

Charlotte County

BOARD OF COUNTY COMMISSIONERS



2018 | 2019 EMPLOYEE BENEFIT HIGHLIGHTS



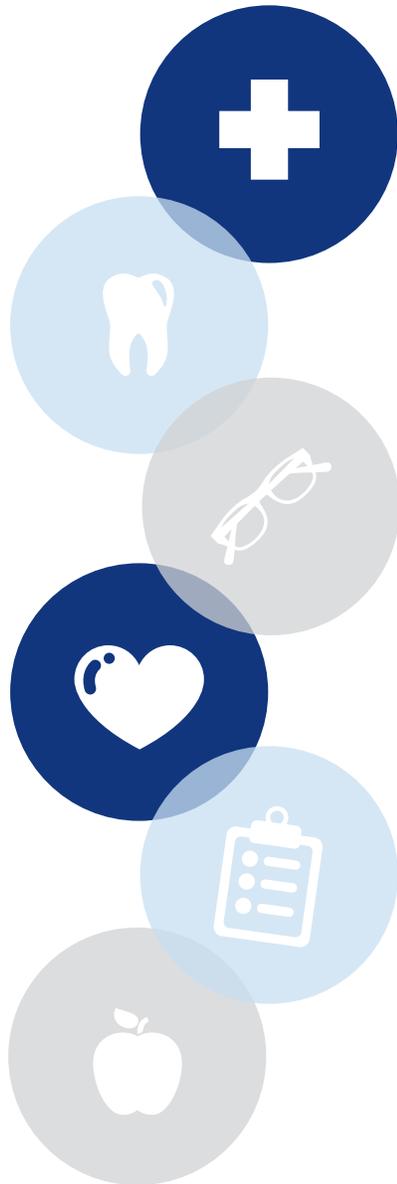
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Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.cigna.com Onsite Cigna Representative: (941) 743-1388
Telehealth	AmWell	Customer Service: (855) 667-9722 www.AmWellforCigna.com
	MDLIVE	Customer Service: (888) 726-3171 www.MDLIVEforCigna.com
Mail-Order Pharmacy Program	Envision Pharmacies	Customer Service: (866) 909-5170 www.envisionpharmacies.com
Health Reimbursement Account	TASC	Customer Service: (877) 933-3539 www.tasconline.com
Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Vision Benefit	EyeMed	Customer Service: (866) 723-0514 www.eyemedvisioncare.com
Flexible Spending Accounts	TASC	Customer Service: (877) 933-3539 www.tasconline.com
Basic Life and AD&D Insurance	Cigna	Customer Service: (800) 732-1603 www.cigna.com
	Cigna	Customer Service: (800) 732-1603 www.cigna.com
Employee Assistance Program	Cigna Behavioral Health	Customer Service: (877) 622-4327 www.mycigna.com
Short & Long Term Disability Insurance	Cigna	Customer Service: (800) 732-1603 www.cigna.com
Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 www.aflacgroupinsurance.com
	Valery Insurance Agency	Customer Service: (800) 330-8445
TransAmerica Insurance	Page Agency	Agent: Steve Alldredge Phone: (386) 228-5082
COBRA Benefits	Wageworks	Customer Service: (877) 266-3947 https://cobrabenefitwageworks.com
Legal Insurance	Legal Shield	Agent: Jim and Andrea Carroll Phone: (941) 235-1770
Employee Health Centers	CareHere	Customer Service: (877) 423-1330 Customer Service: (941) 764-0301



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This booklet is merely a summary of benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The County reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.



Introduction

The County is pleased to offer a comprehensive array of benefits including group insurance coverage, retirement savings plans, and wellness programs. Please refer to the County Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. For further explanation or assistance answering specific questions, please refer to the customer service phone number under each benefit description heading. General inquiries may be directed to Risk Management.

Online Benefit Enrollment

The County provides employees with an online benefits enrollment platform through BenTek's Employee Benefits Center (EBC). The EBC provides benefits-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment period, New Hire Orientation or Qualifying Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefits plans and view and print an outline of benefit elections for employee and dependent(s). Employee has access to important forms and carrier links, can report qualifying life events and review and make changes to life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to www.mybentek.com/charlottecounty
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate to the menu in order to review current elections, learn about benefit options, and make elections, changes or beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-BenTek (523-6835) or email BenTek Support at support@mybentek.com, Monday through Friday, during regular business hours.

To access group insurance benefits online, log on to:
www.mybentek.com/charlottecounty

Please Note: Link must be addressed exactly as written (Due to security reasons, the website cannot be accessed by Google or other search engines.)



Core Benefits

Plan Coverages at Time of Hire

The County's health insurance plan consists of the following core benefits:

- ✓ Medical Insurance (including prescription drug coverage)
- ✓ Dental Insurance
- ✓ Vision Insurance
- ✓ Basic Term Life Insurance
- ✓ Accidental Death and Dismemberment Insurance
- ✓ Employee Assistance Program

Medical, dental and vision coverage is offered to all benefit-eligible employees as a package, however, employee can elect to opt-out of dental and/or vision and remain on the medical plan only (please note that this will not affect employee's deductions). Electing dependent coverage also entitles employee's dependent(s) to receive benefits with the exception of the Basic Life and Accidental Death and Dismemberment Insurance. The employee costs for these Core Benefits are payroll deducted under a pre-payment plan. Deductions are taken out the month before the effective date of coverage. For example, if the effective date is December 1, payroll deductions would be taken in November. There are 24 payroll deductions per year.

Employee will also be offered the following optional benefits that can be elected on a voluntary basis and payroll deducted:

- ✓ Short Term Disability Insurance
- ✓ Long Term Disability Insurance
- ✓ Flexible Spending Accounts (Medical & Dependent Care)
- ✓ Voluntary Term Life Insurance

Open Enrollment

The County's annual Open Enrollment period is the time of year employees may make changes to their benefit elections. These elections will be effective when the new plan year begins on October 1. During Open Enrollment, employees may:

- ✓ Change your Section 125 Tax Election
- ✓ Add Dependent(s)
- ✓ Remove Dependent(s)
- ✓ Apply for Short Term Disability
- ✓ Apply for Long Term Disability
- ✓ Apply for Voluntary Life Insurance
- ✓ Apply for Aflac Products

A special Open Enrollment for Flexible Spending Accounts will be conducted each December for the following year. Employee must re-enroll in Flexible Spending Accounts each year.

Other Coverage

If employee is covered by another medical insurance plan (example: an individual policy, as a dependent under a spouse's policy, military insurance, etc.) and employee wishes to decline the County's medical insurance plan, the County will reimburse employee \$200 per month (considered taxable income). However, employee will still be enrolled in the Basic Life insurance and Accidental Death and Dismemberment insurance at no cost. To be eligible to receive this coverage rebate, employee must be under the age of 65 and not Medicare eligible. Employee must also provide proof of other medical insurance (example; certificate of insurance, copy of identification card or copy of current policy) and sign a declination form. Employee will be required to verify this information on an annual basis.

Coordination of Benefits

When both employee and spouse work, each person may be covered by their employer's health plan, as well as the spouse's health plan. Coordination of benefits determines which group health care plan pays benefits first. The secondary health plan may then pay additional benefits. Health insurers follow a common set of guidelines to determine which plan pays first and which plan pays second for family members. The employee's group health care plan is always primary. If the employee is married, and both the employee and spouse cover dependent child(ren), the plan that covers the parent whose birthdate is first in the calendar year is usually primary for any dependent child(ren).

Other factors that may affect which plan pays first includes eligibility for Medicare, court decrees or custody arrangements, the length of time an employee is covered, and whether employee is active or a retiree. If both the employee and employee's spouse are both County employees, they may not be covered as both an employee and a dependent. Additionally employees may not cover child(ren) as dependent(s) of both employees.

Example: If the employee's birthdate is January 14, and the spouse's birthdate is April 10, the employee's group health plan is primary for the employee and child(ren), but is secondary for the spouse.



Group Insurance Eligibility



The County's group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the County's health insurance plans if they are full-time employees or average 130 working hours a month, under the accepted measurement method elected under the Affordable Care Act. Coverage will be effective the first of the month following 30 days of employment. For example, if employee is hired on February 11, then the effective date of coverage will be April 1.

Termination

If employee separates employment from the County, insurance will continue through the end of the month in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child(ren) of the participant or the spouse. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A stepchild
- A newborn (up to age 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Please see Taxable Dependents if covering eligible dependents over age 26.

Dental Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primary dependent upon the employee support; and
- The dependent is otherwise eligible for coverage under the group medical plan; and
- The dependent has been continuously insured.
- Coverage with the County began prior to age 26.

Proof of disability will be required upon request. Please contact Risk Management if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under employee's medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which dependent reaches age 30, imputed income must be reported on the employee's W-2 for that entire tax year. Imputed income is the dollar value of insurance coverage attributable to covering the adult dependent child. Note: There is no imputed income if adult dependent child is eligible to be claimed as a dependent for Federal income tax purposes on the employee's tax return. Contact Risk Management for further details if covering adult dependent child(ren) who will turn age 27 any time during the upcoming calendar year or for more information.

Annual Over-Age Dependent Audits

At the end of each year Risk Management will conduct an over-age dependent audit of all dependent children over the age of 26 that are on the plan. An employee who meets the criteria to keep an overage dependent on the medical plan must complete an Over-Age Dependent Verification Form, and pay the appropriate post-tax premium. The form includes an affidavit whereby employees must sign verifying they understand; that any person who knowingly and with the intent to defraud or deceive any insurer by providing false or misleading information may result in denial of benefits, termination of coverage and/or disciplinary action (Fl Statute Ch 817.234(1)(b)(200).



Qualifying Events and IRS Code Section 125

IRS Code Section 125

Premiums for medical, dental, vision insurance, and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to an employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Code, Section 125. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Employee, employee's spouse, or dependent(s) terminate or start employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)



IMPORTANT

If employee experiences a Qualifying Event must contact **Risk Management within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Beyond 30 days, requests will be denied and the employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place on the first of the month following the latter, date of the Qualifying Event or date written request for change in coverage is received by Risk Management. Newborns are effective on date of birth. Marriage and divorce are effective date of event. Cancellations will be processed at the end of the month. In the event of death, coverage terminates the date following the death. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided as a supplement to this booklet being distributed to new hires and existing employees during Open Enrollment. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From: Benefits Coordinator
Address: Charlotte County Risk Management
 18500 Murdock Circle #B-201, Port Charlotte, FL 33948
Phone: (941) 743-1244
Email: janine.hewitt@charlottecountyfl.gov
Enrollment Software – BenTek: www.mybentek.com/charlottecounty

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Benefits Coordinator or at the following web address: www.charlottesweb/Risk/handbooks.asp.

If there are questions about the plan offerings or coverage options, please contact the Benefits Coordinator at (941) 743-1244.



Medical Insurance

The County offers medical insurance through Cigna to benefit-eligible employees. The monthly costs for coverage are listed in the premium tables below. For more detailed information about the medical plans, please refer to Cigna's Summary of Benefits and Coverage (SBC) or contact Cigna's customer service.

An Open Access Plan (OAP) is a plan that allows members to access any in-network provider (physician, lab, hospital, etc.) anywhere in the United States of America. Unlike an HMO, members do not need to name a Primary Care Physician, or have referrals to see a specialist. Members who stay within the OAP network, are covered according to the plan benefits.

Medical Insurance – Cigna OAPIN Plan - Premiums

Monthly Cost - Includes Medical, Dental and Vision Coverage

Tier of Coverage	Employee Contribution	County Contribution	Total Monthly Rate
Employee Only	\$26.00	\$988.00	\$1,014.00
Employee + Spouse	\$286.00	\$1,877.00	\$2,163.00
Employee + Child(ren)	\$249.00	\$1,630.00	\$1,879.00
Employee + Family	\$315.00	\$2,061.00	\$2,376.00

Medical Insurance – Cigna OAPIN Plan - With Tobacco Premiums

Monthly Cost - Includes Medical, Dental and Vision Coverage

Tier of Coverage	Employee Contribution	County Contribution	Total Monthly Rate
Employee Only	\$76.00	\$988.00	\$1,064.00
Employee + Spouse	\$336.00	\$1,877.00	\$2,213.00
Employee + Child(ren)	\$299.00	\$1,630.00	\$1,929.00
Employee + Family	\$365.00	\$2,061.00	\$2,426.00

Premium Deductions

Medical, dental and vision coverage is offered to all benefit-eligible employees as a package, however, employee may elect to opt-out of dental and/or vision and remain on the medical plan only (please note that this will not affect the payroll deductions. Electing dependent medical coverage also entitles employee's dependent(s) to receive dental and vision benefits unless they opt-out of dental or vision coverage. Employee costs for benefits are payroll deducted under a pre-payment plan. Deductions are taken the month before the effective date of coverage. For example, if employee's effective date is December 1, payroll deductions would be taken in November. There are 24 deductions per year.

Tobacco User Premiums

Employees must request and complete a nicotine test at one of the Employee Health Centers during the Wellness Initiative period. Employees that do not take the test will receive the "With Tobacco Premium". Employees who test negative for nicotine will qualify for a waiver of With Tobacco Premiums for the plan year. Additionally, employee that tests positive for nicotine but complete a Tobacco Cessation Program will also qualify for a waiver of With Tobacco Premium for the plan year. Any employee that does not complete the test or program by the required deadlines will receive the "with Tobacco" premium.

Other Available Plan Resources

Cigna offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please refer to the Summary of Benefits and Coverage (SBC) document, contact Cigna's customer service at (800) 244-6224, or visit www.cigna.com.

Cigna | Customer Service: (800) 244-6224 | www.cigna.com

Telehealth

Cigna provides access to telehealth services as part of the medical plan - AmWell and MDLIVE. Cigna is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is required and should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with Telehealth, such as:

- ✓ Sore Throat
- ✓ Headache
- ✓ Stomachache
- ✓ Fever
- ✓ Cold And Flu
- ✓ Allergies
- ✓ Rash
- ✓ Acne
- ✓ UTIs And More

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact Risk Management or contact Cigna.

Cigna

AmWell | Customer Service: (855) 667-9722 | www.AmWellforCigna.com
MDLIVE | Customer Service: (888) 726-3171 | www.MDLIVEforCigna.com



Cigna OAPIN Plan At-A-Glance

Network	Open Access Plus
Calendar Year Deductible (CYD)*	
Single	In-Network \$500
Family	\$1,000
Coinsurance	
Member Responsibility	0%
Calendar Year Out-of-Pocket Limit*	
Single	\$1,500
Family	\$3,000
What Applies to the Out-of-Pocket Limit?	Deductible and Copays (Includes Rx)
Physician Services	
Primary Care Physician (PCP) Office Visit (No PCP Election Required)	\$25 Copay
Specialist Office Visit (No Referral Required)	\$35 Copay
Maternity Visit (Initial Visit Only)	\$35 Copay
Telehealth Services	\$25 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab (Blood Work)**	No Charge
X-rays	No Charge
Advanced Imaging (MRI, PET, CT)	0% After CYD
Outpatient Surgery at a Surgical Center	0% After CYD
Physician Services at a Surgical Center	0% After CYD
Urgent Care (Per Visit)	\$50 Copay
Hospital Services	
Inpatient Hospitalization (Per Admission)	0% After CYD
Outpatient Hospital	0% After CYD
Physician Services at Hospital	0% After CYD
Emergency Room (Per Visit: Waived if Admitted)	\$150 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospitalization (Per Admission)	0% After CYD
Outpatient Services (Per Visit)	0% After CYD
Outpatient Office Visit	\$35 Copay
Prescription Drugs (Rx)	
Generic	\$15 Copay
Preferred Brand Name	\$30 Copay
Non-Preferred Brand Name	\$60 Copay
Mail Order Drug (90-Day Supply)	2x Retail Copay



Locate a Provider

To search for a participating provider, contact customer service or go to www.cigna.com. When completing the necessary search criteria, select **OAPIN** network.



Plan References

*Although the plan renews according to the fiscal year (Oct 1 - Sept 30) the deductibles and out-of-pocket limit accrue and reset on a calendar year basis.

**Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.



Important Notes

Services received by providers or facilities **not** in the Open Access network, will not be covered.



Health Reimbursement Account

The County is providing employees who participate in the Wellness Initiative Program a Health Reimbursement Account (HRA) administered through TASC. HRA monies are not taxable, funded by the County and can be used for any qualified medical expense incurred under the medical plan, such as deductibles and coinsurance for physician services and hospital services.

HRA IRS Guidelines

HRA's must be funded solely by an employer. The contribution cannot be paid through a voluntary salary reduction agreement on the part of an employee. Employee is reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. An HRA may be offered with other health plans, including Flexible Spending Accounts.

Employee may enjoy several benefits from having an HRA.

- ✓ Contributions made by the employer can be excluded from gross income.
- ✓ Reimbursements may be tax free if employee pays qualified medical expenses.
- ✓ Any unused amounts in the HRA can be carried forward for reimbursements in later years.

Distributions From an HRA

Generally, distributions from an HRA are paid to reimburse employee for qualified medical, dental or vision expenses incurred. The expense must have been incurred on or after the date employee enrolled in the HRA.

**Debit cards, credit cards, and stored value cards given to employee by the County can be used to reimburse participants in an HRA. If the use of these cards meets certain substantiation methods, employee may not have to provide additional information to the HRA administrator.*

Health Reimbursement Account (HRA)

- ✓ Employer funded account
- ✓ Enrollment is automatic if enrolled in medical plan
- ✓ Funds are used for eligible medical expenses for employee and employee's dependent(s) who are enrolled in medical plan
- ✓ Unused funds accumulate and roll over year to year

Flexible Spending Accounts (FSA)

- ✓ Employee funded account
- ✓ Employee must enroll annually
- ✓ Funds are used for eligible medical, dental, vision & dependent care for employee and employee's qualified dependent(s)
- ✓ Employees can carry over up to \$500 to the next plan year after 90 days.

If an employee has the HRA and also elects an FSA, FSA monies will be used first since it is employee funded.

What are some examples of qualified expenses eligible for reimbursement?

- | | | |
|--------------------------------------|--|--------------------|
| ✓ Acupuncture | ✓ Doctor Fees | ✓ Nursing Services |
| ✓ Ambulance Service | ✓ Drug Addiction/Alcoholism Treatment Prescription Drugs | ✓ Orthodontic Fees |
| ✓ Birth Control Pills | ✓ Experimental Medical Treatment | ✓ Surgery |
| ✓ Chiropractic Care | ✓ Hearing Aids and Exams | ✓ Wheelchairs |
| ✓ Contact Lenses (Corrective) | ✓ Injections and Vaccinations | ✓ X-rays |
| ✓ Diagnostic Tests/Health Screenings | ✓ In Vitro Fertilization | |

Health Reimbursement Account *(Continued)*

The County will fund each employee's Health Reimbursement Account (HRA) if the employee and (dependent spouse covered on the plan) participate in the Wellness Initiative Program. This money is not taxable to employee and can be used to offset the cost of expenses incurred under the medical insurance plan. Examples of these expenses include deductible and copays for items such as doctor visits, inpatient hospital stays and prescription drugs that generate out-of-pocket cost to the employee. If both employee and eligible spouse participate in the program, each could earn the \$500 incentive up to a maximum of \$1,000 (single parent with children can earn a maximum of \$750).

HRA Funding Allotment

- If both employee and eligible spouse participate in the program, each could earn the \$500 incentive up to a maximum of \$1,000 (single parent with children can earn a maximum of \$750).
- Funds remain in account designated for employee until they are claimed for reimbursement.
- Employee will receive a debit card to pay for medical plan expenses. If provider does not accept debit card, the user will pay the cost for the incurred expense at the time of service and then claim reimbursement from the plan administrator.
- Reimbursement is not subject to income tax.
- Claims must be filed within 90 days after the end of the plan year in order to claim reimbursement.
- Unused funds roll forward for use in future years. When employee retires from the County, employee will be able to take these funds to use for qualified medical expenses. Employee must meet the FRS guidelines for retirement to be considered a retiree. If employee leaves County employment not due to retirement, any unused funds will remain with the County.

Distributions From an HRA

Generally, distributions from an HRA must be paid to reimburse employee for qualified medical, dental or vision expenses employee has incurred. The expense must have been incurred on or after the date employee is enrolled in the HRA. Keep all receipts in the event employee is asked to provide them.

How to Login to My HRA Account?

The County has already created an HRA account for employees! Follow these simple steps to access the secure account:

1. Log into the account, by going to www.tasconline.com.
2. Enter username. First initial, last name and the last four digits of employee's Social Security Number (example: John Smith with a SSN of xxx-xx-6789, would enter "jsmith6789").
3. Enter password. The first time logging into the system, the password will be: TASC4me (case sensitive). It will prompt to create a new, unique secure password before accessing the account.

Access employee's account information online at any time, day or night, 24/7/365. With the simple, secure sign-on, employee may:

- ✓ View account balance and details;
- ✓ View claims history;
- ✓ Submit paper claims;
- ✓ Sign up for direct deposit (get your money faster!);
- ✓ Access helpful online tools.

Employee may contact TASC directly by calling 877-933-3539.

Rollover Guidelines

The 2018 plan year will end on December 31, 2018, however employee will have an additional 90 days after the plan ends to submit claims to TASC for service dates from January 1, 2018 to December 31, 2018. Employee will not be able to use the debit card for these services; however employee may submit a claim manually through the online portal, toll free fax, email or mail.

Please Note: Employees should not use the card for services dated in old plan year as the services will be denied and a repayment request will be generated.

TASC | Phone: (877) 933-3539 | www.tasconline.com



Dental Insurance

Cigna Dental PPO Plan

The County offers dental insurance through Cigna to benefit-eligible employees. A brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to Cigna's summary plan document or contact Cigna's customer service.

Please Note: Dental coverage is included as part of employee's medical contribution. Dental cards are available at Risk Management.

In-Network Benefits

The Dental PPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Cigna Total DPPO Network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Plan Year Deductible (PYD) and then coinsurance based on the plan's charge limitations.

Please Note: Total DPPO dental members have the option to utilize a dentist that participates in either Cigna's Advantage Network or DPPO Network. However, members that use the Cigna Advantage Network will see additional cost savings from the added discount that is allowed using an Advantage Network provider. Members are responsible for verifying whether the treating dentist is an Advantage Dentist or a DPPO Dentist.

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Cigna Dental provider. Cigna reimburses out-of-network services based on what it determines as the Maximum Reimbursable Charge (MRC). The MRC is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between the Cigna's MRC and the amount charged by the out-of-network dental providers. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Plan Year Deductible

The Dental PPO plan benefits begin once each covered member satisfies a \$50 deductible (waived for Class I services). The deductible is applied collectively for either in-network or out-of-network services or any combination of both. Once any three (3) covered members in a family each satisfy the \$50 deductible, the deductible will be considered met for all covered members in the family.

Plan Year Benefit Maximum

The maximum benefit (coinsurance) the Dental PPO plan will pay for each covered member is \$1,500 for in-network and out-of-network services or combined. Diagnostic and preventive services will accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next plan year.

Cigna | Customer Service: (800) 244-6224 | www.cigna.com



Cigna Dental PPO Plan At-A-Glance

Network	Total Cigna DPPO	
Plan Year Deductible (PYD)	In-Network	Out-of-Network*
Per Member		\$50
Per Family		\$150
Waived for Class I Services?		Yes
Plan Year Benefit Maximum		
Per Member		\$1,500
Class I Services: Diagnostic & Preventive Care		
Oral Exam	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)
Cleanings		
X-rays (Bitewing / Full Mouth)		
Fluoride Treatments (Restrictions Apply)		
Sealants (Restrictions Apply)		
Space Maintainers		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% After PYD	Plan Pays: 80% After PYD (Subject to Balance Billing)
Simple Extractions		
Endodontics (Root Canal Therapy)		
Periodontal Services		
Oral Surgery		
Anesthetics		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After PYD	Plan Pays: 50% After PYD (Subject to Balance Billing)
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum		\$1,500
Benefit (Dependent Children Up To Age 19)		Plan Pays: 50% Deductible Waived



Locate a Provider

To search for a participating provider, contact Cigna customer service or visit www.cigna.com. When completing the necessary search criteria, select **Cigna Total DPPO** network.



Plan References

**Out of Network Balance Billing: For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Out-Of-Network Benefits section on the previous page.*



Important Notes

- Each covered family member may receive up to two (2) routine cleanings per plan year covered under the preventive benefit.
- For any dental work expected to cost \$200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.
- Waiting periods and age limitations may apply
- Benefit frequency limitations may apply on certain services.



Vision Insurance

EyeMed Vision Care Plan

The County offers vision insurance through EyeMed to benefit-eligible employees. A brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to EyeMed's summary plan document or contact EyeMed's customer service.

Please Note: Vision coverage is included as part of the medical contribution.

In-Network Benefits

The vision plan offers employees and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered employee and dependent(s) can select any network provider who participates in the EyeMed Insight network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may choose to receive services from vision providers who do not participate in the EyeMed Insight network. When going out of network, the provider will require payment at the time of appointment. EyeMed will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

EyeMed | Customer Service: (866) 723-0514 | www.eyemedvisioncare.com



EyeMed Vision Care Plan At-A-Glance

Network	Insight	
	In-Network	Out-of-Network
Services		
Eye Exam	\$10 copay	Up to \$35 Reimbursement
Frequency of Services		
Examination		12 Months
Lenses		12 Months
Frames		24 Months
Contact Lenses		12 Months
Lenses		
Single	Covered at 100%	Up to \$25 Reimbursement
Bifocal	Covered at 100%	Up to \$40 Reimbursement
Trifocal	Covered at 100%	Up to \$60 Reimbursement
Frames		
Allowance	\$200 Retail Allowance then 20% Discount Above \$200	Up to \$45 Reimbursement
Contact Lenses*		
Non-Elective (<i>Medically Necessary</i>)	Covered at 100%	Up to \$210 Reimbursement
Elective (<i>Fitting, Follow-up & Lenses</i>)	\$200 Allowance then 15% Discount Above \$200	Up to \$200 Reimbursement



Locate a Provider

To search for a participating provider, contact EyeMed's customer service or visit www.eyemedvisioncare.com. When completing the necessary search criteria, select **Insight** network.



Plan References

**Contact lenses are in lieu of spectacle lenses.*



Important Notes

Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.



Flexible Spending Accounts

The County offers Flexible Spending Accounts (FSA) administered through TASC. The FSA Plan Year is from January 1, 2018 through December 31, 2018. FSA open enrollment period, will be held in December. Employee may elect to participate in either or both FSAs.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employee to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year. There are two types of FSAs:

Health Care FSA

This account allows participant to set aside up to an annual maximum of \$2,650. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible health care expenses that generate out-of-pocket costs for employee or qualified dependent(s). Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of \$5,000 if single or married and file a joint tax return (\$2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include adult and child day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note, if family annual income is over \$20,000, this reimbursement option will most likely save participant more money than the dependent care tax credit. To qualify, participant's dependent must be:

- a child under the age of 13, or
- a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least eight (8) hours a day in your household.

Please Note: Unlike the Health Care FSA, participant will only be reimbursed up to the amount that has been deducted from participant's paycheck for Dependent Care FSA.

A sample list of qualified expenses eligible for reimbursement include, but not limited to, the following:

- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Prescription Drugs
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

Log on to <http://www.irs.gov/publications/p502/index.html> for additional details regarding qualified and non-qualified expenses.

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Employee may carry over up to \$500 of unused Health Care FSA funds into the next plan year after plan year ends and all claims have been filed. Dependent Care funds cannot be carried over.
- When a plan year ends and all claims have been filed with the exception of the \$500 rollover for the Health Care FSA, all unused funds will be forfeited and not returned.
- Employee can enroll in either or both of the FSAs only during the Open Enrollment period, a Qualifying Event or New Hire Eligibility period.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as federal law does not recognize them as a qualified dependent.

HERE'S HOW IT WORKS!



Employee earning \$30,000 elects to place \$1,000 into their FSA Health Care Savings Account, with payroll deductions being \$41.66 based on a 24 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of \$227.

	With the Plan	Without the Plan
Salary	\$30,000	\$30,000
FSA Contribution	-\$1,000	-\$0
Taxable Pay	\$29,000	\$30,000
Estimated Tax 22.65% = 15% + 7.65% FICA	-\$6,568	-\$6,795
After Tax Expenses	-\$0	-\$1,000
Spendable Income	\$22,432	\$22,205
Tax Savings	\$227	

Filing a Claim

Claim Form: A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card: FSA participants can request a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. TASC may request supporting documentations for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to TASC. If employee has a health care FSA, funds will be deducted first from the FSA until depleted and then from the HRA, when using the debit card.

- The amount employee has available is the balance on the TASC Card. Employee may use the TASC Card up to this amount, but never over. Employee may check available balance at tasconline.com. Please keep TASC Card as it will be used again next plan year, or up to the expiration date on the card. When the expiration nears, a new card will automatically be ordered.
- If employee is close to reaching the balance on TASC Card, it will only allow employee to spend the funds remaining in the account. If the purchase exceeds the account balance, employee will need to pay the difference using another means of payment (i.e., out-of-pocket).
- If employee decides not to use the TASC Card, employee may submit a manual claim for reimbursement either by fax, email, mail, or online through the secure web form at www.tasconline.com (while logged in) or through the TASC mobile app for iPhone or Android at any time during the plan year.

Rollover Guidelines

The 2018 plan year will end on December 31, 2018, however employee will have an additional 90 days after the plan ends to submit claims to TASC for service dates from January 1, 2018 to December 31, 2018. Employee will not be able to use the debit card for these services; however employee may submit a claim manually through the online portal, toll free fax, email or mail.

Please Note: Employees should not use the card for services dated in old plan year as the services will be denied and a repayment request will be generated.

TASC | Phone: (877) 933-3539 | www.tasconline.com



Employee Assistance Program

The County cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Cigna. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program?

An Employee Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes three (3) face-to-face visits with a specialist, per person, per issue, per year, telephonic consultation, online material/tools and webinars. EAP offers counseling services on issues such as:

- ✓ Child Care Resources
- ✓ Legal Resources
- ✓ Grief and Bereavement
- ✓ Stress Management
- ✓ Depression and Anxiety
- ✓ Work Related Issues
- ✓ Adult & Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor/manager), we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor/manager will not receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

To Access Services

Employee and family member(s) must register and create a user ID on www.mycigna.com to access EAP services.

Cigna Behavioral Health

Customer Service: (877) 622-4327 | www.mycigna.com | ID: CCBOCC

Basic Life and AD&D Insurance

Basic Term Life Insurance

The County provides Basic Term Life insurance for all eligible employees at no cost through Cigna. All full-time general employees are covered for a benefit amount of two (2) times base annual salary rounded to the next higher \$1,000 to a maximum of \$50,000.

Accidental Death & Dismemberment Insurance

The County also provides Accidental Death & Dismemberment (AD&D) insurance which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit and a partial benefit is also payable based on the schedule of benefits. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact Cigna's customer service.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- Reduces 65% of the benefit amount at age 65;
- Reduces 40% of the benefit amount at age 70;
- Reduces 25% of the benefit amount at age 75;
- Reduces 15% of the benefit amount at age 80.
- Age based reductions are subject to a minimum benefit of \$10,000.

Beneficiary Designations

Events such as death, marriage, birth of a child, and divorce can drastically change a life. For these reasons, it is important to review Life insurance beneficiaries to make sure beneficiary designations are up to date. Employee may update beneficiary information at any time through BenTek, or may download the form on Charlotte's Web at <http://charlottesweb/Forms.asp>.

***Always remember to keep beneficiary forms updated.
Beneficiary forms may be updated at anytime through BenTek.***

Cigna | Customer Service: (800) 732-1603 | www.cigna.com



Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible employee may elect to purchase additional Life insurance on a voluntary basis through Cigna. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages. Voluntary Life insurance offers coverage for employee, spouse or child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the **Guaranteed Issue amount of \$150,000.**

- Units can be purchased in increments of \$10,000, with a benefit maximum of \$500,000, or not to exceed five (5) times annual salary.
- Benefit amounts are subject to the following age reduction schedule:
 - › Reduces 65% of benefit amount at age 65
 - › Reduces 40% of benefit amount at age 70
 - › Reduces 25% of benefit amount at age 75
 - › Reduces 15% of benefit amount at age 80

Voluntary Spouse Life Insurance

New Hires may purchase Voluntary Spouse Life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the **Guaranteed Issue amount of \$50,000.**

- Employee must participate in the Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of \$5,000 to a maximum of \$250,000, however, coverage cannot exceed 100% of the employee's approved Life insurance coverage amount.
- Spouse Life insurance coverage is subject to the same age reduction schedule as employee with coverage terminating at age 70.

Voluntary Life Rate Table

Rate Per \$1,000 of Benefit

Age Bracket (Based On Employee Age)	Voluntary Life Monthly Rate
Under 35	\$0.128
35-39	\$0.156
40-44	\$0.224
45-49	\$0.337
50-54	\$0.536
55-59	\$0.862
60-64	\$1.321
65-69	\$2.240
70-74	\$4.250
75+	\$8.026
Child(ren)	\$0.248

Voluntary Dependent Child(ren) Life Insurance

- Employee must participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- Children from six (6) months to age 26 may be covered for a \$10,000 benefit.
- Children from birth to six (6) months may be covered for a \$500 benefit.

Cigna | Customer Service: (800) 732-1603 | www.cigna.com

Cigna's Will Preparation Program

The Cigna Will Center is provided by Cigna through ARAG®, a global leader of legal insurance and services for more than 75 years. This site is intended to equip member with the legal tools and information member needs to plan for the future, on member's own time, without additional costs. Estate Planning can be overwhelming and most simply don't know where to begin.

Under the Education and Tools section, there are Guidebooks to assist member with the funeral planning process. In the Legal Tools subsection, there's also an updated Personal Information Organizer tool that helps detail employee and spouse's funeral plans.

Cigna | Customer Service: (800) 901-7534 | www.cignawillcenter.com



Voluntary Short Term Disability

The County offers Voluntary Short Term Disability (STD) insurance to all benefit-eligible employees through Cigna. The STD benefit pays a percentage of weekly earnings if employee becomes disabled due to a non-work related injury or illness. The premium is calculated based on weekly earnings; examples are illustrated in the Voluntary STD Premium Rate Table below. Employee's STD rate and benefit will be adjusted if salary fluctuates throughout the plan year.

Voluntary Short Term Disability (STD) Benefits

- STD provides 60% of weekly earnings, up to a maximum benefit of \$1,000 per week.
- Employee must be disabled 29 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefit begins on the 30th day after the employee is injured in an accident.
- The maximum benefit period is 22 weeks.
- Employee unable to return to work after 22 weeks will be automatically transitioned to Long Term Disability, if elected.
- The benefit amount will be offset by any other income received. Employee may not receive more than 60% total of all income combined.

Please Note: If employee does not elect this coverage when initially eligible, employee will have to complete an evidence of insurability form if electing in the future. This form will ask basic medical history questions and be approved by carrier prior to employee's coverage becoming effective.

Voluntary STD Premium Rate Table

Annual Salary	Weekly Salary	Benefit Per Week	Monthly Premium
\$15,000	\$288.46	\$173.08	\$4.85
\$20,000	\$384.62	\$230.77	\$6.46
\$25,000	\$480.77	\$288.46	\$8.08
\$30,000	\$576.92	\$346.15	\$9.69
\$35,000	\$673.08	\$403.85	\$11.31
\$40,000	\$769.23	\$461.54	\$12.92
\$45,000	\$865.38	\$519.23	\$14.54
\$50,000	\$961.54	\$576.92	\$16.15
\$55,000	\$1,057.69	\$634.61	\$17.77
\$60,000	\$1,153.85	\$692.31	\$19.38
\$65,000	\$1,250.00	\$750.00	\$21.00
\$70,000	\$1,346.15	\$807.69	\$22.62
\$75,000	\$1,442.31	\$865.39	\$24.23
\$80,000	\$1,538.46	\$923.08	\$25.85
\$86,667	\$1,666.67	\$1,000.00	\$28.00

Please Note: There is a maximum benefit of \$1,000 per week.

Voluntary Long Term Disability

The County offers Voluntary Long Term Disability (LTD) insurance to all benefit-eligible employees through Cigna. The LTD benefit pays a percentage of monthly earnings if employee becomes disabled due to a illness or non work-related injury. The premium is calculated based on monthly earnings; examples are illustrated in the Voluntary LTD Premium Rate Table below. Employee's LTD rate and benefit will be adjusted if salary fluctuates throughout the plan year.

Voluntary Long Term Disability (LTD) Benefits

- LTD provides 60% of monthly earnings up to a maximum benefit of \$3,500 per month.
- Benefit payments will commence on the 181st day of disability.
- Benefits are payable to age 65 or are based on a reduced benefit duration if the employee is disabled on or after the age of 62.
- Benefits are payable for the first 24 months if employee is unable to perform own occupation. After 24 months employee is considered disabled if, solely due to injury or sickness, employee is unable to perform the material duties of any occupation for which employee is (or may reasonably become) qualified to perform.
- If employee returns to work part-time, a partial LTD benefit may be payable.
- The benefit amount will be offset by any other income received. Employee may not receive more than 60% total of all income combined.

Please Note: If employee does not elect this coverage when initially eligible, employee will have to complete an evidence of insurability form if electing in the future. This form will ask basic medical history questions and be approved by carrier prior to employee's coverage becoming effective.

Voluntary LTD Premium Rate Table

Annual Salary	Monthly Salary	Benefit Per Month	Monthly Premium
\$15,000	\$1,250.00	\$750.00	\$7.25
\$20,000	\$1,666.67	\$1,000.00	\$9.67
\$25,000	\$2,083.33	\$1,250.00	\$12.08
\$30,000	\$2,500.00	\$1,500.00	\$14.50
\$35,000	\$2,916.67	\$1,750.00	\$16.92
\$40,000	\$3,333.33	\$2,000.00	\$19.33
\$45,000	\$3,750.00	\$2,250.00	\$21.75
\$50,000	\$4,166.67	\$2,500.00	\$24.17
\$55,000	\$4,583.33	\$2,750.00	\$26.58
\$60,000	\$5,000.00	\$3,000.00	\$29.00
\$65,000	\$5,416.67	\$3,250.00	\$31.42
\$70,000	\$5,833.33	\$3,500.00	\$33.83



Supplemental Insurance - Aflac

The County is now offering a variety of new supplemental medical insurance products sponsored by Aflac. These benefits can help off-set copays, deductibles and out of pocket expenses incurred in the event of an accident or illness. Aflac pays cash benefits directly to the policyholder. These coverages may be purchased separately on a voluntary basis and premiums are paid through semimonthly payroll deductions. To learn more about these new plans, please meet with an enrollment counselor during Open Enrollment for a personal one-on-one presentation. Details regarding available plans and services are also available on BenTek.

Aflac Plan Features:

- All coverages for benefit-eligible and new hires employees are guaranteed-issue, meaning medical underwriting is waived.
- Employee may cover a spouse and/or dependent child(ren) regardless of participation level and coverage with other insurance carriers.
- Several plans qualify for pre-tax premium payroll deductions.
- Benefits are paid directly to policyholder.
- Coverage is portable (with certain stipulations). Employee can take it with them if employee changes jobs or retires.
- No age limit to enroll.

Aflac Core Benefits:

Group Accident Advantage Plus - 24-Hour High Plan (Pre-tax Payroll Deduction)

- Pays cash benefits for expenses resulting from injuries on or off the job and pays in addition to any other insurance in force.
- Pays cash benefits fast for expenses that major medical may not cover, including: doctor visits, ambulance rides, ER visits, hospitalization, surgery, stitches, casts, medical appliances, and other medical expenses not covered by major medical insurance.
- Covers accidental fractures dislocations, lacerations burns, concussions, coma and much more.
- Accidental Death & Dismemberment benefit included.
- Annual Wellness benefit per covered policyholder, included.

Group Hospital Indemnity Plan 2 (Pre-tax Payroll Deduction)

- Cash benefits for injuries and illness resulting in hospital admission, daily confinement and ICU confinement.
- Covers treatment services including, outpatient services, physician office visits, Telemedicine, major diagnostic exams, out of hospital Rx, ER visits and rehabilitation facility stays.
- Annual wellness benefit per policyholder annually, included.

Group Critical Illness with Cancer Plan (After-tax Payroll Deduction)

- Guaranteed Issue lump sum benefit payable up to \$30,000 for employee and \$15,000 for spouse coverage.
- Provides cash when needed most that will help with treatment costs for covered critical illnesses and cancer.
- Cash flow to help pay bills so policyholder(s) can focus on recuperation instead of stressing over out of pocket expenses.
- Dependent child(ren) coverage at no additional cost.
- Annual wellness benefit per policyholder, included.
- Payable for the following covered illnesses:

> Cancer (<i>Internal and Invasive</i>)*	> Stroke
> Heart Attack (<i>Myocardial infraction</i>)	> End Stage Renal Failure
> Kidney Failure	> Stem Cell Transplant
> Coronary Artery Bypass Surgery	> Major Organ Transplant
	> Bone Marrow Transplant

To get more information about individualized cost, please contact the Aflac agent.

*Refer to online brochure for full limitation and exclusions.

Aflac Group Plans

Customer Service: (800) 433-3036 | www.aflacgroupinsurance.com

Aflac | Agent: Margaret Pearson

Phone: (561) 881-1964 | Fax: (561) 881-8872

Email: margaret_pearson@us.aflac.com



Retiree Benefits

Group Retiree Health Plan

The County's Group Retiree Health Plan will be provided by the insurance carrier(s) in force at the time of retirement and is subject to change if the County changes carriers, benefits or rates. All of the following requirements must be met in order for a County employee to be eligible for retiree insurance benefits (medical, dental & vision insurance).

- Employees must have a minimum of eight (8) years of service vested with the County in conjunction with the Florida Retirement System (FRS).
- The employee must be eligible to receive and/or be receiving benefits from the FRS.
- Retirement age of 55 or above must be attained (unless the employee has 30 consecutive years of service with the FRS/25 Years for High Risk employees).
- Having a job elsewhere is not a factor.

Please Note: Retiree benefits are offered under a separate plan for the purposes of the Affordable Care Act.

Health Insurance - Retiree Rates

Includes Medical, Dental and Vision Coverage

Tier of Coverage	Total Monthly Rate
Employee Only	\$1,014.00
Employee + Spouse	\$2,163.00
Employee + Child(ren)	\$1,879.00
Employee + Family	\$2,376.00

Supplemental Retiree Program

Supplemental Retiree Program is a subsidized program for eligible County retirees to assist in off-setting the cost of post-retirement medical insurance premiums. To be eligible, the retiree must be under 65 years of age and have a minimum of 20 years of service with the County. The plan participant must be collecting FRS monthly retirement benefits. The monthly supplement will be \$10 for each year of service. Minimum of 20 years of service is required (20 yrs × \$10 = \$200 per month). Time in the FRS "Drop" Program is not included in the calculation of this benefit. The maximum monthly benefit is \$300 per month. This supplement will be deducted from the retiree's medical insurance invoice on a monthly basis. If the retiree's medical insurance is not with the county, a check will be issued on a monthly basis payable to the retiree. Proof of other insurance is required annually. If the subsidy is greater than the premium, the difference is taxable.

The County's Retiree Supplement will cease when the retiree becomes eligible for Medicare. The retiree may continue coverage under the County's Group Retiree Health Plan but the Supplement will no longer be deducted from the premium.

IAFF Supplemental Benefit

Any IAFF retiree must be under 65 years of age to be eligible. Retirees over the age of 65, who are covered under Medicare or a Medicare Supplements are not eligible. At the time of retirement the IAFF employee must have completed 20 years of service with the Charlotte County Fire/EMS Department. The plan participant must be collecting FRS monthly retirement benefits. The monthly supplement is \$20 per each year of service. Minimum of 20 years of service is required (20 yrs × \$20 = \$400 per month). Time in the FRS "DROP" Program is not included in the calculation of this benefit. The maximum monthly benefit is \$600 per month. If retiree's medical insurance is not with the County, a check will be issued on a monthly basis payable to retiree. If retiree is covered under the County's medical insurance, the amount of the supplement will be deducted from the monthly invoice. Any overage due will be paid to retiree and will be handled on an individual basis.

Retiree Life Insurance

At retirement, if employee is age 55+ and has a minimum of eight (8) years of service with Charlotte County, they will have the opportunity to continue 50% of the amount of the term group Basic Life insurance currently in force while employed with Charlotte County. For example, if employee retires with \$50,000 group Basic Life insurance in force, employee would be eligible to keep \$25,000 at retirement.

Group Retiree Life insurance premiums are based on the current contract the County has in force and premiums are subject to change annually. Beneficiary forms may be obtained from Risk Management.

Premium Payments

Medical, dental and vision coverage is offered to all benefit-eligible retirees as a package, however, retiree may elect to opt-out of dental and/or vision and remain on the medical plan only (please note that this will not affect the total premium). Electing dependent medical coverage also entitles retiree's dependent(s) to receive dental and vision benefits unless they opt-out of dental or vision coverage.



COBRA Benefits

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a Federal law that provides employee the opportunity to continue existing group insurance coverage upon separation of service from the County. After electing health insurance benefits at New Hire Orientation, employee will be mailed an initial COBRA Notice which explains the COBRA rights as a County employee. Employee and covered dependent(s) may choose to elect COBRA if one (1) of the following qualifying events occurs:

- Termination of employment from the County, unless it was due to gross misconduct,
- A reduction of hours which would result in no longer meeting the eligibility requirements for coverage,
- In the event of death,
- In the event of divorce or legal separation,
- Becoming eligible for Medicare, or
- A child no longer meets eligibility requirements to be covered as a dependent.

Certain coverages may be continued for up to 18 months in the event of termination or up to 36 months for other qualifying events. Once a qualifying event is reported, employee or employee's covered dependent will be notified of the right to continue coverage and state the current COBRA premiums effective at that time. Employee and dependent(s) will have 60 days in which to elect COBRA coverage. This election period will end on the latter, 60 days from the qualifying event or, 60 days from the date the County notifies employee of COBRA rights.

Medical Insurance - COBRA Rates

*Medical includes Dental, Vision Coverage and the use of Employee Health Center

Tier of Coverage	Employee Monthly Premium	2% Admin Fee	Total Monthly Premium
Employee Only	\$1,014.00	\$20.28	\$1,034.28
Employee + Spouse	\$2,163.00	\$43.26	\$2,206.26
Employee + Child(ren)	\$1,879.00	\$37.58	\$1,916.58
Employee + Family	\$2,376.00	\$47.52	\$2,423.52

Administered through Wageworks

Customer Service: (877) 266-3947 | <https://cobrabenefits.wageworks.com>

Medicare Supplemental Insurance

Medicare-eligible retirees and employees may want to consider American Pioneer Group Medicare Supplemental Insurance as an alternative to electing group insurance coverage. The group supplement is a Guarantee Issue and has low, affordable group rates. There are 10 plans to choose from including those with prescription drug coverage. Depending on employee's personal situation, a Medicare Supplemental Policy combined with current Medicare coverage may provide employee with an adequate, lower cost alternative; especially retirees and employees over the age of 65 who insure a spouse.

To learn more about Medicare Supplemental Insurance or to schedule a personal appointment, contact the Valery Insurance Agency by using the contact information provided below.

Valery Insurance Agency

Customer Service: (800) 330-8445 | www.valeryagency.com

Legal Insurance

Two (2) voluntarily benefits are available to employee and family member(s) from LegalShield to provide protection, security and peace of mind concerning identity theft and other legal issues that touch family's lives. These benefits are paid by employee through personal bank or credit card draft, with no long term commitment. (Payroll deduction is not available at this time.)

LegalShield

Advice on any legal issue - Talk to an attorney about any legal issue from the trivial to the traumatic. **Home** - Purchase, Refinance, Foreclosure, Landlord/Tenant; **Financial** - Collections, Warranties, Guarantees, Contracts; **Family Matters** - Divorce, Child Custody, Child Support; **Estate Issues** - Wills, Living Wills, Power of Attorney; **Auto** - Moving Violations, Accidents

IDShield

Monitor more of what matters - IDShield monitors employee's identity from every angle, not just Social Security; **Counseling** - Identity specialists are focused on protecting employees 24 hours a day, seven (7) days a week; **Restore Identity** - IDShield is the only company with an exclusive partnership with Kroll, the worldwide leader in theft investigative services. If a compromise occurs, a licensed private investigator contacts employee immediately and begins restoring identity to exactly the way it was; **Includes a \$5 Million Service Guarantee.**

Enrollment in these services covers employee, spouse or domestic partner, and dependent child(ren). See plan brochures for more information and details. Rates vary depending on plans selected.

LegalShield | www.legalshield.com

Agent: Jim and Andrea Carroll | (941) 235-1770



Employee Health Centers

The Employee Health Centers (EHC) were established to provide County employees easy and cost-free access to the highest quality medical care for acute and chronic conditions. The EHC is available to individuals who are enrolled in the County's medical plan, including employee, spouse, child(ren) and retirees.

The EHC is administered by CareHere, a third party vendor. Utilization is completely voluntary. All visits with Health Center staff are completely confidential and no personal health information is shared with the employer. Employee still has access to primary care providers, specialists, hospitals, and outpatient facilities through the County's medical plan with Cigna.

Why choose the Employee Health Center?

- ✓ No Copays
- ✓ Online scheduling with dedicated 20-minute appointments — no long stay in a waiting room!
- ✓ Many prescriptions dispensed onsite cost-free
- ✓ 100% confidential and HIPAA compliant

What services can be performed at the Health Center?

- ✓ Primary Care
- ✓ Acute Care & Urgent Care
- ✓ Prescription Dispensing
- ✓ Labs performed onsite — no trip to a separate facility!
- ✓ Digital X-Rays
- ✓ Stress Tests and EKGs
- ✓ Health Risk Assessments

Please be advised that Physicians at the EHC do not have hospital rights and can't admit patients directly from the EHC.

Accessing the Employee Health Center

All employees, dependents and retirees on the County's medical plan have cost-free access to the EHC. Appointments are required for all primary care visits and are scheduled in 20-minute intervals. The medical staff will advise if a longer appointment is needed.

If access is needed to the EHC without an appointment, it is recommended to call (877) 423-1330 or visit www.carehere.com to schedule the next available time. Walk-ins will be accommodated based on the EHC's open appointment times and severity of the medical issue. To contact the EHC with questions for a doctor or nurse, please call (941) 764-0301.

In all emergency situations, please call 911.

CareHere Registration

Register to Use the EHC

1. Go to www.carehere.com and click "Member Login."
2. Click "I need to register for the first time with my Access Code."
3. Beside First time registration enter Access Code: CHAC7.
4. Consent Page: Review the consent form. If employee agrees, check "I agree."
5. Identification: Enter the required information.
6. Enter email address and create a username and password.
7. Contact Page: Review all the fields and enter or update the appropriate information.
8. Health Page: Skip any field for which employee does not know the answer.

Please Note: Each covered dependent must register with CareHere and create an account.



Bob Pryor EHC Location



Bob Pryor Employee Health Center/CareHere
 1050 Loveland Blvd., Port Charlotte, FL 33980
 (877) 423-1330 • 941-764-0301 • www.carehere.com

Health Center Hours of Operation

Monday	8:00 a.m. - 7:00 p.m. (closed 1:00 - 2:00)
Tuesday	8:00 a.m. - 7:00 p.m. (closed 1:00 - 2:00)
Wednesday	8:00 a.m. - 7:00 p.m. (closed 1:00 - 2:00)
Thursday	8:00 a.m. - 7:00 p.m. (closed 1:00 - 2:00)
Friday	8:00 a.m. - 6:00 p.m. (closed 1:00 - 2:00)
Saturday	8:00 a.m. - 4:30 p.m. (closed 12:30 - 1:00)

Lab Hours

Monday	8:00 a.m. - 11:00 a.m.
Tuesday	7:00 a.m. - 10:00 a.m.
Wednesday	8:00 a.m. - 11:00 a.m.
Thursday	8:00 a.m. - 11:00 a.m.
Friday	8:00 a.m. - 11:00 a.m.

South County EHC Location



South County Employee Health Center/CareHere*
 514 E. Grace Street, Punta Gorda, FL 33950
 877-423-1330 • 941-764-0301 • www.carehere.com

Health Center Hours of Operation

Monday	8:00 a.m. - 5:00 p.m. (closed 1:00 - 2:00)
Tuesday	8:00 a.m. - 5:00 p.m. (closed 1:00 - 2:00)
Wednesday	8:00 a.m. - 7:00 p.m. (closed 1:00 - 2:00)
Thursday	8:00 a.m. - 7:00 p.m. (closed 1:00 - 2:00)
Friday	8:00 a.m. - 5:00 p.m. (closed 1:00 - 2:00)
Saturday	Closed

Lab Hours

Monday	8:00 a.m. - 11:00 a.m.
Tuesday	8:00 a.m. - 11:00 a.m.
Wednesday	8:00 a.m. - 11:00 a.m.
Thursday	8:00 a.m. - 11:00 a.m.
Friday	8:00 a.m. - 11:00 a.m.

**Please Note: This location does not treat any workers compensation or occupational visits, nor do they have a x-ray machine.*



Employee Health Centers Services

Save Money - Use the Employee Health Centers

Prescription Medications

The EHCs use generic and brand name medications at no cost to patients. Health Center staff can prescribe medication for a variety of acute and chronic conditions. If the Health Center does not stock a prescribed medication, staff will provide a prescription to take to the local pharmacy and purchase through the Cigna medical plan.

Schedule an appointment with a staff provider today to review current prescriptions. Please Note: The Health Centers are not pharmacies. Member is required to meet with the medical staff before a prescription can be dispensed for employee or a dependent.

Brand Name Generics Available at the EHC

- ✓ Glucophage
- ✓ Mevacor
- ✓ Synthroid
- ✓ Prilosec Omeprazole
(Can often be substituted for Nexium)
- ✓ Metformin
- ✓ Lovastatin
- ✓ Levothyroxine Sodium

FREE Medications Available

- ✓ Acid Reflux/Heartburn
- ✓ Allergy
- ✓ Anti-Depressants
- ✓ Diabetes
- ✓ Blood Pressure
- ✓ Cholesterol
- ✓ Antibiotics
- ✓ And Many More!

CareHere Rx Mail-Order Program with Envision

The EHCs offer medications available through an exclusive mail-order program. This program will not replace the Cigna program, but will provide an alternative at a reduced cost. Narcotics will not be available through this program, but employee will have access to additional medications, including name brand. If employee is currently filling medication through Cigna and paying a copay, please schedule an appointment today and have medications reviewed by the EHC physicians.

Employee Cost for 90-Day Supply

Tier 1 - Generic	
Cigna Copay	Envision
\$30.00	\$10.00
Tier 2 - Formulary Brand	
Cigna Copay	Envision
\$60.00	\$20.00
Tier 2 - Non-Formulary Brand	
Cigna Copay	Envision
\$120.00	\$40.00

Radiology/Imaging Referrals

The EHCs have an agreement for County employees to obtain radiology services at no cost, such as CT scans, MRI's, mammograms and bone density screenings through American Imaging, as well as Advanced Imaging of Charlotte County. Employee may get a referral for these services from a EHCs. Employees may even bring a prescription from an outside provider to a EHCs for the referral.

Smoking Cessation - Self Paced

Employee may be supported with an online program, educational material, or reading material and will work with a Health Coach to become tobacco free. The provider may also request the County to pay for Chantix.



To access your benefits online,
visit the Employee Benefits Center at:

<https://www.mybentek.com/charlottecounty>



EMPLOYEE BENEFITS | RISK MANAGEMENT

4200 Northcorp Parkway, Suite 185
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970
www.gehringgroup.com

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