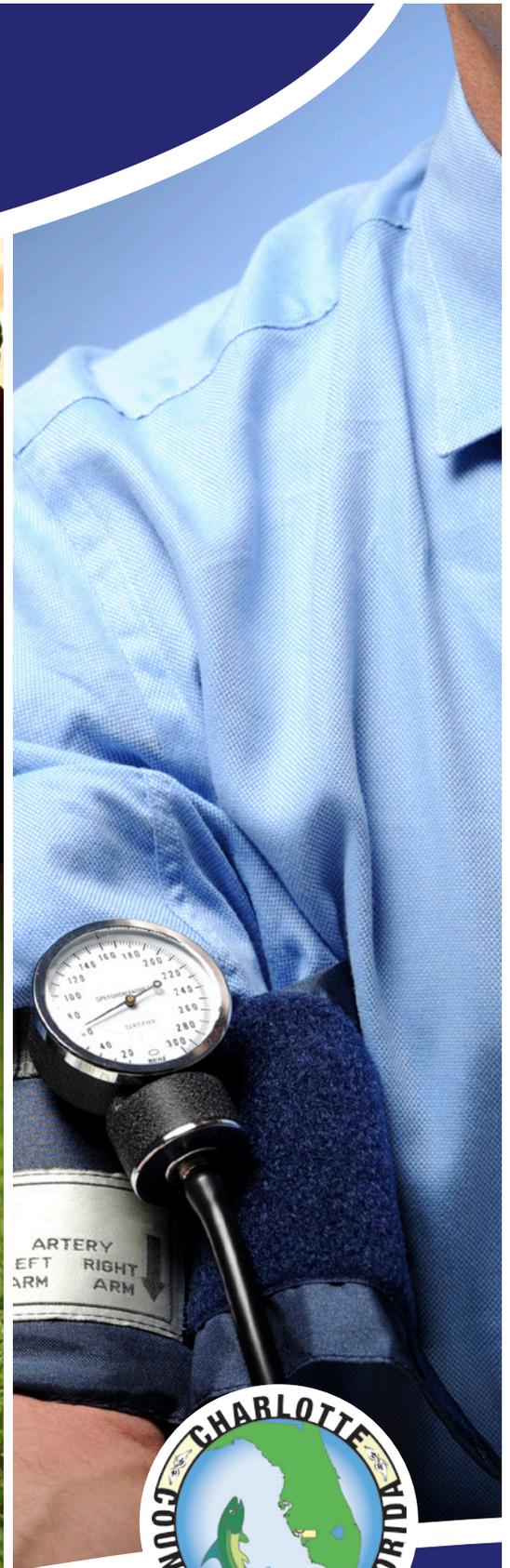


# Charlotte County

Board of County Commissioners



**2016 | 2017**

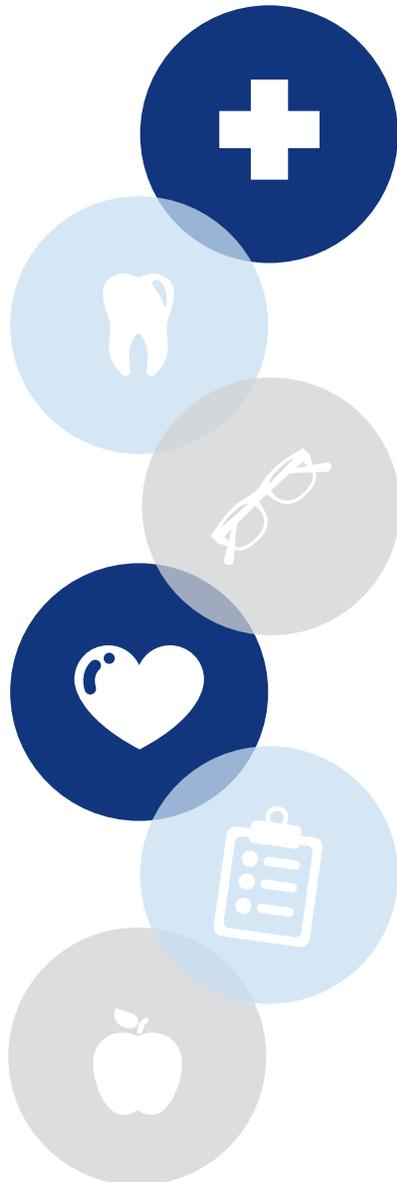
**EMPLOYEE BENEFIT HIGHLIGHTS**





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## Contact Information

|  |  |   |
|--|--|---|
| <b>Risk Management</b>   | Janine Hewitt,<br>Risk/Benefits Coordinator        | Phone: (941) 743-1244<br><a href="http://charlottesweb/risk">http://charlottesweb/risk</a>  |
|  | Rosemarie Tsourkas,<br>Onsite Cigna Representative | Phone: (941) 743-1388   |
|  | Stephanie Phillips,<br>Wellness Coordinator        | Phone: (941) 764-4927   |
|  <b>Online Benefit Website</b>  | BenTek Support                                     | (888) 5-BenTek (523-6835)<br><a href="http://www.mybentek.com/charlottecounty">www.mybentek.com/charlottecounty</a>                 |
|  <b>Medical Insurance</b>   | Cigna  | Customer Service: (800) 244-6224<br><a href="http://www.cigna.com">www.cigna.com</a><br>Onsite Cigna Representative: (941) 743-1388 |
|  <b>Mail-Order Pharmacy Program</b>   | Orchard Rx   | Customer Service: (866) 909-5170<br><a href="http://www.orchardrx.com">www.orchardrx.com</a>  |
|  <b>Health Reimbursement Account</b>  | TASC   | Customer Service: (877) 933-3539<br><a href="http://www.tasconline.com">www.tasconline.com</a>                                      |
|  <b>Dental Insurance</b>   | Cigna  | Customer Service: (800) 244-6224<br><a href="http://www.cigna.com">www.cigna.com</a>  |
|  <b>Vision Benefit</b>  | EyeMed   | Customer Service: (866) 723-0514<br><a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>                          |
|  <b>Flexible Spending Account</b>   | TASC   | Customer Service: (877) 933-3539<br><a href="http://www.tasconline.com">www.tasconline.com</a>                                      |
|  <b>Basic Life and AD&amp;D Insurance</b>                                     | Cigna  | Customer Service: (800) 732-1603<br><a href="http://www.cigna.com">www.cigna.com</a>  |
|  <b>Employee Assistance Program</b>   | Cigna Behavioral Health                            | Customer Service: (877) 622-4327<br><a href="http://www.cignabehavioral.com">www.cignabehavioral.com</a>                            |
|  <b>Short &amp; Long Term Disability Insurance</b>                            | Cigna  | Customer Service: (800) 732-1603<br><a href="http://www.cigna.com">www.cigna.com</a>  |
|  <b>Supplemental Insurance</b>  | Boston Mutual                                      | Customer Service: (800) 669-2668  |
| <b>Medicare Supplemental Insurance</b>   | Valery Insurance Agency                            | Customer Service: (800) 330-8445  |
|  <b>TransAmerica Cancer, Accident, Supplemental Life &amp; Long Term Care</b> | Page Agency  | Agent: Steve Alldredge<br>Phone: (386) 228-5082   |
| <b>COBRA Benefits</b>  | Conexis  | Customer Service: (877) 266-3947<br><a href="http://www.conexis.com">www.conexis.com</a>  |
|  <b>Bob Pryor Employee Health Center</b>                                      | CareHere   | Customer Service: (877) 423-1330<br>Customer Service: (941) 764-0301  |



## Introduction

The County is pleased to offer a comprehensive array of benefits including group insurance coverage, retirement savings plans, and wellness programming. Please refer to the 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 numbers under each benefit description heading. General inquiries may be directed to Risk Management.

## Notices

### COBRA Continuation of Medical Coverage Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees and/or dependents may be able to continue their enrollment in certain health plans such as medical, dental, and vision if such coverage is terminated or changed due to a qualifying event.

### Medicare Part D Creditable Coverage

The County's prescription drug coverages are considered Creditable Coverage under Medicare Part D. If an employee or their dependents are or will be eligible for Medicare, they may obtain more information by requesting a Medicare Part D Disclosure of Creditable Coverage Notice.

### Health Insurance Portability & Accountability Act (HIPAA)

HIPAA requires compliance on many levels including privacy, security, transaction standards, information control and access, education and training. The County is committed to protecting the privacy of the personal health information (PHI) of its employees. The County pays careful attention to various aspects of privacy protection such as identity verification, minimal disclosure of information, limited access of employees' personal identifiable information and safeguarding information.

## Coordination of Benefits

When both spouses work, each person may be covered by their employer's health plan, as well as their 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 their spouse cover dependent children, the plan that covers the parent whose birthday falls first in the calendar year is usually primary for any dependent children.

Other factors that can change which plan pays first include eligibility for Medicare, court decrees or custody arrangements, the length of time an employee is covered, and whether an active employee or 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 their children as dependents of both employees.

### Children's Health Insurance Program (CHIP)

This provision provides employees and dependents a special enrollment right in group medical plan coverage, without having to wait for an open enrollment period, for a loss of eligibility or becoming eligible for premium assistance under CHIP or Medicaid if requested within 60 days of gain/loss of eligibility for premium assistance under CHIP or Medicaid.

### Notice of Privacy Practice of Charlotte County

The Privacy Notice of the County is available and employee can obtain a copy by contacting Risk Management or by logging onto [www.charlottesweb/risk/handbooks.asp](http://www.charlottesweb/risk/handbooks.asp).

*Please Note: Copies of certificates of coverage for all plans are available on Charlotte's web at: <http://charlottesweb/Risk/handbooks.asp>*

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



### BenTek Support

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.



### BenTek Important Info

Accessible 24 hours a day at any time during the plan year, you have the option to print out your enrollment confirmation statement outlining your benefit elections for you and your dependents including your life insurance beneficiary designations. You can also log on to the EBC to review your benefits, access carrier links, update life insurance beneficiaries and report qualifying events..



### BenTek Quick Tips

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

## Online Benefit Enrollment

The County will provide an electronic enrollment through BenTek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change their insurance benefits online during the annual open enrollment period, new hire orientation, and for qualifying events.

Accessible 24 hours a day at any time during the plan year, you have the option to print out your enrollment confirmation statement outlining your benefit elections for you and your dependents including your life insurance beneficiary designations. You can also log on to the EBC to review your benefits, access carrier links, update life insurance beneficiaries and report qualifying events.



### To access the Employee Benefits Center:

- ✓ Log on to [www.mybentek.com/charlottecounty](http://www.mybentek.com/charlottecounty)
- ✓ Sign in by using your previously created username and password or follow the instructions to set up your own username and password. *If you have forgotten your 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 your benefit options, and make any elections or changes.
- ✓ You may also update your life insurance beneficiary designation(s).
- ✓ You have the option to print out your enrollment confirmation statement containing all your benefit elections for you and your family.

### Enroll Online for the 2016-2017 Plan Year

Please access the Employee Benefits Center if you would like to review or make benefit changes for the 2016-2017 Plan Year:

1. Log on to <https://www.mybentek.com/charlottecounty>.
2. Sign in by using your previously created username and password or follow the instructions to set up your own username and password. *If you have forgotten your username and/or password, click on the link "Forgot Username/Password" and follow the instructions.*
3. Once logged on, navigate to the menu and select the open enrollment menu option. Here you can learn about your benefit options, and make any elections or changes.
4. Enter EBC to review current elections, learn about your benefit options, and make any elections or changes.
  - You may also update your life insurance beneficiary designation(s)
  - You have the option to print out your enrollment confirmation statement containing all your benefit elections for you and your family

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 your group insurance benefits online, log on to [www.mybentek.com/charlottecounty](http://www.mybentek.com/charlottecounty)**



## 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, you can elect to opt-out of dental and/or vision and remain on the medical plan only (please note that this will not affect your deduction). Electing dependent coverage also entitles your dependent(s) to receive these 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 your effective date is December 1, your payroll deductions would be taken in November. There are 24 deductions per year.

Employees 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)

## Open Enrollment

The County has an Open Enrollment period every year when changes to your benefit elections can be made that will be effective when the new plan year begins on October 1. During Open Enrollment, employees may:

- ✓ Change your Section 125 Tax Election
- ✓ Add Dependents
- ✓ Remove Dependents
- ✓ Apply for Short Term Disability
- ✓ Apply for Long Term Disability

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

## Other Coverage

If you are covered by another Medical Insurance Plan (example: an individual policy, as a dependent under a spouse's policy, military insurance, etc.) and you wish to decline the County's Medical Insurance plan, the County will reimburse you \$200 per month (which is taxable income). However, you will still be enrolled in the Basic Life Insurance and the Accidental Death and Dismemberment Insurance at no cost to you. To be eligible to receive this other coverage rebate, you must be under the age of 65 and not Medicare eligible. You 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. You will be required to verify this information on an annual basis.



## 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 hours a month under the accepted measurement method elected under the Affordable Care Act. Coverage will be effective the 1st of the month following 30 days of employment. For example: If an employee is hired on February 11, then the effective date of coverage will be April 1.

### Termination

If an 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 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 foster child
- 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 26.

Over-age dependents 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 over age dependents over age 26.*

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

**Vision Coverage:** A dependent child may be covered through the end of the calendar year in which the child turns 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
- The dependent is otherwise eligible for coverage under the group medical plan; and
- The dependent has been continuously insured.

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

### Taxable Dependents

Beginning January 1 of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, that portion of health insurance premium that is attributable to covering the over-age dependent (the "OAD value") will be deducted on a post tax basis. If the OAD value is greater than the payroll deduction, the additional employer subsidized portion of the value (OAD value minus payroll deduction) will be reported as imputed income to the employee and included as income on the W-2.

## 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 their health 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 that 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, and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-taxed to the extent permitted. Under Section 125, changes to employees pre-tax benefits can be made **ONLY** during the Open Enrollment period unless the employee or their qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employees may be allowed to make changes to their benefit elections during the plan year, if the event affects their own, their spouse's, or their dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of 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 employees 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 an employee experiences a qualifying event, **the employee must contact Risk Management within 30 days of the qualifying event** to make the appropriate changes to their 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 the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place in accordance with the carrier's policies and procedures, except for newborns which are effective on the date of birth. Employees 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 inserted here or provided as a supplement to this booklet which is being distributed to New Hires and Existing Employees during open enrollment. The summary is an important item in understanding your 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  
**At Website URL:** [www.charlottesweb/risk/handbooks.asp](http://www.charlottesweb/risk/handbooks.asp)  
 Through the enrollment software – BenTek: [www.mybentek.com/charlottecounty](http://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 actual group certificate of coverage can be reviewed and obtained by contacting the Benefits Coordinator or on the following web address: [www.charlottesweb/Risk/handbooks.asp](http://www.charlottesweb/Risk/handbooks.asp).

If you have any 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 costs per pay period for coverage are listed in the premium table below. For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided.

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, nor do members need to have referrals to see a specialist. As long as members stay within the OAP network, they are covered according to the plan benefits.

### Medical Insurance – Cigna OAPIN Plan - Premiums

Monthly Payroll Deductions - Includes Medical, Dental and Vision Coverage

| Tier of Coverage      | Employee Contribution | County Contribution | Total Monthly Premium |
|-----------------------|-----------------------|---------------------|-----------------------|
| Employee Only         | \$26.00               | \$895.83            | \$921.83              |
| Employee + Spouse     | \$286.00              | \$1,702.43          | \$1,988.43            |
| Employee + Child(ren) | \$249.00              | \$1,478.47          | \$1,727.47            |
| Employee + Family     | \$315.00              | \$1,869.49          | \$2,184.49            |

### Medical Insurance – Cigna OAPIN Plan - With Tobacco Premiums

Monthly Payroll Deductions - Includes Medical, Dental and Vision Coverage

| Tier of Coverage      | Employee Contribution | County Contribution | Total Monthly Premium |
|-----------------------|-----------------------|---------------------|-----------------------|
| Employee Only         | \$76.00               | \$895.83            | \$971.83              |
| Employee + Spouse     | \$336.00              | \$1,702.43          | \$2,038.43            |
| Employee + Child(ren) | \$299.00              | \$1,478.47          | \$1,777.47            |
| Employee + Family     | \$365.00              | \$1,869.49          | \$2,234.49            |

## Premium Deductions

Medical, dental and vision coverage is offered to all benefit eligible employees as a package, however, employees can 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 deduction). 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. The employee costs for 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 employee's effective date is December 1, payroll deductions would be taken in November. There are 24 deductions per year.

## Tobacco User Premiums

Employees and eligible spouses must request and complete a nicotine test at the Employee Health Center between April 1, 2016 and August 1, 2016. Any employee that does not take the test between those dates will receive the "with Tobacco" premium. Employees and eligible spouses who test negative for nicotine will qualify for a waiver of increased premiums for the plan year. Additionally, employees that test positive for nicotine but complete a Tobacco Cessation Program by December 1, 2016 will also qualify for a waiver of increased premium for the plan year. Any employees that do not complete the test or Program by the required deadlines will receive the "with Tobacco" premium.

Cigna | Customer Service: (800) 244-6224 | [www.cigna.com](http://www.cigna.com)



## Other Available Plan Resources

Cigna offers all enrolled members and dependents additional services and discounts through value added programs. **For more details regarding other available plan resources, please refer to your Summary of Benefits and Coverage (SBC).**

### 24 Hour Help Information Hotline (800) CIGNA-24

The Cigna 24-Hour Health Information Line provides you access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do when your child has a fever in the middle of the night? Have you injured yourself and are not sure if you should seek treatment or go see a doctor? There are over 1,000 topics in the Health Information Library that include FREE audio, video and printed information on aging, women's health, nutrition, surgery and specific medical conditions to help you weigh the risks and advantages of treatment options. The call is FREE and is strictly confidential.

### Healthy Rewards

Cigna's Healthy Rewards is provided to you automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to [www.mycigna.com](http://www.mycigna.com) and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- ✓ Vision care
- ✓ LASIK vision correction services
- ✓ Fitness club discounts
- ✓ Nutrition discounts
- ✓ Hearing care
- ✓ Tobacco cessation
- ✓ Alternative medicine

### The myCigna Mobile App

The myCigna Mobile App gives you an easy way to organize and access your important health information. Anytime. Anywhere. Download it today from the App Store<sup>SM</sup> or Google Play<sup>TM</sup>. With the myCigna Mobile App you can:

- ✓ Find a doctor, dentist or health care facility
- ✓ Access maps for instant driving directions
- ✓ View ID cards for the entire family
- ✓ Review deductibles, account balances and claims
- ✓ Compare prescription drug costs
- ✓ Speed-dial Cigna Home Delivery Pharmacy<sup>TM</sup>
- ✓ Store and organize all important contact info for doctors, hospitals, and pharmacies
- ✓ Add health care professionals to contact list right from a claim or directory search
- ✓ And, much more!

## CIGNA Secure Travel<sup>®</sup>

All employees covered under Cigna's Accidental Death & Dismemberment benefit are automatically covered under the CIGNA Secure Travel program which provides emergency medical and travel services, as well as helpful pre-trip planning assistance, when traveling 100 miles or more away from home on company business or on vacation.

### CIGNA Secure Travel Services

Cigna's Healthy Rewards is provided to members automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to [www.mycigna.com](http://www.mycigna.com) and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- ✓ Emergency medical evacuation
- ✓ 24 hour multilingual assistance
- ✓ Pre-trip planning services, including foreign travel
- ✓ Medical referrals
- ✓ Prescription refill services
- ✓ Assistance with lost or stolen items
- ✓ Translation and interpretation services
- ✓ Emergency travel services
- ✓ Repatriation of remains

Cigna | U.S. & Canada: (800) 244-6224 | Other Locations: (202) 331-7635

Email: [cigna@europeassistance.com](mailto:cigna@europeassistance.com)

Policyholder Name: Charlotte County Board of Commissioners

Policy #OK-964258 Group #57



## Cigna OAPIN Plan At-A-Glance



### Locate a Provider

To search for a participating provider, contact customer service or go to [www.cigna.com](http://www.cigna.com). Select "Find a Doctor" tab. Select "For plans offered through work or school. . . Find a Doctor or Dentist using this Directory" under the "Select a Directory" tab. Select "Pick," then select "Select a Plan." Choose the plan name based on the plan enrolled in: Open Access Plus or OA Plus Choice Fund OA Plus. Enter the additional search criteria, then click "Search."



### 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 be sure to confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.

| Network  | Open Access Plus                    |
|--|-------------------------------------|
| <b>Calendar Year Deductible (CYD)*</b>                               |                                     |
| Single   | In Network<br>\$500                 |
| Family   | \$1,000                             |
| <b>Coinsurance</b>   |                                     |
| Member Responsibility  | 0%                                  |
| <b>Calendar Year Out-of-Pocket Limit*</b>                            |                                     |
| Single   | \$1,500                             |
| Family   | \$3,000                             |
| What Applies to the Out-of-Pocket Limit?                             | Deductible and Copays (Excludes Rx) |
| <b>Physician Services</b>  |                                     |
| 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                          |
| <b>Non-Hospital Services; Freestanding Facility</b>                  |                                     |
| Clinical Lab (Blood Work): LabCorp or Quest**                        | No Copay                            |
| X-rays   | No Copay                            |
| 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  | \$50 Copay                          |
| <b>Hospital Services</b>   |                                     |
| Inpatient Hospitalization  | 0% After CYD                        |
| Physician Services at Hospital                                       | 0% After CYD                        |
| Emergency Room (Waived if Admitted)                                  | \$150 Copay                         |
| <b>Mental Health/Alcohol &amp; Substance Abuse</b>                   |                                     |
| Inpatient/Outpatient Facility  | 0% After CYD                        |
| Physician's Office Visit   | \$35 Copay                          |
| <b>Prescription Drugs (Rx)</b>                                       |                                     |
| Generic  | \$15 Copay                          |
| Preferred Brand Name   | \$30 Copay                          |
| Non-Preferred Brand Name   | \$60 Copay                          |
| Mail Order Drug (90 Day Supply)                                      | 2x Retail Copay                     |



## 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 and are funded by the County. They can be used for any qualified medical expense incurred under the medical plan, such as deductibles and coinsurance for physician services, and hospital services, etc.

### 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. Employees are 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.

What are the benefits of an HRA? Employees 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 must be paid to reimburse employee for qualified medical expenses that have incurred. The expense must have been incurred on or after the date you are enrolled in the HRA.

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

| Health Reimbursement Account (HRA)   | Flexible Spending Accounts (FSA)  |
|--|---|
| <ul style="list-style-type: none"> <li>✓ Employer Funded Account</li> <li>✓ Enrollment is automatic if enrolled in medical plan</li> <li>✓ Funds used for eligible medical expenses for employee and employee's dependents who are enrolled in medical plan</li> <li>✓ Unused funds accumulate and roll over year to year</li> </ul> | <ul style="list-style-type: none"> <li>✓ Employee Funded Accounts</li> <li>✓ Employee must enroll annually</li> <li>✓ Funds used for eligible medical, dental, vision &amp; dependent care for employee and employee's qualified dependents</li> <li>✓ Employees can carry over up to \$500 to the next plan year after 90 days.</li> </ul> |

**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 that would be eligible for reimbursement?

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>✓ Acupuncture</li> <li>✓ Ambulance service</li> <li>✓ Birth control pills</li> <li>✓ Chiropractic care</li> <li>✓ Contact lenses (Corrective)</li> <li>✓ Dental fees</li> <li>✓ Diagnostic tests/Health screenings</li> </ul> | <ul style="list-style-type: none"> <li>✓ Doctor fees</li> <li>✓ Drug addiction/Alcoholism treatment prescription drugs</li> <li>✓ Experimental medical treatment</li> <li>✓ Eyeglasses</li> <li>✓ Hearing aids and exams</li> <li>✓ Injections and vaccinations</li> </ul> | <ul style="list-style-type: none"> <li>✓ In vitro fertilization</li> <li>✓ Nursing services</li> <li>✓ Orthodontic fees</li> <li>✓ Surgery</li> <li>✓ Wheelchairs</li> <li>✓ X-rays</li> </ul> |
|--|--|--|



## Dental Insurance

### Cigna Dental PPO Plan

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

*Please Note: Dental coverage is included as part of your medical contribution. Dental cards are available to Risk Management.*

#### In-Network Benefits

The 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 for 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 members receive services by a non-participating Cigna Dental provider. Cigna reimburses out-of-network services based on what it determines is 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 will pay the out-of-network benefit plus the difference between the amount that Cigna reimburses (MRC) for such services and the amount charged by the dentist. This is known as balance billing. 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- or out-of-network services or any combination of both. Once any 3 covered members in a family each satisfies the \$50 deductible, the deductible will then be considered met for all covered members in that family.

#### Plan Year Benefit Maximum

The maximum benefit (coinsurance) the dental PPO plan will pay for each covered member is \$1,500 for in- or out-of-network services or a combination of both. Preventive services will accumulate towards the benefit maximum.

Cigna | Customer Service: (800) 244-6224 | [www.cigna.com](http://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   |
| <b>Plan Year Benefit Maximum</b>                            |                                      |   |
| Per Member  |                                      | \$1,500   |
| <b>Class I Services: Diagnostic &amp; Preventative Care</b> |                                      |   |
| Oral Exam   | Plan Pays: 100%<br>Deductible Waived | Plan Pays: 100%<br>Deductible Waived<br><i>(Subject to Balance Billing)</i> |
| Cleanings   |                                      |   |
| X-rays <i>(Bitewing / Full Mouth)</i>                       |                                      |   |
| Fluoride Treatments <i>(Restrictions Apply)</i>             |                                      |   |
| Sealants <i>(Restrictions Apply)</i>                        |                                      |   |
| Space Maintainers   |                                      |   |
| <b>Class II Services: Basic Restorative Care</b>            |                                      |   |
| Fillings  | Plan Pays: 80%<br>After PYD          | Plan Pays: 80% After PYD<br><i>(Subject to Balance Billing)</i>             |
| Simple Extractions  |                                      |   |
| Endodontics <i>(Root Canal Therapy)</i>                     |                                      |   |
| Periodontal Services  |                                      |   |
| Oral Surgery  |                                      |   |
| Anesthetics   |                                      |   |
| <b>Class III Services: Major Restorative Care</b>           |                                      |   |
| Crowns  | Plan Pays: 50%<br>After PYD          | Plan Pays: 50% After PYD<br><i>(Subject to Balance Billing)</i>             |
| Bridges   |                                      |   |
| Dentures  |                                      |   |
| <b>Class IV Services: Orthodontia</b>                       |                                      |   |
| Lifetime Maximum  |                                      | \$1,500   |
| Benefit <i>(Dependent Children Up To Age 19)</i>            |                                      | Plan Pays: 50%<br>Deductible Waived   |



### Locate a Provider

To search for a participating provider, contact customer service or go to [www.cigna.com](http://www.cigna.com). Select "Find a Doctor" tab. Select "For Plans Offered Through Work or School... Find a Doctor or Dentist using this Directory" under the "Select a Directory" tab. Select "Pick," then select "Select a Plan." Choose "Cigna Dental PPO or EPO" and select "Choose." Enter the additional search criteria, then click "Search."



### Important Notes

- It is recommended for members to request their provider to obtain a pretreatment plan review when services are expected to exceed \$200 in costs.
- Each covered family member may receive up to 2 routine cleanings per plan year covered under the preventative benefit.
- Service frequencies and age limitations may apply for some services.



## Vision Insurance

### EyeMed Vision Care Plan

The County offers vision insurance through EyeMed to benefit eligible employees. A 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 your medical contribution.*

#### In-Network Benefits

The vision plan offers employees and their covered dependents coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered employees and their dependents 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

Employees and their covered dependents may also 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](http://www.eyemedvisioncare.com)



## EyeMed Vision Care Plan At-A-Glance

| Network   | Insight  |                           |
|---|--|---------------------------|
|   | In-Network   | Out-of-Network            |
| <b>Services</b>                                     |  |                           |
| Eye Exam  | \$10 copay   | Up to \$35 Reimbursement  |
| <b>Frequency of Services</b>                        |  |                           |
| Examination   |  | 12 Months                 |
| Lenses  |  | 12 Months                 |
| Frames  |  | 24 Months                 |
| Contact Lenses                                      |  | 12 Months                 |
| <b>Lenses</b>                                       |  |                           |
| Single  | Covered at 100%                                      | Up to \$25 Reimbursement  |
| Bifocal   | Covered at 100%                                      | Up to \$40 Reimbursement  |
| Trifocal  | Covered at 100%                                      | Up to \$60 Reimbursement  |
| <b>Frames</b>                                       |  |                           |
| Allowance   | \$200 Retail Allowance then 20% Discount Above \$200 | Up to \$45 Reimbursement  |
| <b>Contact Lenses*</b>                              |  |                           |
| Non-Elective ( <i>Medically Necessary</i> )         | Covered at 100%                                      | Up to \$210 Reimbursement |
| Elective ( <i>Fitting, Follow-up &amp; 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](http://www.eyemedvisioncare.com). When completing the necessary search criteria, select **Insight** as the network.



### Important Notes

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



### Plan References

*\*Contact lenses are in lieu of spectacle lenses and a frame.*



## Flexible Spending Account

The County offers Flexible Spending Accounts (FSA) administered through TASC. The FSA Plan Year is from January 1, 2016 through December 31, 2016. FSA has its own open enrollment period, which will be held in December. You may elect to participate in either FSA or both simultaneously.

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

### Health Care FSA

This account allows participants to set aside up to an annual maximum of \$2,550. This money will not be taxable income to the participants and can be used to offset the cost of a wide variety of eligible health care expenses that generate out-of-pocket costs for you or your qualified dependents. Participating employees 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 to you on the first day coverage is effective.*

### Dependent Care FSA

This account allows participants to set aside up to an **annual maximum of \$5,000 if you are single or married and file a joint tax return (\$2,500 if you are 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 adults.

Please note that if your family's annual income is over \$20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your 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 8 hours a day in your household.

*Please Note: Unlike the Health Care FSA, you will only be reimbursed up to the amount that has been deducted from your paycheck for Dependent Care expenses.*

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

- ✓ Ambulance service
- ✓ Chiropractic care
- ✓ Dental fees/Orthodontic fees\*
- ✓ Diagnostic tests/Health screenings\*
- ✓ Doctor fees
- ✓ Drug addiction/Alcoholism treatment\*
- ✓ Experimental medical treatment
- ✓ Eyeglasses/Contact lenses (corrective)\*
- ✓ Hearing aids and exams\*
- ✓ Injections & vaccinations\*
- ✓ Lasik surgery\*
- ✓ Mental healthcare
- ✓ Nursing services
- ✓ Optometrist fees\*
- ✓ Physician office visits
- ✓ Prescription drugs
- ✓ Medically necessary sunscreen
- ✓ Wheelchairs

*\*These items are eligible expenses under the Limited Purpose FSA*

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

## Flexible Spending Account

### FSA Guidelines

- Employees can carry over up to \$500 of unused Health Care FSA funds into the next plan year after a 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 will not be allowed to be returned.
- Employees can enroll in either or both of the FSAs only during the open enrollment period, a qualifying event, or new hire eligibility.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employees and their dependents cannot be reimbursed for services they have not received.
- Employees and their dependents cannot receive insurance benefits or any other compensation for expenses which are 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!



An 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<br>22.65% = 15% + 7.65% FICA | -\$6,568      | -\$6,795         |
| After Tax Expenses                         | -\$0          | -\$1,000         |
| Spendable Income                           | \$22,432      | \$22,205         |
| <b>Tax Savings</b>                         | <b>\$227</b>  |                  |

### 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 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 an 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 you have available is the balance on the TASC Card. You may use the TASC Card up to this amount, but never over. You may check your available balance at [tasconline.com](http://tasconline.com). Please keep your TASC Card as it will be used again your next plan year, or up to the expiration date on the card. When the expiration nears, a new card will automatically be ordered.
- If you're close to reaching the balance on your TASC Card, it will only allow you to spend the funds remaining in the account. If your purchase exceeds the account balance, you'll need to pay the difference using another means of payment (i.e., out-of-pocket).
- If you decide you don't want to use your TASC Card, you may submit a manual claim for reimbursement either by fax, email, mail, online through the secure web form at [www.tasconline.com](http://www.tasconline.com) (you must login) or through the TASC mobile app for iPhone or Android at any time during the plan year.

### Rollover Guidelines

The 2016 plan year will end on December 31, 2016, however employees will have an additional 90 days after the plan ends to submit claims to TASC for service dates from January 1, 2016 to December 31, 2016. Employees will not be able to use their debit card for these services; however employees 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 their old plan year as they will be denied and a repayment request will be generated.*

TASC | Phone: (877) 933-3539 | [www.tasconline.com](http://www.tasconline.com)



## Basic Life and AD&D Insurance

### Group Term Life

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

When you are age 65 or older, your Life Insurance Benefit will reduce to:

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

### Accidental Death & Dismemberment

The County also provides Accidental Death & Dismemberment (AD&D) insurance which pays in addition to the basic 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.

***Always remember to keep your beneficiary forms updated.  
You may update your beneficiary information at anytime  
through BenTek.***

**Cigna** | Customer Service: (800) 732-1603 | [www.cigna.com](http://www.cigna.com)

## Cigna's Will Preparation Program

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

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

**Cigna** | Customer Service: (800) 901-7534 | [www.cignawillcenter.com](http://www.cignawillcenter.com)

## Employee Assistance Program

A comprehensive Employee Assistance Program (EAP) is available to you and each member of your family through Cigna Behavioral Health as part of your core benefits package. The EAP offers access to mental health professionals through a confidential program that is protected by State and Federal laws. The EAP program is available 24 hours a day, 7 days a week to help you gain a better understanding of problems that affect you and your family so that the best professional help can be located and utilized to help you establish a plan of action.

### EAP Areas of Service:

- ✓ Child care
- ✓ Legal resources
- ✓ Mental/Relationship issues
- ✓ Grief issues
- ✓ Stress management
- ✓ Work related issues
- ✓ Adult & elder dependent assistance
- ✓ Parenting issues
- ✓ Financial resources

The County recognizes that employees' personal responsibilities may, at times, spill over into the workplace. To help ensure employees are able to address these concerns with minimal disruption, the program provides employees and their family members assistance through a variety of ways including 3 face-to-face sessions per issue per year, telephonic consultation, online material/tools and webinars.

### Are Your Services Confidential?

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

### Cigna Behavioral Health

Customer Service: (877) 622-4327 | [www.cignabehavioral.com](http://www.cignabehavioral.com) | ID: CCBOCC



## Short Term Disability

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

### STD Plan Summary

- STD provides a benefit of 60% of your weekly earnings, to a maximum benefit of \$1,000 per week.
- The benefit begins on the 30th day after the employee experiences the disabling event.
- The maximum benefit period is 22 weeks.
- Employees unable to return to work after 22 weeks are automatically transitioned to Long Term Disability, if elected.
- The benefit amount will be offset by any other income received. You may not receive more than 60% total of all income combined.

*Please Note: If you do not elect this coverage when initially eligible, you will have to complete an evidence of insurability form if you elect it in the future. This form will ask you some basic medical history questions and will have to be approved prior to your coverage becoming effective.*

**STD Premium 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         |

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

## Long Term Disability

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

### Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of your monthly earnings, to a maximum benefit of \$3,500 per month.
- The benefit begins on the 181st day after the employee experiences the disabling event.
- 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 you are unable to perform your own occupation. After 24 months you are considered disabled if, solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified to perform.
- If you return to work part-time, a partial LTD benefit may be payable.
- The benefit amount will be offset by any other income received. You may not receive more than 60% total of all income combined.

*Please Note: If you do not elect this coverage when initially eligible, you will have to complete an evidence of insurability form if you elect it in the future. This form will ask you some basic medical history questions and will have to be approved prior to your coverage becoming effective.*

**LTD Premium Rate Table**

| Annual Salary | Monthly Salary | Benefit Per Month | Monthly Premium |
|---------------|----------------|-------------------|-----------------|
| \$15,000      | \$1,250.00     | \$750.00          | \$5.00          |
| \$20,000      | \$1,666.67     | \$1,000.00        | \$6.67          |
| \$25,000      | \$2,083.33     | \$1,250.00        | \$8.33          |
| \$30,000      | \$2,500.00     | \$1,500.00        | \$10.00         |
| \$35,000      | \$2,916.67     | \$1,750.00        | \$11.67         |
| \$40,000      | \$3,333.33     | \$2,000.00        | \$13.33         |
| \$45,000      | \$3,750.00     | \$2,250.00        | \$15.00         |
| \$50,000      | \$4,166.67     | \$2,500.00        | \$16.67         |
| \$55,000      | \$4,583.33     | \$2,750.00        | \$18.33         |
| \$60,000      | \$5,000.00     | \$3,000.00        | \$20.00         |
| \$65,000      | \$5,416.67     | \$3,250.00        | \$21.67         |
| \$70,000      | \$5,833.33     | \$3,500.00        | \$23.33         |



## 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         | \$921.83           |
| Employee + Child(ren) | \$1,988.43         |
| Employee + Spouse     | \$1,727.47         |
| Employee + Family     | \$2,184.49         |

### Supplemental Retiree Program

This 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 x \$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 Supplement are not eligible. The employee at the time of retirement 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 x \$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 the retiree's medical insurance is not with the County, a check will be issued on a monthly basis payable to the retiree. If the 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 the retiree and will be handled on an individual basis.

### Retiree Life Insurance

At retirement, if an 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 their term group Basic Life Insurance currently in force while employed with Charlotte County. For example, if an employee retires with \$50,000 group Basic Life Insurance in force, they 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.

### Retirement Options Booklet

The 2016-2017 Retirement Options Booklet is a resource that contains valuable information about various retirement options. If you would like a copy of the 2016-2017 Retirement Options Booklet please contact Risk Management.



## COBRA Benefits

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a Federal law that provides employees the opportunity to continue their existing group insurance coverage upon separation of service from the County. After electing your Health Insurance benefits at New Hire Orientation, you will be mailed an Initial COBRA Notice which explains your COBRA rights as a County employee. You and your covered dependent(s) may choose to elect COBRA if one 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,
- You become eligible for Medicare, or
- Your 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, you or your covered dependent will be notified of your right to continue coverage as well as the current COBRA premiums effective at that time. You or your dependent(s) will have 60 days in which to elect COBRA coverage. This election period will end on the later of (1) 60 days from the qualifying event, or (2) 60 days from the date the County notifies you of your 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         | \$921.83                 | \$18.44      | \$940.27              |
| Employee + Child(ren) | \$1,988.43               | \$39.77      | \$2,028.20            |
| Employee + Spouse     | \$1,727.47               | \$34.55      | \$1,762.02            |
| Employee + Family     | \$2,184.89               | \$43.69      | \$2,228.18            |

Administered through Conexis

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

## Medicare Supplemental Insurance

Medicare eligible retirees and employees may want to consider American Pioneer Group Medicare Supplemental Insurance as an alternate 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 your personal situation, a Medicare Supplemental Policy combined with your current Medicare coverage may provide you 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 above.

**Valery Insurance Agency**

Customer Service: (800) 330-8445 | [www.valeryagency.com](http://www.valeryagency.com)

## LegalShield & IDShield Insurance

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

### HIGHLIGHTS of LegalShield

**Advise 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

### HIGHLIGHTS of IDShield

**Monitor more of what matters** - We monitor your identity from every angle, not just your Social Security; **Counsel when you need it** - Our identity specialists are focused on protecting you 24/7; **Restore your identity completely** - IDShield is the only company with an exclusive partnership with Kroll, the worldwide leader in theft investigative services. If a compromise occurs, your licensed private investigator contacts you immediately and begins restoring your identity to exactly the way it was; **Includes a \$5 Million Service Guarantee.**

Enrollment in these services covers you, your spouse or domestic partner, and dependent children. See plan brochures for more information and details. Rates vary depending on plans selected. Information may be obtained from Risk Management, or directly from our LegalShield representatives, Jim and Andrea Carroll at 941-235-1770.



## Bob Pryor Employee Health Center

The Bob Pryor Employee Health Center (EHC) was 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 employees, spouses, children, 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 your employer. Employees still have 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 you if you may need a longer appointment.

Should you need access to the EHC without an appointment it is recommended that you call (877) 423-1330 or visit [www.carehere.com](http://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.***



### Health Center Hours of Operation

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

### Lab Hours

|          |                        |
|----------|------------------------|
| Monday   | 8:00 a.m. – 10:00 a.m. |
| Tuesday  | 8:00 a.m. – 10:00 a.m. |
| Thursday | 7:00 a.m. – 10:00 a.m. |
| Friday   | 8:00 a.m. – 10:00 a.m. |

**Bob Pryor Employee Health and Wellness Center/CareHere**

1050 Loveland Blvd., Port Charlotte, FL 33980

Phone: (877) 423-1330 | Phone: (941) 764-0301

[www.carehere.com](http://www.carehere.com)



## Bob Pryor Employee Health Center Services

### Save Money - Use the Bob Pryor Employee Health Center

#### Prescription Medications

The EHC uses 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, the staff will provide a prescription to take to the local pharmacy and purchase through the Cigna medical plan.

Schedule an appointment with one of the staff providers today to review your current prescriptions. Please Note: The Health Center is not a pharmacy. You are required to meet with the medical staff before a prescription can be dispensed for you 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 Orchard

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

#### Employee Cost for 90-Day Supply

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

### Advanced Imaging of Charlotte County

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

### Smoking Cessation - Self Paced

An employee may be supported with an online program, educational material, or reading material, and will work with a Health Coach to become tobacco free.

### Smoking Cessation - Beat the Pack and Kick the Can

The CareHere Tobacco Cessation program includes 8 weeks of group workshops. There will also be face to face group meetings and the provider may also request the County pay for Chantix.



## CareHere Registration

### Register to Use the EHC

1. Go to [www.carehere.com](http://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 you agree, check "I agree."
5. Identification: Enter the required information.
6. Enter your 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 you do not know the answer.

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

## CareHere Connect

CareHere Connect is an online wellness program. You can custom design a plan for your goals and earn points by completing tasks and improving your lifestyle. It is also a network to connect with others who are dealing with some of the same issues you're facing.

### CareHere Log In Instructions

1. Go to [www.carehere.com](http://www.carehere.com).
2. Click on "Member Login" and fill in your username and password and then click "Go."
3. At the left-hand side of the screen, you will find the CareHere "Connect" button. Click that button to start.
4. This will pull up a registration screen, click "Join Now."
5. Fill out the form with the requested information and click "Next" to get started.
6. On the home page, you will see an overview of the site.
7. My Plans: A plan is a set of recommendations to guide your day-to-day activities, helping you to achieve your goals.
8. My Targets: Targets will show how you're progressing with each goal.
9. My Updates: This tab displays important information, such as your overall accomplishments, Healthies™ earned and targets you are working toward.
10. Healthies™: Points can be earned by completing tasks and improving your lifestyle.
11. My Network: This tab tells you how others in your network are dealing with some of the same issues you are facing.

For more information refer to the Wellness Initiative Program Document available at Risk Management or online at:

**<http://charlottesweb/Risk/WellnessProgram>**

If you have questions, please contact the Wellness Coordinator.





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

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

**GEHRING GROUP**  
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[www.gehringgroup.com](http://www.gehringgroup.com)