Item #9
10/13/2020

HUMAN RESOURCES DEPARTMENT
600 W. 4TH Street
Davenport, IA 52801

Office: (563) 326-8767
Fax: (563) 328-3285
www.scottcountyiowa.com

Date: October 6, 2020

To: Mahesh Sharma, County Administrator

From: Mary J. Thee, Human Resources Director/Asst. County Administrator

Subject: Insurance Recommendations

Health/Pharmaceutical

We received a one year agreement for our third party administrative services with United Health Care. The agreement is for a rate per employee per month (PEPM) of $55.56 that after rebate nets at $9.33 PEPM. The rate guarantee for CY22 is guaranteed at $56.94, but the rebate amount is unknown at this time. Overall this results in a reduction of $6.79 PEPM or ≈ $40,659 annually in administrative costs.

Stop Loss Coverage

Once again Holmes Murphy has engaged their strategic partner, Stealth, to procure proposals for stop loss coverage. They are recommending we remain with Highmark Insurance Group's (HM's) proposal. This results in an 11% increase, this is comparable to last year's increase. We are recommending we maintain our specific stop loss coverage to $175,000.

Dental

We have received our renewal information for a three year Administrative Services Agreement with Delta Dental of Iowa. The administrative rate increase is $.30 per contract and locks in the rate for 3 years. This equates to approximately $1,840 annually.

Vision

We are in year 3 of a four year agreement with Avesis, who has been our provider since 2010.

Health Care Rates

The County has reviewed our health care rates with our actuarial, Silverstone Group. Our claims have remained relatively close to last year, but this has proved to be a challenging year for predictions due to claim processing delays related to COVID-19. Their recommendation is for a 4.1% increase for health. We did not increase dental last year but there is a recommendation for a 3.7% increase this year. As the vision plan is fully funded and under contract, there is no increase needed this year. These changes result in an employee single increase of $1.45 a month and a family premium increase of $10.06 a month. This is our lowest rate increase since CY15, with an overall increase of 4.05%.

Plan Design

In December, 2018 we asked Holmes Murphy to do an audit of our health plan to determine if it met the long term needs of the County. In April 2019 suggestions were presented to the Health Benefit Team, which includes representation of all unions and buildings. After feedback and discussion the proposal was revised and eventually presented to the Deputy Sheriff Association (DSA) as it remains a mandatory subject of bargaining. The final changes were negotiated and ratified in January. The agreement for plan design changes included the waiver of our grandfather plan status thus opening more wellness benefits under the affordable care act (ACA) to staff. Pharmaceutical design changes include adding a 4th tier for co-pays and structuring co-pays as $5/$30/$60/$100. Also included is the implementation of medical necessity for medications prescribed for non-FDA approved conditions. The medical design changes are implementing no co-pay for virtual visits, charging $300 co-pay for emergency room visits over 4 to encourage other means of care, a $50 co-pay for imaging services, the maternity co-pay increasing to $500 and instituting a 10% co-insurance for home health/skilled nursing/DME/hospice. These changes will take effect January 1, 2021.

Wellness Program/Policy P

We have worked with the Health Benefit Team to review our Healthy Lifestyles program to provide discounts instead of surcharges for participation. We believe this presents a fresh and more positive view of our continued wellness efforts. We've reviewed different programs and believe our continued relationship with Genesis at Work serves our needs best. We've developed a customized wellness program that will utilize their WellSteps program. Employees and spouses on the health plan have been invited to participate in biometric screening this month and in 2021 will be provided opportunities to earn points toward a discounts on the health plan for 2022.

Flex Savings Plan

We recommend the automatic renewal of our flex savings plan with Wage Works. The flex savings plan allows employees to pay pre-tax dollars for medical and dependent care expenses. The County pays $5.25 PPPM (per participant per month). The cost averages around $1,541 monthly or $18,492 annually and is based on participation of employees. We recommend reviewing the vendor for this service in the coming year. Additionally we updated our Section 125 plan, which addresses the elements related to our flex savings plan. The plan is attached for your approval.

The supporting documentation is attached.

Cc: David Farmer, Director of Budget and Administrative Services
Anna Evans, Holmes Murphy
Andrea Ahmann, Benefits Specialist

UnitedHealthcare

Medical Plan Design and Fee Detail

Customer Name:	Scott County Iowa
Effective Date:	1/1/2021

	CH+ Current Plan
Plan Offering	Single Option
Multiple Option with:	
Plan Name	CH+
Product	Choice +
HRA or HSA	No
Benefits*	In-Network
Office Copay (PCP/SPC)	PCP $20, SPC $20
Other Copays (IP/UC/ER)	IP 100, UC $20, ER $75
Deductible	$0/$0
Coinsurance	100%
Out-of-Pocket	$1,000/$2,500
Pharmacy Plan (Deductible, Copays, Mail Order)	$5/15/30; 2.5x M.O.; Sep OOP $5600/10700 3X MO
	Out-of-Network
Deductible	$200/$400
Coinsurance	80%
Out of Pocket	$1,500/$3,000
	Other
Lifetime Maximum	Unlimited
UBH Option	Behavioral Health Solutions
Plan Decrement	1.00

ADMINISTRATION FEE DETAIL

Fee Prior to Rebates	$55.56
Rx Rebate Credit	-$46.23
Total Net Quoted Fee	**$9.33**
Second Year Fee Guarantee Prior to Rebates	$56.95
Second Year Rx Rebate Credit	TBD
Total Net Second Year Fee Guarantee	**TBD**

THE COUNTY AUDITOR'S SIGNATURE CERTIFIES THAT THIS RESOLUTION HAS BEEN FORMALLY APPROVED BY THE BOARD OF SUPERVISORS ON _____.
DATE

SCOTT COUNTY AUDITOR

R E S O L U T I O N

SCOTT COUNTY BOARD OF SUPERVISORS

October 15, 2020

APPROVAL OF ONE YEAR AGREEMENT FOR ADMINISTRATIVE SERVICES WITH UNITED HEALTH CARE

BE IT RESOLVED BY the Scott County Board of Supervisors as follows:

Section 1. That the proposal from United Health Care for one year for CY21 for third party administration services.

Section 2. That the Human Resources Director hereby authorized to sign the health insurance contracts for services on behalf of the Board.

Section 3. This resolution shall take effect immediately.

STOP LOSS PREMIUMS-FINAL THRU 10.15
CURRENT ISL OF $175,000 & AGG. SPEC OF $50K

	HM Current	Initial HM Renewal	Final HM Renewal	Initial HCC Option	Final HCC Option
ISL Fee (PEPM)	Single: $32.06 Family: $85.51	Single: $37.04 Family: $99.65	Single: $35.51 Family: $95.52	Single: $30.42 Family: $100.80	Single: $28.35 Family: $93.95
Estimated Annual Premium	$403,509	$469,593	$450,141	$460,974	$429,643
Aggregate Fee (PEPM)	$4.68	$4.82	$4.82	$6.67	$12.03
Estimated Annual Premium	$27,912	$28,746	$28,746	$39,780	$71,747
Estimated Total Annual Cost	**$431,421**	**$498,340**	**$478,898**	**$500,754**	**$501,390**
Change from Current		15.5% $66,919	11% $47,477	16.1% $69,333	16.22% $69,969

- All Quotes Final Thru 10.15.20
- There are no policy riders included such as no-new-laser at renewal or renewal rate caps

Premium estimates based on current medical plan enrollment of 161 Employee Only Contracts & 331 Family Contracts – Total of 497.

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DATE

SCOTT COUNTY AUDITOR

R E S O L U T I O N

SCOTT COUNTY BOARD OF SUPERVISORS

October 15, 2020

APPROVAL OF ONE YEAR AGREEMENT FOR STOP LOSS COVERAGE

BE IT RESOLVED BY the Scott County Board of Supervisors as follows:

Section 1. That the proposal from Highmark Insurance Group (HM) for one year agreement for specific and aggregate stop loss coverage is hereby accepted and approved.

Section 2. That the Human Resources Director hereby authorized to sign the health insurance contracts for services on behalf of the Board.

Section 3. This resolution shall take effect immediately.

HUMAN RESOURCES DEPARTMENT
600 West Fourth Street
Davenport, Iowa 52801-1030

Ph: (563) 326-8767 Fax: (563) 328-3285
www.scottcountyiowa.com

Date: October 6, 2020

To: Mahesh Sharma, County Administrator

From: Mary J. Thee, Human Resources Director/Asst. County Administrator

Subject: Approval of Health Insurance Premium Rates for CY21

The final rates for the Medical, Dental and Vision benefits are as follows:

United Healthcare Plan (TPA) **(Self Funded as of 1-1-10)**	CY20 Rates	CY21 Rates	Employee Rate
	$ 676.26 Single $1,842.58 Family	$704.10 Single $1,918.44 Family	$ 35.20 Single $ 242.86 Family

Delta Dental (TPA) **(Self funded as of 7-1-10)**	CY20 Rates	CY21 Rates	Employee Rate
	$ 30.36 Single $ 90.96 Family	$31.46 Single $94.36 Family	$ 1.56 Single[1] $ 12.58 Family[1]

[1] Employee's opting to take the Dental supplemental plan shall pay an additional $8.30/month for single or $16.60/month for family coverage.

Avesis Vision **(Contracted since 7-1-10)**	CY20 Rates	CY21 Rates	Employee Rate
	$7.57 Single $17.43 Family	$7.57 Single $17.43 Family	$0.38 Single $1.96 Family

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DATE

SCOTT COUNTY AUDITOR

R E S O L U T I O N

SCOTT COUNTY BOARD OF SUPERVISORS

October 15, 2020

APPROVAL OF HEALTH CARE PREMIUM RATES FOR SCOTT COUNTY EMPLOYEES IN CALENDAR YEAR 2021

BE IT RESOLVED BY the Scott County Board of Supervisors as follows:

Section 1. The following schedule of single health care premium rates for Scott County employees in calendar year 2021 is hereby approved:

Health/Pharmaceutical	$ 35.20 / mo
Dental	$ 1.56 / mo
Avesis Vision	$ 0.38 / mo

Section 2. The following schedule of family health care premium rates for Scott County employees in calendar year 2021 is hereby approved:

Health/Pharmaceutical	$ 242.86 / mo
Dental	$ 12.58 / mo
Avesis Vision	$ 1.96 / mo

Section 3. Employee's opting to take the Dental supplemental plan shall pay an additional $8.30/month for single or $16.60/month for family coverage.

Section 4. This resolution shall take effect on January 1, 2021.

DELTA DENTAL

Scott County
Group # 33671
Rating Period 1/1/21 through 12/31/23
Financial Exhibit

		Delta Dental PPO[SM]
Experience Period	Claims Paid 6/1/19 through 5/31/20	
Claims Paid 6/1/19 through 5/31/20		$373,909
Adjustment of Claims to Incurred Basis		$11,564
Incurred Claims		$385,473
Trend in Claims		$24,709
Projected Claims Based on Current Experience		$410,182
Claims and Enrollment Fluctuation Adjustment		$26,552
Projected Annual Claims Based on Current Enrollment		$436,734
	Per Contract	
Fixed Fees		
Operating Costs	$5.54	$33,971
Broker Fee	$0.00	$0
Subtotal Fixed Fees	$5.54	$33,971
Projected Annual Expense		$470,705

DELTA DENTAL OF IOWA

THE COUNTY AUDITOR'S SIGNATURE CERTIFIES THAT THIS RESOLUTION HAS BEEN FORMALLY APPROVED BY THE BOARD OF SUPERVISORS ON _____.
DATE

SCOTT COUNTY AUDITOR

R E S O L U T I O N

SCOTT COUNTY BOARD OF SUPERVISORS

October 15, 2020

APPROVAL OF THREE YEAR AGREEMENT WITH DELTA DENTAL FOR THIRD PARTY ADMINISTRATOR SERVICES

BE IT RESOLVED BY the Scott County Board of Supervisors as follows:

Section 1. That the proposal from Delta Dental for three years for third party administration services is hereby accepted and approved.

Section 2. That the Human Resources Director hereby authorized to sign the dental insurance contracts for services on behalf of the Board.

Section 3. This resolution shall take effect immediately.

SCOTT COUNTY IOWA

HEALTH PLAN

SUMMARY PLAN DESCRIPTION

01/01/2021

SCOTT COUNTY IOWA
HEALTH PLAN
SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Scott County Iowa (the "Employer") established the Scott County Iowa Health Plan (the "Plan") 01/01/2021. The Plan is a cafeteria plan that provides an eligible employee with the opportunity to choose among benefits offered under the Plan.

This summary supersedes all previous summaries of the Plan. Although the purpose of this document is to summarize the more significant provisions of the Plan, it is only a summary - the terms of the Plan document ultimately govern the operation and administration of the Plan. The Employer and any employer who has adopted the Plan is referred to in this document as the "Employer".

ELIGIBILITY

You are an "Eligible Employee" if you are an employee of the Employer or any affiliate who has adopted the Plan on the first day of the calendar month next following the date you have attained at least 18 years of age and you have completed at least 30 Hours Per Week hours of service.

However, you are not an "Eligible Employee" if you are any of the following:

- A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.
- A leased employee.
- A part-time employee who is expected to work fewer than 30 hours per week.
- Temporary and Seasonal Employees.

If you are eligible to participate in the Employer-sponsored group health plan, then you are eligible to participate in the Health Flexible Spending Account, even if you do not elect to participate in the Employer-sponsored group health plan.

ELECTION PROCEDURES

You may elect to participate in the Benefits under the Plan within 30 days after your eligibility date (or a shorter period if established by the Plan Administrator).

If you do not enroll in the Plan upon your initial eligibility, you may enroll during the enrollment period established by the Plan Administrator. Your election will be effective as of the first day of the Plan Year following the enrollment period.

You may also enroll in the Plan upon a change in status event as described below.

To enroll in the Plan, you may need to submit a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. If, as of the start of a Plan Year, you have not submitted a completed election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

If you fail to submit an election form, prior year elections will automatically apply to the following benefits: Premium Conversion Account. An election to participate in the Plan is generally irrevocable for the Plan Year. You may not change your election during a Plan Year unless you experience a change in status. Your change in election must be on account of and correspond with a change in status that affects your eligibility for coverage under the Plan.

Depending on the Benefit, a "change in status" includes:

- Change in your marital status.
- Change in the number of your dependents.
- Change in your employment status or the employment status of your spouse or dependents.
- Your dependent satisfies or ceases to satisfy eligibility requirements.
- Change in your place of residence.
- Commencement or termination of an adoption proceeding.
- Court judgment, decree, or order.
- Entitlement to Medicare or Medicaid by you, your spouse, or your dependent.
- Significant cost or other coverage changes.

- You change coverage under another cafeteria plan.
- You take leave under the FMLA.
- You lose coverage under the group health plan due to a reduction in hours.
- You are eligible to enroll in a qualified health plan through the Marketplace.

BENEFITS

Contributions pertaining to a Benefit will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes. Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

If you are a highly paid employee or an owner of your Employer, federal law may impose limits on your behalf to participate in the Plan and/or the benefits you may receive from the Plan. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify your election in order to assure compliance with such requirements or limitations.

Premium Conversion Account

If you elect to contribute to a Premium Conversion Account, the Plan will establish a Premium Conversion Account in your name. Your Premium Conversion Account will be credited with amounts withheld from your compensation. The amount of the contribution to your Premium Conversion Account is equal to the amount of your portion of the premium due for the following benefits/contracts:

- Employer Health
- Employer Dental
- Employer Vision

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts sponsored by the Employer as permitted by applicable law.

If you affirmatively elect not to participate in the Premium Conversion Account for a Plan Year, you will not be enrolled unless and until you elect to participate in the Premium Conversion Account as described in the "Election Procedures" above. Contributions to the Premium Conversion Account are not subject to federal income tax or social security taxes.

In the event of a conflict between the terms of this Plan and the terms of the applicable contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Flexible Spending Account (Health FSA)

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA

General Purpose Health FSAs may only be used to reimburse for qualifying medical expenses during the Plan Year.

If you are eligible, you may elect to contribute to a Health FSA in accordance with the "Election Procedures" described above.

Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to participate in the Employer-sponsored group health plan, then you are not eligible to participate in a Health FSA.

Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted under the tax

code ($2,750 for 2020). The Employer will not make additional contributions to your General Purpose Health FSA on your behalf.

Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone you may claim as a dependent on your federal tax return and also includes a child until their 26th birthday. The entire annual amount you elect to contribute for the Plan Year to your Health FSA, less any reimbursements already distributed from your Health FSA, will be available for reimbursement throughout the Plan Year.

You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your Health FSA. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return. Health insurance premiums are not an eligible expense for the Health FSA.

You will not be reimbursed for any expenses that were (1) incurred before you are eligible to participate in the Health FSA; (2) incurred after you have become ineligible to participate in the Health FSA and are attributable to a tax deduction you took in a prior taxable year; or (3) covered, paid, or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

You must submit claims for reimbursement from your General Purpose Health FSA no later than 04/30. Any amounts remaining in your Health FSA after all timely claims have been paid will be forfeited.

Notwithstanding the forfeiture provisions above, if you have a balance in your Health FSA as of the last day of the Plan Year after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed, the Plan will carry over the balance from your Health FSA, up to $550, which may be used to pay or reimburse eligible expenses for the subsequent Plan Year. Any amounts in your Health FSA that exceed the limit above will be forfeited.

Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, you may elect to continue to make contributions to your General Purpose Health FSA on an after-tax basis, subject to the following limitations: Terminated employees may continue to contribute through COBRA.. You may submit claims for reimbursements from your General Purpose Health FSA for expenses incurred any time during the Plan Year. You must submit claims for reimbursement from your Health FSA no later than 120 days days after the date your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

Dependent Care Assistance Plan Account (DCAP)

A Dependent Care Assistance Plan Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCAP Account in accordance with the "Election Procedures" described above.

DCAP Contributions

Your DCAP Account will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCAP Account is the maximum amount permitted under the tax code ($5,000 for 2020, $2,500 if you are married and filing separately.)

The Employer will not make additional contributions to your DCAP Account on your behalf.

DCAP Eligible Expenses/Reimbursement

The amount available for reimbursement is the balance in your DCAP Account at the time the reimbursement request is received by the Plan Administrator or Claims Administrator. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCAP Account. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for themselves. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

You must submit claims for reimbursement from your DCAP Account no later than 04/30 following the Plan Year. Any amounts remaining in your

DCAP Account after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, you may elect to continue to make contributions to your DCAP Account on an after-tax basis. You may submit claims for reimbursements from your DCAP Account for expenses incurred any time during the Plan Year subject to the following limitations: Terminated employees may continue to contribute through COBRA.. You must submit claims for reimbursement from your DCAP Account no later than 120 days days after the date your employment terminates. Any balance remaining in your DCAP Account will be forfeited after claims submitted prior to this date have been processed.

CLAIMS PROCEDURES

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to Take Care by WageWorks at:

Address: Flex Claims Group, P.O. Box 14054, Lexington KY 40512
Phone number: 800-950-0105

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

To the extent that the Plan Administrator approves a claim, the Employer may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Claims for Plan Benefits (except for Health FSAs)

You must file a claim for benefits under this Plan in accordance with the Plan Administrator's guidelines. If your claim does not include enough information to process the claim, you will be given an opportunity to provide the missing information. You may designate an authorized representative by providing written notice of the designation to the Plan Administrator.

You may apply for benefits under the Plan by completing and filing a claim with the Plan Administrator. Your claim must include all information and evidence that the Plan Administrator deems necessary to evaluate the merit of your claim and to make any necessary determinations on your claim. The Plan Administrator may request any additional information from you as necessary to evaluate the claim.

Claims for Health FSA Benefits

If you file a claim for benefits from your Health FSA and that claim is denied, the Plan Administrator will notify you within a reasonable period of time, but no later than 30 days after the Plan Administrator received the claim. The Plan Administrator may notify you, prior to the expiration of this 30-day period, of the need to extend the period by up to 15 days due to matters beyond its control. In such case the Plan Administrator will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator will notify you of its decision. If the extension is necessary because you did not submit information necessary to decide the claim, the notice of extension will describe the required information, and you will have at least 45 days from the day you receive the notice to provide the specified information.

If your claim is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for the denial, (B) the Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA after following the Plan's claims procedures. The notice will also include (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or (2) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If you wish to appeal the denial of a claim, you must file an appeal with the Plan Administrator on or before the 180th day after you receive the Plan Administrator's notice that the claim has been denied. You will lose the right to appeal if the appeal is not made within this 180-day period. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will be provided, upon request and free of charge, documents and other information relevant to your claim. Your appeal may also include any comments, statements or documents that you desire to provide. The Plan Administrator will consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator will:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any denial that is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the denial; and

(D) Provide that the health care professional engaged for purposes of a consultation under (B) above will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of the denial.

Denial of Appeal. If your appeal is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for such denial, (B) the Plan provisions on which the denial is based, (C) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (D) a statement describing your right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

Exhaustion of Remedies; Limitations Period for Filing Suit. Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Benefits Provided under Contracts. Please see the underlying contracts for any additional claims and reimbursement rules under those contracts.

Debit/Credit Cards

Scott County Iowa will provide you with a debit/credit and/or other stored-value card for purposes of making purchases that are eligible for reimbursement from your Health Flexible Spending Account and/or Dependent Care Assistance Plan Account. The Plan Administrator will provide you with more information about these cards as well as any limitations at the time you enroll in the Plan. You do not have to use the cards and may request reimbursements as listed above.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your Employer is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs fewer than 20 employees, but you should contact the Plan Administrator who can inform you if the Employer is a small employer not subject to COBRA and is not required to comply with these rules. Depending on your Health FSA balance at the time of the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."
If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice which explains your rights regarding COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of their COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides a Health FSA to any of its employees.

YOUR RIGHTS UNDER ERISA

As a participant in the Health FSA under this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in a plan governed by ERISA shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all

documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants in plans governed by ERISA, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, if applicable, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining an ERISA welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for an ERISA welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of ERISA plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court if you have exhausted the Plan's claims procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court if you have exhausted the Plan's claims procedures. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact the Plan Administrator for more information under the Plan.

Unclaimed Reimbursements

Payments from the Account that are not claimed on a timely basis (for example, checks issued from the Plan that are not timely cashed) will be forfeited and returned to the Plan. Please contact your Plan Administrator about what constitutes "timely" claims of payment from the Plan.

Excess Payments/Reimbursements

If you receive an excess benefit or payment under the Plan, you must immediately repay any such excess payments/reimbursements. You must also reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable to you under this Plan.

Beneficiaries

If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents, or a representative of your estate.

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your Account(s) under the Plan if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

Non-Alienation of Benefits

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary to receive benefits under the Plan in the event of your death.

Amendment and Termination of the Plan

The Employer may amend or terminate the Plan at any time.

Plan Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding on all persons and parties.

Taxation

The Employer intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Governing Law

The Plan is governed by the laws of Iowa to the extent not pre-empted by Federal law.

PLAN INFORMATION

1. The Plan Sponsor and Plan Administrator is Scott County Iowa.

2. The Plan Sponsor's and Plan Administrator's Address is 600 W. 4th Street, Davenport, IA 52801-1030

3. The Plan sponsor's EIN is 426004465

4. The Plan Sponsor and Plan Administrator's phone number is 563-326-8767

5. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code. The Health FSA Benefit under the Plan is a welfare benefit plan.

6. The Plan number is 075.

7. The Plan's designated agent for service of legal process is the Plan Sponsor. Any legal papers should be delivered to the Plan Sponsor at the address listed above. However, service may also be made upon the Plan Administrator.

8. The Plan Year is the 12-consecutive month period ending on 12/31.

9. Amount contributed by Plan Participants and the Employer to the Plan are general assets of the Employer. All payments of benefits under the Plan are made solely out of the general assets of the Employer. The Employer has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. The Employer may, in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.

THE COUNTY AUDITOR'S SIGNATURE CERTIFIES THAT THIS RESOLUTION HAS BEEN FORMALLY APPROVED BY THE BOARD OF SUPERVISORS ON _____.
DATE

SCOTT COUNTY AUDITOR

R E S O L U T I O N

SCOTT COUNTY BOARD OF SUPERVISORS

October 15, 2020

APPROVAL OF ONE YEAR RENEWAL FOR FLEX SAVINGS PLAN ADMINISTRATION AND FLEXIBLE SAVINGS ACCOUNT PLAN

BE IT RESOLVED BY the Scott County Board of Supervisors as follows:

Section 1. That the annual renewal with WageWorks for administration of the County's flex savings program is hereby approved.

Section 2. That the Human Resources Director hereby authorized to sign any necessary contracts for services on behalf of the Board.

Section 3. That the County's Flexible Savings Account Plan (aka Section 125 plan) is hereby updated and adopted. The carryover limit shall comply with IRS regulations.

Section 4. This resolution shall take effect immediately.

P. INSURANCE AND DEFERRED COMPENSATION

GENERAL POLICY

It is the policy of Scott County to offer medical, prescription drug, dental, vision, life insurance coverage and deferred compensation options to its benefit-eligible employees.

SCOPE

This policy is applicable to the following:

All employees responsible to the Scott County Board of Supervisors;

All employees responsible to a County elected office holder with the exception of the elected office holder themselves and Deputies;

All elected office holders and/or Deputies provided the appropriate elected office holder and the Board of Supervisors have certified its applicability;

All employees not directly responsible to either the Board of Supervisors or an elected office holder and whose governing body and the Board of Supervisors have certified its applicability.

Whenever the provisions of this policy are in conflict with the Code of Iowa, or with a collectively-bargained agreement between the County and a certified bargaining unit, the provisions of the collectively-bargained agreement and/or the Code of Iowa will prevail.

HEALTH BENEFIT ELIGIBILITY

To be eligible for group health and/or life insurance benefits, an employee must occupy a regular full-time position or a regular part-time position scheduled to work at least one thousand, five hundred and sixty (1,560) hours per year. Coverage for employees expected to work full-time is normally effective the first day of the month following appointment to a benefit-eligible position.

The County will use the safe harbor measurements permitted under the Affordable Care Act for variable hour part-time (not anticipated to work thirty (30) or more hours a week) and seasonal employees to determine employee eligibility for group health coverage. The standard measuring period and stability periods are established at twelve (12) months. The County will review at the conclusion of the initial measuring period if the employee worked one thousand, five hundred and sixty (1,560) hour or more to determine eligibility, and if so consider the employee full-time and eligible for group health coverage through the stability period (regardless of hours worked). The administrative period for enrollment following the initial measuring period is thirty (30) days. If the employee worked less than one thousand, five hundred and sixty (1,560) hours during the initial measuring period

then the employee will not be treated as eligible for group health benefits during the stability period. When calculating hours for non-exempt employees under FLSA, the County will include hours worked plus hours where payment was made for vacation/PTO, holiday, sick/medical leave, jury duty, military leave or other paid leave of absence.

GROUP HEALTH BENEFITS

Coverage available under the County's group health plan include: hospital and medical benefits; prescription drug benefits. Additionally the County provides group coverage for dental benefits and vision benefits. A detailed description of benefits, including deductible, premiums and coinsurance requirements, is available through the Human Resources Department.

The specific amount to be contributed by the County for single and family coverage will be established each year by the Board of Supervisors and become effective January 1st. Where there are two married employees covered by the County's plan, they may take either one family plan or two single plans and pay premiums accordingly.

Any errors made relative to insurance premiums or flexible spending account deductions will be adjusted accordingly either in the employee's favor (refunding premiums) or in the County's favor (deducting missed premiums). Repayment arrangements will be made between the affected employee and the Auditor's Office Payroll staff on a case-by-case basis.

GROUP LIFE BENEFITS

Department Heads, Elected Officials, and Deputy Office Holders are eligible to receive term life and AD & D insurance coverage equal to two hundred percent of their annual salary as of September 1st of each year. Benefit-eligible employees in positions classified as exempt under FLSA and in a salary range of 27 or above are eligible to receive term life and AD & D insurance coverage equal to one hundred percent of their annual salary as of September 1st of each year. Employees previously provided this benefit of equal to 100%, who no longer qualify will be grandfathered into the existing coverage. All other benefit-eligible employees in positions are eligible to receive term life and AD & D insurance coverage equal to $20,000.

The County will pay the monthly premium for the term life and AD & D coverage described above.

TERMINATION OF GROUP COVERAGE

Life insurance coverage under the County's group plan will end on the employee's date of employment termination.

Health, dental and vision coverage under the County's group plan will normally terminate at the end of the month in which the employee terminates employment with the County. However, an employee may be eligible to extend coverage under the group plan as required by state or federal law. An employee shall be considered a retiree for purposes of continued insurance coverage until age 65 if one of the following occurs: 1) the employee qualifies for full retirement benefits through IPERS with service from the County, another employer, or purchased service quarters; 2) the employee is age 55 or more and has at least 20 years of service with the County; or 3) the employee is a Sheriff's deputy, is age 50 or more and has 22 or more years of service. Premiums for extended coverage after employment shall be paid by the employee at 102% of the actual cost. Information on the extension of group coverage and/or conversion to an individual medical insurance policy is available through the Human Resources Department

LONG TERM DISABILITY

Benefit eligible employees (excluding deputy sheriff, sergeant, lieutenant, captain, major and sheriff) are provided with a long term disability insurance policy with the premium paid entirely by the County. The amount of coverage is sixty-six and two thirds percent (66 2/3%) of the employee's annual salary, following a determination of eligibility and a 90 day waiting period. Specific details are found in the insurance plan document.

DEFERRED COMPENSATION PLAN

Employees shall have the option of deferring a portion of their compensation for the purpose of building retirement security in a tax-sheltered investment plan in accordance with state and federal law. Payroll deductions can only be made for Deferred Compensation Plan Providers who have completed Deferred Compensation Plan Administrator Agreement and have a minimum of 10 employees requesting enrollment in the plan. All Deferred Compensation Plan Providers must satisfy the requirements of Section 457 of the Internal Revenue Code and the Administrator Agreement to maintain eligibility as a provider.

The County will match an employee's contribution at $.50 for each dollar the employee contributes during that calendar year, up to a maximum of $1,000.00. The matching contribution will be paid no later than the second paycheck in January of the following calendar year or upon termination of employment, whichever occurs first. The employee is responsible for monitoring and not exceeding the maximum allowable annual contribution in accordance with Section 457 of the Internal Revenue Code.

Information regarding payroll deduction for deferred compensation and selection of Providers, distribution, change or designation of beneficiaries is available through the Human Resources Department. The County does not solicit, nor endorse any Deferred Compensation Plan Provider.

FLEXIBLE BENEFITS PLAN (SECTION 125)

Pursuant to Section 125 of the Internal Revenue Code, the County offers employees the option of using a portion of their before tax compensation for one or more of the following flexible benefit plans:

1. Premium Only Plan - Provides for the reduction of compensation by the employee contribution for health and life insurance premiums before taxes.

2. Dependent Care Reimbursement Account - Employees fund the flexible spending account by regular payroll deductions prior to tax pursuant to federal law. Dependent care expenses are then reimbursed up to the amount of the annual election.

   Unused annual elected amounts are forfeited.

3. Health Care Reimbursement Account - Employees determine an annual election amount permitted by federal law, to be put into a flexible spending account for non-covered health-related expenses. The elected amount is deducted from compensation prior to tax and expenses are then reimbursed up to the amount of the employee's annual election.

   An employee may roll over up to $500.00 into the next calendar year pursuant to the IRS regulations and plan design.

Employees electing to participate in one or more of the plans may have expenses for group health premiums, dependent care, or out-of-pocket health care costs deducted from compensation prior to taxes. Detailed information and enrollment forms regarding these flexible benefit plans are available through the Human Resources Department.

HEALTH INSURANCE BILL AUDIT PROGRAM

A participant can receive cash payments by auditing his/her own hospital, medical and/or dental bills. The participant should check each bill for unrecognizable charges such as laboratory tests and procedures that were not received or therapy charges that do not reflect the treatment received. Scott County will share the savings with the participant. The procedures outlined below should be followed.

Before the participant leaves the hospital, physician's or dentist's office, or upon receipt of the itemized bill, the participant should carefully review the charges, looking for errors such as the following:

- an incorrect number of days was billed for a period of hospital confinement;
- an incorrect number of days in an intensive care unit was billed;
- the participant was billed for tests not performed;
- an incorrect number of hours of physical therapy was billed;

- the participant was inaccurately billed for drugs; and/or
- on the day the participant left the hospital, he/she was charged for take-home drugs that were not received.

If the participant questions any charges and believes they are incorrect, he/she should contact the dentist, physician or hospital's billing office. The participant should ask for an explanation of any charges he/she does not understand.

Hospital, medical and dental bills eligible for this program are those for the employee and his/her covered dependents incurred after January 1, 2011 and covered by the County's Plan. This Plan must pay before coordinating benefits with other group health insurance plans also providing benefits.

As an incentive to carefully review healthcare bills, Scott County will pay the participant 25% of the saving of $100.00 or more to this Plan for overcharges or for charges he/she has eliminated from any hospital, medical or dental bill for treatment, services or supplies not received to a maximum incentive payment of $250.00 per confinement, illness or injury. Obvious errors (e.g., $1,000 for an office visit) will not be eligible for this program.

It will be the participant's responsibility, within 90 days of discharge or treatment to contact the hospital's or provider's billing department to report the error and obtain a corrected billing and to forward the original and corrected billing with corrected items circled to the Human Resources Department.

Upon review of the corrected billing, Scott County will notify the participant of the amount of payment for which he/she is eligible.

Employees should note that reimbursements of this nature are considered income for tax purposes.

HEALTHY LIFESTYLES PROGRAM

Scott County will offer a Healthy Lifestyles Program that allows employees and/or spouses on the health plan to earn points by participating in a variety of wellness activities. To enroll employee and/or spouse will be provided the opportunity to complete a wellness/biometric screening in the fall of each year and provided access to an online wellness portal. Employee and/or spouse who earn a minimum of 100 points by completing the wellness/biometric screening and various wellness activities by September of the following year will receive a $25.00 monthly health premium reduction beginning January of 2022.

Employees (whose insurance is not covered by a collective bargaining agreement) are eligible to participate in the Y@Work program through the Quad Cities YMCA. The County will pay twenty dollars ($20.00) a month as a taxable benefit to the Quad Cities YMCA toward a membership for the employee, two adults or family. The employee must attend at least twenty four (24) times a quarter in order for the County to continue its monthly contribution. The employee is responsible for any additional financial obligations to the Quad Cities YMCA.

ADMINISTRATIVE PROCEDURES

1. The Human Resources Department is responsible for administering the County's group health, dental, vision, life, LTD, deferred compensation and Section 125 flexible benefit plans.

2. The County retains full authority to change the plan of benefits described in this policy, to self-insure all or any portion of said benefits, and to select the insurance carrier or claims administrator.

THE COUNTY AUDITOR'S SIGNATURE CERTIFIES THAT THIS RESOLUTION HAS BEEN FORMALLY APPROVED BY THE BOARD OF SUPERVISORS ON

_____.
DATE

SCOTT COUNTY AUDITOR

R E S O L U T I O N

SCOTT COUNTY BOARD OF SUPERVISORS

October 15, 2020

APPROVING CHANGES TO GENERAL POLICY P "INSURANCE AND DEFERRED COMPENSATION"

BE IT RESOLVED BY the Scott County Board of Supervisors as follows:

Section 1. General Policy P "Insurance and Deferred Compensation" revises the policy to address modifications to the healthy lifestyles programming.

Section 2. This resolution shall take effect immediately.