,345	\$5,398
QPOS/POS II Only 10/25/50 30 Day Supply	\$2,235	\$3,249	\$5,240	\$5,293
Dental Insurance:				
Horizon Dental	\$177	\$374	\$295	\$449
Vision Insurance:				
NVA	\$63	\$107	\$101	\$150

Percentages

Annual Salary Up To:	Single	P/C or 2 Adult	Family
19,999.99	4.5%	3.5%	3.0%
24,999.99	5.5%	3.5%	3.0%
29,999.99	7.5%	4.5%	4.0%
34,999.99	10.0%	6.0%	5.0%
39,999.99	11.0%	7.0%	6.0%
44,999.99	12.0%	8.0%	7.0%
49,999.99	14.0%	10.0%	9.0%
54,999.99	20.0%	15.0%	12.0%
59,999.99	23.0%	17.0%	14.0%
64,999.99	27.0%	21.0%	17.0%
69,999.99	29.0%	23.0%	19.0%
74,999.99	32.0%	26.0%	22.0%
79,999.99	33.0%	27.0%	23.0%
84,999.99	34.0%	28.0%	24.0%
89,999.99	34.0%	30.0%	26.0%
94,999.99	34.0%	30.0%	28.0%
99,999.99	35.0%	30.0%	29.0%
109,999.99	35.0%	35.0%	32.0%
9,999,999.99	35.0%	35.0%	35.0%

Your percentage will be used in the Employee Cost Contribution Estimator on the back of this worksheet.

UNIONS:

- UAW2327
- UAWLIB
- UAWOET
- PBA299
- PBA299S
- PBA231
- CWA1036
- CWA1036M
- FOP194
- UPSEU

Salary Example: \$43,000

Add Premium:

Medical Insurance	\$ 7,548
Rx Insurance	\$ 2,280
Dental Insurance	\$ 177
Vision Insurance	\$ 63
Total Annual Cost	\$ 10,068

Can be found in salary chart

x Percentage 10% = \$ 1,008.16 Annual Contribution

\$ 1,008.16 / 24 = \$ 50.34
Annual Contribution Contribution Per Pay (Approximate)

Dental and/or Vision Insurance ONLY:

(If you are opting out of medical and prescription insurance, yet are enrolling in dental and/or vision.)

Dental Insurance	\$ 177
Vision Insurance	\$ 63
Total Annual Cost	\$ 240

Base Salary x 1.5% \$ 642.60

Lesser of the Total Annual Cost or Base Salary x 1.5%: \$ 240 / 24 = \$ 10
Contribution Per Pay (Approximate)

Benefits Member Advocacy Center (MAC)

Provided by Conner Strong & Buckelew, the Benefits MAC can assist you navigating through your benefits.

Contact the Benefits MAC to:

- Find answers to your benefits questions
- Clarify information received from a provider or insurance company or explanation of a bill, claim, EOB

Benefits MAC can be reached at 1-800-563-9929, cssteam@connerstrong.com or submit a request [online](#)



Voluntary Benefit Providers

AMERICAN FIDELITY

- Provider for FSA/HSA
- Accident, Cancer, Critical Illness Insurance
- Disability Insurance, Group Term Life Insurance
- [Learn About Flexible Spending Accounts | American Fidelity](#)

Account Manager: Joe Santo

Email: Joe.Santo@americanfidelity.com

Phone: (302) 220-8719

NATIONWIDE

- Deferred Compensation and helping plan for retirement
- [Learning Video Link- What is a 457\(b\) and why should you enroll? \(nrsforu.com\)](https://nrsforu.com)

Account Manager: Nikki Cibelli

Email: Cibeln1@nationwide.com

Phone: (888) 401-5272

METLIFE

- Governmental 457(b) Deferred Compensation Plan



Account Manager: Matthew Galasso

Email: mgalasso@financialguide.com

Phone: (732) 751-3085

Thank you!

Any Questions?

Aaron Smith

Dept. of Personnel & Human Resources

Confidential Assistant/Employee Benefits Manager

aaronsm@cumberlandcountynj.gov

856-453-2123 ext. 12123

