



Please note: If you are enrolling eligible dependents (spouse, children, etc.) in ANY coverage or on a life insurance policy, you will need to bring proof of your relationship to them (marriage license for spouse, birth certificate for child, etc.) at the time you are enrolling in your benefits. The documents provided must be certified copies. You must enroll or waive coverage within the first 30 days from your hire date and you will not be able to enroll your dependents without proof of the relationship.



2021-2022

EMPLOYEE BENEFITS HIGHLIGHTS

Clerk of Court and Comptroller



CONTACTS

Office	Contact	Phone	Email
Clerk of Court and Comptroller	Laura McIver	(772) 226-3101	LMcIver@clerk.indian-river.org

HUMAN RESOURCES

Coverage	Carrier/Policy #	Phone	Website/Email
Medical Insurance	Florida Blue Group #: 90000	Customer Service: (800) 664-5295	www.floridablue.com
Express Scripts administered by RxBenefits, Inc. Retail & Mail Order	Express Scripts RXBIN: 610014 RXGRP: RXBINDI	Pharmacy Member Services: 800-334-8134 Pharmacist Helpdesk: 800-922-1557	www.express-scripts.com
Planned Surgery	SurgeryPlus	Customer Service: (833) 709-2444	irc@surgeryplus.com
Telemedicine Services	Teladoc	Customer Service: (800) 835-2362	www.Teladoc.com
Dental Insurance	Ameritas Group #: 41058	Customer Service: (800) 487-5553	www.ameritas.com
Vision Insurance	EyeMed	Customer Service: (866) 800-5457	www.eyemed.com
Flexible Spending Accounts	P&A Group	Customer Service: 1-800-688-2611	www.padmin.com
Life Insurance	Mutual of Omaha Group #: GLUG-AJFS	Customer Service: (800) 877-5176	www.mutualofomaha.com
Voluntary Long Term Disability Insurance	Mutual of Omaha Group #: GLUG-AJFS	Customer Service: (800) 877-5176	www.mutualofomaha.com
Employee Assistance Program	Health Advocate	Customer Service: (866) 799-2728	www.healthadvocate.com/ members
Supplemental Insurance	Aflac	Customer Service: (800) 992-3522	www.aflac.com
Diabetes Management Program	Kannact	Customer Service: (501) 200-5011	www.kannact.com/irc

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Indian River County Clerk of Court and Comptroller appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefits plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Any time you have questions about benefits or the enrollment process, you can contact your human resources representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD) at ircgov.com.



INTRODUCTION

The Indian River County Clerk of Court and Comptroller provides a comprehensive compensation package including group insurance benefits administered by Indian River County. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. If an employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service telephone numbers located on page 2 or contact Human Resources.

GROUP INSURANCE ELIGIBILITY

Employee Eligibility

Employees are eligible to participate in the Clerk's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first day of the month following 60 days of full-time employment. For example, if employee is hired on April 11, then effective date of coverage would be July 1.

Termination

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

FYI: The Clerk's group insurance plan year is October 1 through September 30.



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 stepchild
- A legally adopted child
- 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.
- Dental Coverage: Dependent children may be covered through the end of the calendar year in which they turn 26.
- Vision Coverage: Dependent children may be coverage through the end of the calendar year in which they turn 26.

Disabled Dependents

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

- The dependent is physically or mentally disabled and incapable of self-sustaining employment; 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 the Human Resources department if further clarification is required.





QUALIFYING EVENTS AND IRS CODE SECTION 125

IRS Code Section 125

Premiums for medical, dental, vision, and/or certain Aflac 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 an employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience a qualifying event and the request to make a change is made within 30 days of the qualifying event, or 60 days for the birth of a child.

Under certain circumstances, an 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 Service (IRS) 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 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)
- Enrollment in a qualified health plan offered through an Exchange during a special enrollment period
- Change in cost or need of childcare (Dependent Care FSA ONLY)

Important Notes

An employee who experiences a qualifying event must contact the benefits representative of the Human Resources department within 30 days of the event (60 days for birth of a child) to request the appropriate changes to coverage. Late requests will be denied. As a result of a qualifying event, changes are effective the date of the qualifying event. For newborns the change is effective on the date of birth. Cancellations will be processed at the end of the month except for divorce or death. Divorce or death, coverage will terminate the date following divorce or death. Employee will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Please Note

If an employee knowingly commits fraud by enrolling or continuing coverage for an ineligible person(s) in the Clerk's insurance program, the Clerk will take appropriate disciplinary action up to and including termination.

QUALIFYING EVENTS AND COBRA

Please remember the following: In order to enroll dependents on the Group Insurance plan, to maintain enrollment for those dependents in the coming year, or to enroll any new dependents in the Group Insurance plan during the open enrollment period, the employee may be required to provide documentation verifying the eligibility of such dependent(s).

Qualifying Event Q&A	
Can I add or delete dependent coverage and make changes to my benefit elections during the year?	A participant is permitted to make changes to his or her elections mid-plan year only for a legitimate Qualifying Event, meaning “on account of and corresponding with a Qualifying Event that affects eligibility for coverage.” If an employee experiences a Qualifying Event, the election changes must be requested within 30 days from the Qualifying Event date and the change must be consistent with the type of event. Based on the event, an employee may add or delete dependents to existing coverage.
If I experience a Qualifying Event, how and when must I request the change?	Within 30 days of the Qualifying Event the employee must notify Human Resources and will be asked to furnish supporting documentation. Upon the approval and completion of processing the election change request, the existing benefit elections will be stopped or modified. Requests made later than 30 days from the date of the event will not be approved.
If I add dependents due to a Qualifying Event, when does their coverage become effective?	Coverage for dependents becomes effective on the date of the Qualifying Event OR for all others, on the date of notification, subject to approval by Human Resources. The employee must notify Human Resources of the Qualifying Event within 30 days.
If I delete a dependent due to a Qualifying Event, when does their coverage end?	Coverage for a deleted dependent ends effective the last day of the month in which the Qualifying Event occurred. In the event of a death or divorce, coverage ends effective with the date of death or divorce. The employee must notify Human Resources of the Qualifying Event within 30 days.
If I waive the County’s healthcare coverage but then I lose my other group health coverage, can I enroll in a health plan mid-year?	Yes, an employee can enroll in a County plan mid-year if they have lost other group insurance coverage. The employee must notify Human Resources of the Qualifying Event within 30 days and may be asked to provide documentation.

Please Note: If an employee knowingly commits fraud by enrolling or continuing coverage for an ineligible person(s) in the Clerk’s insurance program, the Clerk will take appropriate disciplinary action up to and including termination.

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.



HEALTH ADVOCACY

Benefit for Employees Enrolled in the Medical Plan – Health Advocacy
Unlimited one-on-one support, 24/7

Resolution of complex claim and benefit issues

- Help members understand their benefits
- Sort out claims and billing issues; correct duplicate or erroneous charges
- Assist with filing an appeal with a health plan

Help locating the right care including second opinions

- Research and arrange second opinions and clinical trials
- Research credentials and availability of in-network physicians, hospitals, dentists and other healthcare providers
- Facilitate the transfer of medical records, X-rays and lab results

Support for medical issues or difficult diagnoses

- Help members understand diagnoses, tests, treatments and medications
- Coordinate care between physicians and insurance companies
- Research current literature to identify new treatment opportunities/cutting-edge services
- Provide health information to help members make the right decisions about their care

The whole family can use Health Advocate at no cost to you!

- Employees
- Spouses/Domestic Partners Dependents
- Parents and Parents-in-law
- Dependents

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Email: answers@HealthAdvocate.com
www.healthadvocate.com

MEDICAL INSURANCE

Medical Insurance is offered through Florida Blue to benefit eligible employees. The costs per pay period for coverage are listed in the premium table below. For information about the medical plan, please refer to the Summary of Coverage or contact Florida Blue's customer service.

Florida Blue BlueOptions Plan

24 Payroll Deductions

Tier of Coverage	Employee Cost
Silver Eligible Employee	\$7.50
Silver Employee + Family	\$103.75
Gold Eligible Employee	\$55.00
Gold Employee + Family	\$200.00

Other Available Plan Resources

Florida Blue 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 the Summary of Coverage document, or contact Florida Blue's customer service.

Florida Blue

Customer Service: 800.664.5295
www.floridablue.com

Locate A Provider

To search for a participating provider, contact customer service or visit www.floridablue.com.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is an important item in understanding the benefit options. The SBC is available online on the employee benefits portal. A free paper copy of the SBC document may be requested or is available as follows:

From: Human Resources Department
Address: 2000 16th Ave
Vero Beach, FL 32960
Phone: 772.226.3101
Email: Imciver@clerk.indian-river.org

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 Human Resources. If employees have any questions about the plan offerings or coverage options, please contact Human Resources.



Florida Blue BlueOptions Plan At-A-Glance

Product	BlueOptions	
Plan Number	Premier Gold Plan-03559	Premier Silver Plan-05302
Cost Sharing – Member’s Responsibility		
Calendar Year Deductible (DED)	Single/Family	Single/Family
In-Network (INN)	\$600/\$1,200	\$1,000/\$2,000
Out-of-Network	\$1,200/\$2,400	\$2,000/\$4,000
Coinurance (Member pays after Calendar Year Ded)		
In-Network	20%	30%
Out-of-Network	30%	40%
Calendar Year Out of Pocket Maximum	Single/Family	Single/Family
In-Network	\$3,000/\$6,000	\$6,000/\$12,000
Out-of-Network	\$4,000/\$8,000	\$8,000/\$16,000
Medical/Surgical Care by a Physician		
Office Services		
In-Network Family Physician	\$30 Copayment	\$40 Copayment
In-Network Specialist	\$50 Copayment	\$65 Copayment
Out-of-Network	DED + 30%	DED + 40%
Telemedicine Services		
In-Network General Medical	\$10 Copayment	\$10 Copayment
In-Network Dermatology	\$20 Copayment	\$20 Copayment
Out-of-Network	N/A	N/A
Allergy Injections (Office)		
In-Network Family Physician	\$5 Copayment	\$5 Copayment
In-Network Specialist	\$5 Copayment	\$5 Copayment
Out-of-Network	DED + 30%	DED + 40%
Convenient Care Center		
In-Network	\$30 Copayment	\$40 Copayment
Out-of-Network	DED + 30%	DED + 40%
Physician Services at Hospital		
In-Network	DED + 20%	INN DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 30%
Radiology, Pathology and Anesthesiology Provider Services at Hospital		
In-Network	DED + 20%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%
Preventive Services-Adult Wellness Services		
Office Services		
In-Network Family Physician/Specialist	No Charge	No Charge
Out-of-Network	30%	40%
Non-Hospital Services Freestanding Facility		
Clinical Lab (Blood Work): Quest**		
In-Network	No Charge	No Charge
Out-of-Network	DED + 30%	DED + 40%

X-rays (Independent Diagnostic Center)		
In-Network	\$15 Copayment	\$25 Copayment
Out-of-Network	DED + 30%	DED + 40%
Outpatient Hospital Facility (per visit) (Surgical)	Premier Gold Plan-03559	Premier Silver Plan-05302
In-Network	Option 1: DED + 20%	Option 1: DED + 30%
Out-of-Network	DED + 30%	DED + 40%
Emergency and Urgent Care		
Emergency Room Facility (per visit)		
In-Network	(Copayment Waived if Admitted) \$250 Copayment + DED + 20%	\$500 Copayment + DED + 30%
Out-of-Network	\$250 Copayment + INN DED + 20%	\$500 Copayment + INN DED + 30%
Urgent Care Centers		
In-Network	\$30 Copayment	\$40 Copayment
Out-of-Network	\$30 Copayment	\$40 Copayment
Ambulance		
In-Network	DED + 20%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%
Advanced Imaging (MRI, MRA, PET, CT and Nuclear Medicine)		
Physician Office		
In-Network Family Physician or Specialist	\$200 Copayment	30%
Out-of-Network	DED + 30%	DED + 40%
Independent Diagnostic Testing Center		
In-Network	\$200 Copayment	30%
Out-of-Network	DED + 30%	DED + 40%
Outpatient Hospital Facility		
In-Network	DED + 20%	DED + 30%
Out-of-Network	DED + 30%	DED + 40%
Mental Health/Alcohol and Substance Abuse Services		
Inpatient/Outpatient Hospital Facility	PAD (Per Admission Deductible)	PAD (Per Admission Deductible)
In-Network	PAD \$200 + DED + 20%	\$500 PAD + DED + 30%
Out-of-Network	PAD \$400 + DED + 30%	\$1,000 PAD + DED + 40%
Specialist Visits		
In-Network	\$45 Copayment	\$60 Copayment
Out-of-Network	DED + 30%	DED + 40%
Prescription Drugs (RX Administered through RX Benefits)		
1X Calendar Year Deductible Per Person	N/A	\$100 (must be met before Copayments apply)
Generic	\$10 Copay	\$5 Copayment
Preferred Brand Name	\$50 Copay	\$65 Copayment
Non-Preferred Brand Name	\$75 Copay	\$95 Copayment
Mail Order Drug (90-Day Supply)	Express Script 2x Retail Copay	Express Script 2x Retail Copay
Maintenance Medication	2X Copayment at Covered Pharmacies	2X Copayment at Covered Pharmacies

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 Summary of Coverage document.

**Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest, please be sure to confirm they are contracted with Florida Blue's BlueOptions Network prior to receiving services.



SURGERYPLUS

The SurgeryPlus benefit is included at no additional cost to you when you are enrolled in one of the County's group medical plans. SurgeryPlus is a comprehensive benefit that provides access to a premiere specialized network of high-performing surgeons for non-emergent, planned surgical procedures.

Freedom to Choose: When you are facing a planned surgery that is provided under SurgeryPlus, you can choose to use either the group medical plan through Florida Blue OR to use SurgeryPlus. When using SurgeryPlus, you will not have any deductible, copays, or coinsurance. The SurgeryPlus bills are paid at 100% by the County.

Labs, Testing, Physical Therapy, Durable Medical Equipment & Prescriptions: Pre-operative labs and testing will be done at your PCP or Quest and will be submitted to your current medical plan through Florida Blue. Additionally, follow-up care such as physical therapy, durable medical equipment and lab work will still be processed by the Florida Blue medical plan (subject to medical plan benefits) and necessary prescription drugs will be covered under RxBenefits through Express Scripts (subject to pharmacy plan benefits).

To learn more about SurgeryPlus,
call 833.709.2444 or
email them at irc@surgeryplus.com

No Enrollment Necessary

If you are covered under the County's medical plan, you have been automatically enrolled in this extra benefit at no additional cost. If you are planning a procedure, call SurgeryPlus at (833) 709-2444 and you could save thousands of dollars.

Save Money

If you choose to use the SurgeryPlus benefit, the County will waive your deductible and coinsurance, eliminating all out-of-pocket costs, including consultation, your surgical procedure and post-procedure appointments for up to 90 days.

The same dedicated care advocate manages the entire pathway of care for you.



Surgeon Selection

SurgeryPlus will recommend at least three of the best fitting surgeons for your individualized needs.



Scheduling

SurgeryPlus will book appointments, transfer medical records and manage logistics.



Advocacy

SurgeryPlus will listen and anticipate your surgery related needs.



Follow-up

SurgeryPlus will work to ensure your complete satisfaction.

TELEMEDICINE SERVICES THROUGH TELADOC

When You Don't Have Time to Wait, You've Got Teladoc!

Provides 24/7 Access to Care

When you or a family member don't feel well and your primary care doctor or your child's pediatrician can't see you right away, you can now get care within minutes without leaving home with Teladoc.

For a cost that's less than an urgent care or ER visit, Teladoc gives you 24/7/365 access to U.S. board-certified doctors by web, phone or mobile app. It's a more convenient and affordable option for quality general and even dermatological care. This service is included with your medical plan!

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Before you can start using this new service, you must set up your account with Teladoc. Set up your account today—so when you need care, a Teladoc doctor is just a call or click away. Just call Teladoc at 800-835-2362 or visit www.Teladoc.com to set up your account.

You can even download the mobile app for fast and convenient service. Just visit www.Teladoc.com/mobile or visit your app store.

Teladoc can help with many non-emergency illnesses, including:

- Sinus infection
- Flu
- Cough
- Sore throat
- Rash
- Allergies
- Upset stomach
- Nausea
- Other minor health issues and more

Teladoc

Customer Service: 800.835.2362

www.Teladoc.com

DENTAL INSURANCE

Ameritas Plans

Dental insurance is offered through Ameritas to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plans, please refer to Ameritas' summary plan document or contact Ameritas' customer service.

Ameritas

Customer Service: 800.487.5553

www.ameritas.com

24 Payroll Deductions

Tier of Coverage	Employee Cost	
	LOW Option	HIGH Option
Employee Only	n/a	\$0.00
Employee + Spouse	\$7.38	\$16.86
Employee + Child(ren)	\$11.58	\$23.68
Employee + Family	\$23.46	\$40.48

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 Classic (PPO) Network. These participating dental providers have contractually agreed to accept Ameritas' contracted fee or "allowed amount." This fee is the maximum amount an Ameritas dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

Out-of-network benefits are used when members receive services by a non-participating Ameritas Class (PPO) Network provider. Ameritas reimburses out-of-network services based on what it determines is the Maximum Allowable Benefit (MAB). The MAB 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 Ameritas reimburses (MAB) 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.

Calendar Year Deductible

LOW Option

The dental LOW Option plan requires a \$50 individual or a \$150 family in-network deductible, and a \$100 individual and \$300 family out-of-network deductible to be met before most benefits will begin. The deductible is waived for preventive services. The deductible does not apply to Class I Services.

HIGH Option

The dental HIGH Option plan requires a \$25 individual or a \$75 family in-network deductible, and a \$50 individual and \$150 family out-of-network deductible to be met before most benefits will begin. The deductible is waived for preventive services. The deductible does not apply to Class I Services.

Calendar Year Benefit Maximum

LOW Option

The maximum benefit the dental LOW Option plan will pay for each covered member is \$1,000 for in-network services.

HIGH Option

The maximum benefit the dental HIGH Option plan will pay for each covered member is \$1,500 for in-network.

Locate A Provider

To search for a participating provider, contact customer service or visit www.ameritas.com.

Dental Rewards Rollover

Dental Rewards (DR) allows an employee to carry over part of the unused annual maximum. An employee earns DR by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. An employee and their covered dependent(s) may accumulate rewards up to the maximum carry over amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member does not submit a dental claim during a benefit year, all accumulated rewards are lost for that year, but member can begin earning rewards again the very next year. In addition, if an employee stays in the PPO network, employee will earn extra DR called the PPO Bonus.

Dental Reward	LOW Option Amount	HIGH Option Amount	Description
Benefit Threshold	\$500	\$750	Dental benefits received for the year cannot exceed this amount.
Annual Carry Over Amount	\$250	\$400	Amount added to the following year's benefit maximum.
Annual PPO Bonus	\$100	\$200	Additional bonus is earned if the covered member sees a PPO provider.
Maximum Carry Over	\$1,000	\$1,200	Maximum possible accumulation for benefit rollover and PPO bonus combined.

Ameritas Plans At-A-Glance

Network	Classic (PPO) LOW Option		Classic (PPO) HIGH Option	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible (CYD)				
Per Member	\$50	\$100	\$25	\$50
Per Family	\$150	\$300	\$75	\$150
Waived for Class I Services?	Yes	Yes	Yes	Yes
Calendar Year Benefit Maximum				
Per Member	\$1,000	\$1,000	\$1,500	\$1,500
Class I Services: Diagnostic and Preventive				
Routine Oral Exam (1 Per 6 Months)	Plan Pays: 100% Deductible Waived	Plan Pays: 80% Deductible Waived (Subject to Balance Billing)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)
Routine Cleanings (1 Per 6 Months)				
Complete X-rays (1 Per 12 Months)				
Bitewing X-rays (1 Per 5 Years)				
Class II Services: Basic Restorative**				
Fillings (Amalgam and Composite)	Plan Pays: 80% After CYD	Plan Pays: 70% After CYD (Subject to Balance Billing)	Plan Pays: 100% After CYD	Plan Pays: 80% After CYD (Subject to Balance Billing)
Anesthesia				
Simple Extractions				
Root Canal/Endodontics				
Periodontal Services				
Denture Repair				
Class III Services: Major Restorative**				
Crowns	Plan Pays: 50% After CYD	Plan Pays: 40% After CYD (Subject to Balance Billing)	Plan Pays: 60% After CYD	Plan Pays: 50% After CYD (Subject to Balance Billing)
Bridges				
Dentures				
Oral Surgery				
Dental Implants				
Class IV: Major Orthodontia				
Lifetime Maximum	N/A	N/A	\$1,000	\$1,000
Benefit (Dependent Children to Age 19)	N/A	N/A	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)

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 for services rendered, please refer to the Out-of-Network Benefits section on page 12.

**Late entrant limitations apply for 12 months after enrollment if an employee does not elect coverage during their initial eligibility period. Please contact Ameritas for additional information.

Important Notes

- Each covered family member may receive up to two (2) cleanings per calendar year (1 per 6 months) covered under the preventive benefit.
- A pretreatment estimate is recommended for all work that is considered expensive. An employee must request that their dentist submit the request to Ameritas.
- Teeth missing prior to coverage under the Ameritas dental plan will not be covered.
- All services, including Class I, count toward the calendar year maximum.

VISION INSURANCE

EyeMed Vision Plan

Vision insurance is offered through EyeMed to benefit eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more information about the vision plan, including exclusions and stipulations, please refer to the carrier's benefit summary or contact EyeMed customer service.

24 Payroll Deductions

Tier of Coverage	Employee Cost
Employee Only	\$2.62
Employee + Spouse	\$4.98
Employee + Child(ren)	\$5.25
Employee + Family	\$7.71

EyeMed

Customer Service: 866.800.5457

www.eyemed.com

In-Network Benefits

The vision plan offers employee 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 also choose to receive services from vision providers who do not participate in the 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.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

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

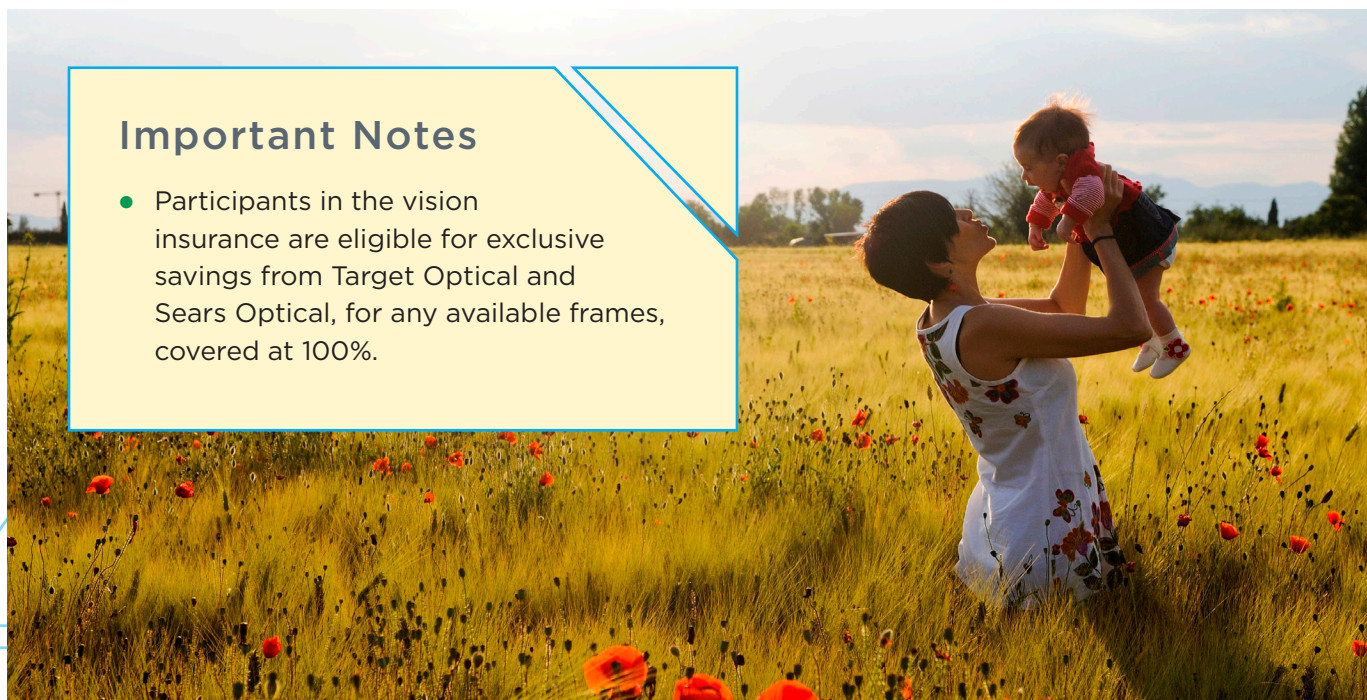


EyeMed Vision Plan At-A-Glance

Network	Insight	
	In-Network	Out-of-Network*
Services		
Eye Exam	\$10 copay	Up to \$40 Reimbursement
Frequency of Services		
Examination	12 Months	12 Months
Lenses	12 Months	12 Months
Frames	24 Months	24 Months
Contact Lenses	12 Months	12 Months
Lenses		
Single	\$25 Copay	Up to \$30 Reimbursement
Bifocal		Up to \$50 Reimbursement
Trifocal		Up to \$70 Reimbursement
Frames		
Allowance	\$0 Copay, \$150 allowance, 20% Off Balance Over \$150	Up to \$91 Reimbursement
Contact Lenses		
Non-Elective (Medically Necessary; With Prior Authorization)	Covered at 100%	Up to \$210 Reimbursement
Elective Lenses	\$0 Copay, \$130 allowance, 15% Off Balance Over \$130	Up to \$130 Reimbursement
LASIK		
Discount Programs	15% Off Retail Price or 5% Off the Promotional Price	N/A

Important Notes

- Participants in the vision insurance are eligible for exclusive savings from Target Optical and Sears Optical, for any available frames, covered at 100%.



FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending accounts (FSA) are administered through P&A Group. The FSA plan year is from October 1 to September 30.

If an employee or family member 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 their paycheck for reimbursement of health care and day care expenses employee regularly pays. 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 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 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 \$2,750. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. 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.

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 and Vaccinations
- Lasik Surgery
- Mental Healthcare
- Nursing Services
- Optometrist Fees
- Physician Office Visits
- Prescription Drugs
- Sunscreen SPF15 or Greater
- Wheelchairs

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



Dependent Care FSA

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

Please note that if a family's income is over \$20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents 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 the participant's household.

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

FSA Guidelines

- The Health Care FSA allows a grace period (December 15) at the end of the plan year. The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends. Once the grace period ends, any unused funds still remaining in the account will be forfeited.
- The Health Care FSA has a deadline of January 31 to file claims for expenses incurred through the end of the grace period (December 15)
- The Dependent Care FSA has a deadline of January 31 to file claims for expenses incurred through the end of the plan year.
- Any unused funds after a plan year ends and all claims have been filed cannot be returned or carried forward to the next plan year.
- When a plan year ends and all claims have been filed, all unused funds will be forfeited and will not be returned.
- Employee 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.
- Employee and dependent(s) cannot be reimbursed for services they have not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.

Filing a Claim

Claim Form

Go to www.padmin.com. In the login box, make sure “participant” is selected under “user type” and “Reimbursement Accounts” is selected under account type. Click “Go to Login” and enter your username and password. In the My Benefits portal, click Upload Claim/Documentation. Using the drop-down menu, select New Claim. Next, you will be prompted to choose from which account you are requesting reimbursement. Enter the service dates and dollar amount request. Upload an attachment if needed. View summary of uploaded claims and once you are finished uploading your claims, click Submit Claim. A confirmation containing a UPV number will be sent to your e-mail address we have on file.

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.

Here's How It Works!

An employee earning \$30,000 elects to place \$1,000 into a Health Care FSA. The payroll deduction is \$38.46 based on a 26 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 a Health Care FSA	Without a Health Care FSA
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	

Please Note: Be conservative when estimating medical and/or dependent care expenses. IRS regulations state any unused funds which remain in the FSA after a plan year ends and after all claims have been filed cannot be returned or carried forward to the next plan year. This rule is known as “use it or lose it.”

P&A Group

1.800.688.2611

www.padmin.com





BASIC LIFE AND AD&D INSURANCE

Basic Term Life and Accidental Death and Dismemberment

Basic Term Life and Accidental Death and Dismemberment (AD&D) insurance is offered through Mutual of Omaha to benefit eligible employees. This insurance is provided to employees at no cost at an amount equal to one times annual earnings (rounded to the next higher multiple of \$1,000) to a maximum of \$200,000. Coverage will reduce to 50% at age 70. Coverage cancels at termination of employment.

Voluntary Life and AD&D Coverage

Employee Coverage Amount

- An employee may elect Voluntary Life and AD&D coverage in units of \$10,000 up to a maximum of ten times an employee's annual salary, not to exceed \$500,000.
- Each year at Open Enrollment, employees currently enrolled in coverage may increase coverage by \$10,000, up to the Guarantee Issue Amount of \$150,000 without going through medical underwriting (age banded Life coverage only)
- Employees who apply for Voluntary Life and AD&D over ten times employee's salary, up to \$150,000 (the Guaranteed Issue Amount), will be subject to medical underwriting approval for the excess amount during initial enrollment or subsequent Open Enrollment periods.
- Coverage will reduce to 50% of the benefit amount at age 70. Coverage terminates at termination of employment.
- All late applications are subject to medical underwriting approval.

Spouse Coverage Amount

- An employee may elect coverage for spouse in increments of \$5,000 to a maximum of \$250,000, not to exceed 100% of the employee's benefit.
- If the Spouse Voluntary Life Insurance amount exceeds \$20,000 (the Guarantee Issue Amount), the excess amount will be subject to medical underwriting approval during initial enrollment or subsequent Open Enrollment Periods.
- Coverage will reduce to 50% of the benefit amount at age 70. Coverage terminates when the employee terminates employment (or reaches age 100 if the employee is still actively employed).
- All late applications are subject to medical underwriting approval.
- Please note, the age/rate table is based on the employee's age.

Please Note: An employee who does not elect this coverage when initially eligible, will have to complete an evidence of insurability form if electing coverage now or in the future. This form will ask some basic health history questions and will have to be approved prior to coverage becoming effective.

Voluntary Life Rate Table

Rate Per \$1,000 of Benefit

Age Bracket	Voluntary Life Rate
Under Age 25	\$0.06
25-29	\$0.07
30-34	\$0.08
35-39	\$0.11
40-44	\$0.16
45-49	\$0.26
50-54	\$0.41
55-59	\$0.71
60-64	\$0.76
65-69	\$1.30
70-75	\$2.30
75+	\$8.73

Coverage Amount for Child(ren)

- An employee may elect coverage for child(ren) in the amount of \$10,000 (the Guarantee Issue Amount). Child(ren) may be covered from birth to age 21, or 25 if a full time student).

Child(ren) Life with AD&D Rates

The monthly rate per member is \$0.64 for \$10,000 of Dependents Life insurance for eligible child(ren) regardless of the number of children covered.

Always remember to keep beneficiary forms updated.
Employee may update beneficiary information at
anytime throughout the year.



Mutual of Omaha

Customer Service:
 800.775.8805

www.mutualofomaha.com

Example

	÷ 1,000 =		x		=		x 12 =		÷ 24 =	
Benefit Election Premium				Rate by Age (in table)				Pay Periods	Per Pay Period Premium	

VOLUNTARY LONG TERM DISABILITY

Voluntary Long Term Disability (VLTD) insurance is offered through Mutual of Omaha to all eligible employees. The VLTD benefit pays an employee a percentage of earnings if the employee becomes disabled due to an accident or injury. The premium is calculated based on an employee's annual earnings; examples are illustrated in the VLTD premium rate table. An employee's VLTD rate and benefit will be adjusted annually on the plan anniversary date.

Mutual of Omaha

Customer Service:
800.775.8805

www.mutualofomaha.com

Voluntary Long Term Disability (VLTD) Plan Summary:

- The VLTD benefit pays 60% of monthly pre-disability earnings up to a monthly maximum benefit amount of \$5,000.
- The VLTD benefit begins on the 91st or 181st day following the disabling event.
- VLTD benefits are payable to age 65 or are based on a reduced benefit duration if the employee is disabled at or after the age of 62.
- If an employee returns to work part time, a partial VLTD benefit may be payable.

Please Note: An employee who does not elect this coverage when initially eligible, will have to complete an evidence of insurability form if electing coverage now or in the future. This form will ask some basic health history questions and will have to be approved prior to coverage becoming effective.

Voluntary Long Term Disability Elimination Period

	90 Day	180 Day
Age	Rate Per \$100 covered Payroll	
< 19	\$0.100	\$0.081
20 - 24	\$0.100	\$0.081
25 - 29	\$0.100	\$0.081
30 - 34	\$0.176	\$0.143
35 - 39	\$0.217	\$0.181
40 - 44	\$0.315	\$0.263
45 - 49	\$0.488	\$0.407
50 - 54	\$0.716	\$0.598
55 - 59	\$0.865	\$0.721
60 - 64	\$0.902	\$0.751
65 - 69	\$0.902	\$0.751
70 - 99	\$0.902	\$0.751

Example

\$	÷ 12 = \$	÷ 100 =	= \$	× 12 = \$	÷ 24 = \$
Annual Salary	or \$8,333*	Rate by Age (in table)		Pay Periods	Per Pay Period Premium
(whichever is less)					

*Benefit is 60% of monthly earnings up to maximum of \$5,000 per month.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

A comprehensive Employee Assistance Program (EAP) is offered to full-time, part-time and temporary employees and family member(s) through Health Advocate, at no cost to the employee. Health Advocate offers access to licensed mental health professionals through a confidential program protected by state and federal laws. The EAP program is available to help employees gain a better understanding of problems, locate the best professional help for their particular problem, and decide upon a plan of action.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employee and family member(s) free and convenient access to a range of confidential and professional services to help address a variety of problems that can negatively affect their well-being such as:

- Anxiety
- Legal and Financial Concerns
- Childcare, Eldercare, Adoption
- Family and/or Marriage Problems
- Stress
- Grief and Bereavement
- Substance Abuse
- Workplace Issues

What is Health Advocate Works?

The Clerk recognizes that employees' personal responsibilities may, at times, spill over into the workplace. To help ensure an employee is able to address these concerns with minimal disruption, the program provides employee and family member(s) assistance for a variety of concerns – including child care, elder care, daily-living issues, and other issues they may encounter. Each employee and family member is allowed one to six in-person counseling sessions per issue per year. There is no limit to the number of issues. Unlimited telephone and web-based sessions are also available.

Are 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), 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 will not, however, receive specific information regarding the referred employee's case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Health Advocate

Customer Service: 866.799.2728

Website: www.healthadvocate.com/members

Organization Name: Indian River County

Government



SUPPLEMENTAL INSURANCE

Plans may be purchased separately on a voluntary basis and premiums are paid through payroll deduction. The following plans are offered to employees:

Personal Accident Indemnity Plan

Provides an employee with cash if employee or a covered dependent receives treatment for injuries sustained in a covered accident. This policy provides an emergency treatment benefit, specific-sum injuries benefit, initial hospitalization benefit and even accidental death benefit.

Personal Cancer Indemnity Plan

Provides an employee with cash benefits if employee or covered dependent is diagnosed with an internal cancer or skin cancer. This policy gives an employee an initial diagnosis benefit, hospital confinement benefit, radiation and chemotherapy benefit, surgical/anesthesia benefit, as well as ambulance, transportation and lodging benefits.

Personal Disability Policy

Provides an employee with a source of income if unable to work due to an off-the-job injury or a covered sickness. Now with the option of guaranteed-issue. Monthly benefits range from \$500-\$6,000, subject to income requirements and benefit period restrictions. Available benefit periods are 3, 6, 12, 18, or 24 months. Available elimination periods are (Accident/Sickness): 0/7, 0/14, 7/7, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90 or 180/180.

Critical Care and Recovery Plan

Provides an employee with cash benefits if employee or covered dependent has a hospital stay as a result of a heart attack, stroke, coronary bypass surgery, end-stage renal failure, major third degree burns and continuing care benefit.

Hospital Confinement Plan

Provides an employee with cash benefits, if the employee or covered dependent receive services in the hospital, such as hospital confinement, hospital emergency room or upon hospital exit is in a rehab facility. This plan can also include benefits for physician visits, medical diagnostics and imaging services, ambulance transport and intensive care unit.

Vision Plan

Provides an employee with cash benefits when an employee or covered dependent receives an eye exam. Also pays benefits for vision correction materials, eye surgeries, specific eye diseases, and permanent visual impairment.

Aflac

Customer Service: 800.992.3522
Website: www.aflac.com

- Agent: John Martin
Phone: 772.532.1362
Email: john_martinsr@us.aflac.com

RETIREMENT PLANS

Florida Retirement System (FRS)

The Clerk is a member of the Florida Retirement System (FRS) and pays a percentage of employees' salaries to FRS as shown below. Employee has a choice of participating in one of two plans: the pension plan or the investment plan, funded by:

Contribution Rate	Employee Pays	Employer Pays	Total Percentage
Regular Class	3.00%	10.82%	13.82%

457 Deferred Compensation and Roth 457 Deferred Compensation

The 457 Deferred Compensation Plan is voluntary retirement plan. Contributions to this plan are made on a tax deferral, so the money is not taxable until the employee takes a distribution.

The Roth 457 Deferred Compensation Plan is voluntary. Contributions to this plan are made post tax, so the money is not taxable when an employee takes a distribution (provided an employee meets the IRS requirements at the time of distribution) to complement FRS and Social Security. For both the 457 Deferred Compensation and Roth 457 Deferred Compensation, the maximum contribution for 2021 is \$19,500 (\$26,000 for "Age 50 Catch Up Provision" and \$39,000 under "Normal Catch Up Provision").

Please be advised that the limits apply to all contributions made to the 457 Deferred Compensation Plan and Roth 457 Deferred Compensation Plan. Please consult a financial advisor for more information.



KANNACT – DIABETES MANAGEMENT

Expanded Program with added benefits!

Employees or covered dependent(s) who have been diagnosed with Type 2 Diabetes and are covered on the County's health plan, receive access to Kannact Diabetes Management as an available benefit for Diabetes support and supplies. Kannact gives you the tools, support, and confidence you need to better manage your Diabetes and make changes that last. Participants receive a **dedicated** expert health coach to assist with questions about Diabetes care management and understanding your health. Kannact's personal coaches meet you where you are and help you set and reach goals, adjust your diet, find an exercise routine you'll love and provide ongoing encouragement and support. Coaching and supplies are provided to you at no cost!

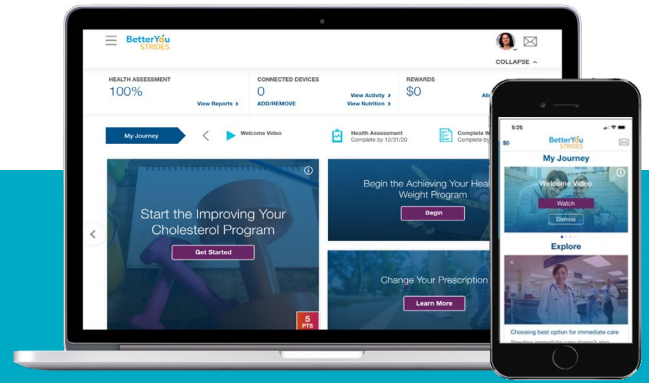
When you enroll in the Kannact program, you will receive a Bluetooth-enabled glucometer for real-time data sharing with your health coach, test strips, and lancing devices all delivered straight to your door. Participation in the program is confidential and voluntary, will save you money on supplies and copays while helping you become the best version of yourself.

Kannact

501.200.5011

www.kannact.com/irc

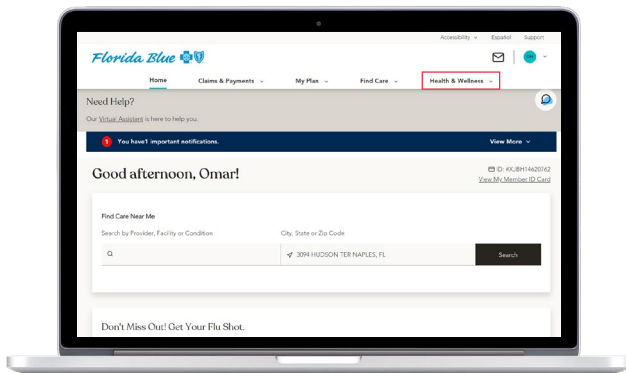
Start Your Journey to Better Health!



Take strides toward better health today.

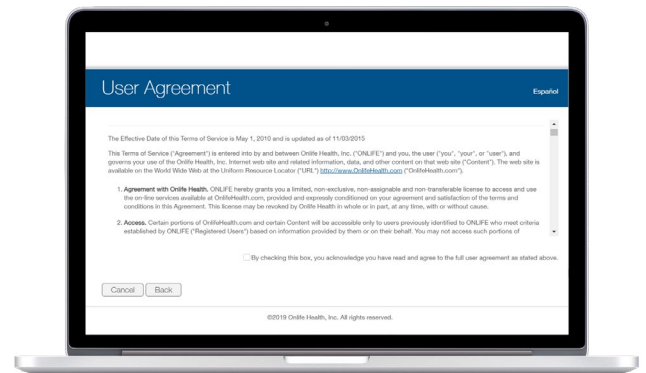
Register now for Better You Strides, a personal wellness program that creates a custom-made plan to help you meet your health and wellness goals. Registering takes just a few steps.

Online



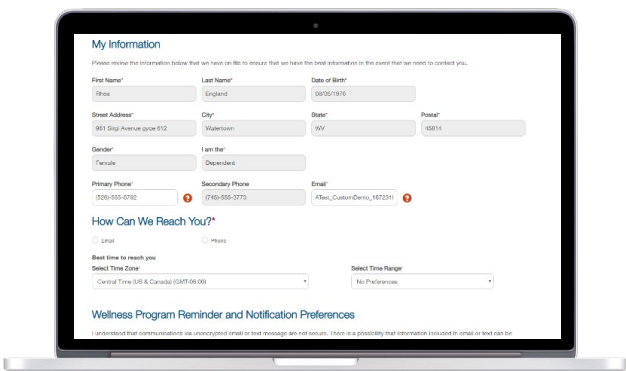
Step 1.

Log in to your member account at floridablue.com. Click **Health & Wellness**, then **Better You Strides**.



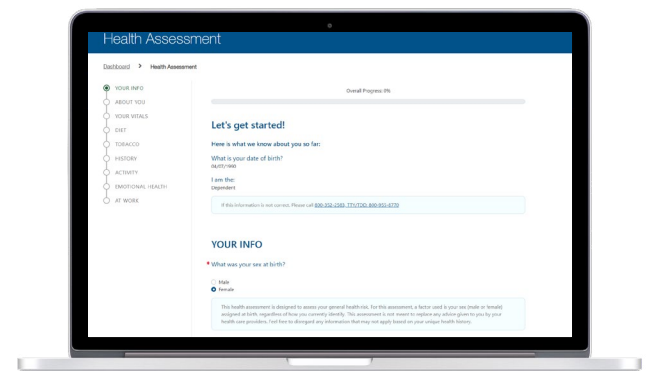
Step 2.

Read and Accept the Terms of Service.



Step 3.

Choose your communications preferences.



Step 4.

Complete your Personal Health Assessment.

QUESTIONS?

Give us a call at **800-352-2583**.

Introduction:

IRCMeds is a voluntary international prescription drug program that is available to eligible employees, retirees and their dependents of Indian River County, FL. For your convenience, a list of eligible medications is located on the back of this page.

Copayments:

All member copayments have been waived for this program only.

IRCMeds		Vs.		Current Purchase Plan			
Annual Cost No Copays!		Plan		Current Retail Copays		Refills	Annual Savings
\$0	Vs.	Premier Gold		\$50 (Preferred Brand)	x	12	= \$600 / Script
				\$75 (Non-Preferred Brand)	x	12	= \$900 / Script
	Vs.	Premier Silver		\$65 (Preferred Brand)	x	12	= \$780 / Script
				\$95 (Non-Preferred Brand)	x	12	= \$1140 / Script

Ordering Instructions:

To place your first order please submit: a completed enrollment form; a new prescription for each medication; and a copy of your photo identification*.

**Similar to a number of states in the US, some Canarx pharmacies require a copy of photo ID be provided prior to dispensing the medications. In order to prevent order delays, we encourage patients to include a clear copy of their photo identification with their enrollment form or upload directly to our secure site www.CanarxDocs.com. If not included, a Canarx representative will contact you when required by the pharmacy dispensing your medications.*

Ask your doctor for a prescription for a **3 month supply** with **3 refills**. We will call you prior to each renewal to ensure that you have a continuous supply. Please allow 4 weeks for delivery.

Medications must be tried for 30 days before ordering through **IRCMeds**.

RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:



BY FAXING TO: 1-866-715-MEDS (6337) TOLL FREE

Faxed prescriptions are ONLY accepted if sent directly from the physician's office.

OR



BY MAILING TO: IRCMeds

235 Eugenie St. West
Suite 105D
Windsor, ON, Canada
N8X 2X7

OR

P.O. Box 3009
Windsor, ON, Canada
N8N 2M3



Receive a one-time **\$25 Gift Card** for enrolling in the **IRCMeds** program with a qualifying prescription for a 90 day supply with 3 refills!

**Offer available to new program members only.*



More forms are available:

Additional forms may be obtained by printing them from the website at www.IRCMeds.com or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

WELCOME TO IRCMeds

ABILIFY (G) 2MG ABILIFY (G) 5MG ABILIFY (G) 10MG ABILIFY (G) 15MG ABILIFY (G) 200MG ABILIFY (G) 30MG ACTONEL 5MG ACTONEL 30MG ACTONEL 35MG ACTONEL 150MG ACTOPLUS 15MG-850MG ACULAR (G) 0.5% ACULAR LS (G) 0.4% ACZONE 5% ADCIRCA 20MG ADVAIR DISKUS 100MCG ADVAIR DISKUS 250MCG ADVAIR DISKUS 500MCG ADVAIR HFA 45/21MCG ADVAIR HFA 115/21MCG ADVAIR HFA 230/21MCG ALOCRIL 2% ALOMIDE 0.1% ALPHAGAN-P 0.15% ALREX 0.2% ALVESCO 80MCG 100MCG ALVESCO 160MCG 200MCG ANORO ELLIPTA 62.5/25MCG APTIOM 200MG APTIOM 400MG APTIOM 600MG APTIOM 800MG ARAVA (G) 10MG ARAVA (G) 20MG ARCAPTA NEOHALER 75MCG ARNUITY ELLIPTA 100MCG ARNUITY ELLIPTA 200MCG AROMASIN 25MG ARTHROTEC 50MG ARTHROTEC 75MG ASACOL HD 800MG ASMANEX TWISTHALER 110MCG ASMANEX TWISTHALER 220MCG ASTAGRAF XL 1MG ASTAGRAF XL 5MG ASTELIN 137MCG ATACAND 4MG ATACAND 8MG ATACAND 16MG ATACAND 32MG ATACAND HCT 16MG/12.5MG ATACAND HCT 32MG/12.5MG ATELVIA DR 35MG ATROVENT HFA 20UG AUBAGIO 14MG AVANDIA 2MG AVANDIA 4MG AVODART (G) 0.5MG AXERT 12.5MG AZILECT 0.5MG AZILECT 1MG AZOPT 1% AZOR 20/5MG AZOR 40/5MG AZOR 40/10MG BANZEL 200MG BANZEL 400MG BENICAR (G) 20MG BENICAR (G) 40MG BENICAR HCT (G) 20MG/12.5MG BENICAR HCT (G) 40MG/12.5MG BENICAR HCT (G) 40MG/25MG BETIMOL 0.25% BETIMOL 0.5% BINOSTO 70MG BREO ELLIPTA 100/25MCG BREO ELLIPTA 200/25MCG BRILINTA 60MG BRILINTA 90MG BYSTOLIC 2.5MG BYSTOLIC 5MG BYSTOLIC 10MG	BYSTOLIC 20MG CARDURA XL 4MG CARDURA XL 8MG CELEBREX 100MG CELEBREX 200MG CLIMARA PATCH 25MCG CLIMARA PATCH 50MCG CLIMARA PATCH 75MCG CLIMARA PATCH 100MCG COMBIGAN 0.2-0.5% COMBIVENT RESPIMAT 20MCG/100MCG COMTAN 200MG CRESTOR (G) 5MG CRESTOR (G) 10MG CRESTOR (G) 20MG CRESTOR (G) 40MG CYMBALTA (G) 20MG CYMBALTA (G) 30MG CYMBALTA (G) 60MG DALIRESP 500MCG DEXILANT DR 30MG DEXILANT DR 60MG DIFFERIN CREAM 0.1% DIFFERIN GEL 0.1% DIFFERIN GEL 0.3% DIOVAN (G) 40MG DIOVAN (G) 80MG DIOVAN (G) 160MG DIOVAN (G) 320MG DIPROLENE OINT 0.05% DIVIGEL 0.25MG DIVIGEL 0.5MG DIVIGEL 1MG DUAVEE 0.45-20MG DULERA 100MCG/5MCG DULERA 200MCG/5MCG DYMISTA 137/50MCG EDARBI 40MG EDARBI 80MG EDARBYCLOR 40MG/12.5MG EDARBYCLOR 40MG/25MG EDECRIN 25MG EFFIENT (G) 5MG EFFIENT (G) 10MG ELIDEL 1% ELIQUIS 2.5MG ELIQUIS 5MG ELMIRON 100MG ENABLEX 7.5MG ENABLEX 15MG ENTOCORT 3MG ENTRESTO 24MG-26MG ENTRESTO 49MG-51MG ENTRESTO 97MG-103MG EPIDUO GEL PUMP 0.1%/2.5% EPIPEN 0.3MG EPIPEN JR 0.15MG EPIVIR/HBV 100MG ESTROGEL 0.06% EUCRISA 2% EVISTA 60MG EXELON 3MG EXELON 6MG EXELON 4.6MG/24HR EXELON 9.5MG/24HR EXELON 13.3MG/24HR EXFORGE HCT 160/12.5/5MG EXFORGE HCT 160/12.5/10MG EXFORGE HCT 160/25/5MG EXFORGE HCT 320/25/10MG FARESTON 60MG FARXIGA 5MG FARXIGA 10MG FELDENE 10MG FELDENE 20MG FETZIMA 20MG FETZIMA 40MG FETZIMA 80MG FETZIMA 120MG FINACEA GEL 15% FLAREX 0.1% FLOVENT 44MCG 50MCG FLOVENT 110MCG 125MCG FLOVENT 220MCG 250MCG FLOVENT DISKUS 100MCG	FLOVENT DISKUS 250MCG FOSRENOL CHEW 500MG FOSRENOL CHEW 750MG FOSRENOL CHEW 1000MG FOSRENOL POWDER 750MG FOSRENOL POWDER 1000MG GENVOYA 150-150-200-10MG GILENYA 0.5MG GLUCAGEN HYPOKIT 1MG GLYXAMBI 10MG/5MG GLYXAMBI 25MG/5MG IMITREX AUTOINJECTOR STATDOSE 6MG/0.5ML IMITREX NASAL SPRAY 5MG-2DOSE IMITREX NASAL SPRAY 20MG-2DOSE INCRUSE ELLIPTA 62.5MCG INVEGA 3MG INVEGA 6MG INVEGA 9MG INVOKAMET 50MG-500MG INVOKAMET 50MG-1000MG INVOKAMET 150MG-500MG INVOKAMET 150MG-1000MG INVOKANA 100MG INVOKANA 300MG IRESSA 250MG JALYN 0.5MG/0.4MG JANUMET 50/500MG JANUMET 50/1000MG JANUMET XR 50MG/500MG JANUMET XR 50MG/1000MG JANUMET XR 100MG/1000MG JANUVIA 25MG JANUVIA 50MG JANUVIA 100MG JARDIANCE 10MG JARDIANCE 25MG JENTADUETO 2.5MG-500MG JENTADUETO 2.5MG-850MG JENTADUETO 2.5MG-1000MG KAZANO 12.5/1000MG KEPPRA (G) 250MG KEPPRA (G) 500MG KEPPRA (G) 750MG KEPPRA (G) 1000MG KOMBIGLYZE XR 2.5MG/1000MG KOMBIGLYZE XR 5MG/500MG KOMBIGLYZE XR 5MG/1000MG LATUDA 20MG LATUDA 40MG LATUDA 60MG LATUDA 80MG LATUDA 120MG LESCOL XL 80MG LEXIVA 700MG LIALDA 1.2GM LINZESS 72MCG LINZESS 145MCG LINZESS 290MCG LOCOID LIPOCREAM 0.1% LOTEMAX GEL 0.5% LOTEMAX OINT 0.5% LOTEMAX SUSP 0.5% LOTRISONE CREAM (G) 1%/0.05% LOVENOX 40MG LOVENOX 60MG LOVENOX 80MG LOVENOX 100MG LUMIGAN 0.01% MESNEX 400MG MESTINON TS 180MG METRO CREAM 0.75% METROGEL PUMP 1% MICARDIS HCT 40/12.5MG MICARDIS HCT 80/12.5MG MICARDIS HCT 80/25MG MIGRANAL 4MG/ML MOTEGRITY 1MG MOTEGRITY 2MG MULTAQ 400MG MYRBETRIQ 25MG	MYRBETRIQ 50MG NAMENDA 10MG NASONEX 50MCG NESINA 6.25MG NESINA 12.5MG NESINA 25MG NEUPRO 1MG NEUPRO 2MG NEUPRO 3MG NEUPRO 4MG NEUPRO 6MG NEUPRO 8MG NEXIUM 20MG NEXIUM 40MG NEXIUM DR 10MG ONGLYZA 2.5MG ONGLYZA 5MG ORILISSA 150MG ORILISSA 200MG OTEZLA 30MG PATADAY 0.2% PATANOL 0.1% PAZEO 0.7% PENTASA 500MG PRADAXA 75MG PRADAXA 150MG PRED FORTE 1% PREMARIN 0.3MG PREMARIN 0.625MG PREMARIN 1.25MG PREMARIN CREAM 0.625MG/GM PREMPRO 0.3MG/1.5MG PREZISTA 800MG PRISTIQ 50MG PRISTIQ 100MG PROMETRIUM 100MG PROTOPIC OINT 0.03% PROTOPIC OINT 0.1% QTERN 10-5MG QVAR REDHALER 40MCG QVAR REDHALER 80MCG RANEXA 500MG RAPAFLO 4MG RAPAFLO 8MG RAPAMUNE 0.5MG RAPAMUNE 2MG RELPAX 20MG RELPAX 40MG RENAGEL 800MG RENVELA 800MG RESTASIS VIALS 0.05% RETIN A MICRO GEL PUMP 0.04% RETIN-A MICRO GEL PUMP 0.1% REXULTI 0.25MG REXULTI 0.5MG REXULTI 1MG REXULTI 2MG REXULTI 3MG REXULTI 4MG SAPHRIS 5MG SAPHRIS 10MG SEASONIQUE 0.15/0.03/0.01MG SENSIPAR 30MG SENSIPAR 60MG SEREVENT DISKUS 50MCG SIMBRINZA 1%/0.2% SOOLANTRA 1% SPIRIVA 18MCG SPIRIVA RESPIMAT 2.5MCG STARLIX 60MG STARLIX 120MG STIOLTO RESPIMAT 2.5/2.5MCG STRIBILD SYNAREL NASAL SYNJARDY 5MG/500MG SYNJARDY 5MG/1000MG SYNJARDY 12.5MG/500MG SYNJARDY 12.5MG/1000MG TARKA 2/180MG TARKA 4/240MG TASMAR 100MG TAZORAC CREAM 0.05%	TAZORAC CREAM 0.1% TAZORAC GEL 0.05% TAZORAC GEL 0.1% TECFIDERA 120MG TECFIDERA 240MG TEKTURN 150MG TEKTURN 300MG TEKTURN HCT 150-25MG TEKTURN HCT 300-12.5MG TEKTURN HCT 300-25MG TIVICAY 50MG TOBREX OINT 0.3% TOVIAZ 4MG TOVIAZ 8MG TRADJENTA 5MG TRAVATAN Z 0.004% TRELEGY ELLIPTA 100-62.5-25MCG TRIBENZOR 20/5/12.5MG TRIBENZOR 40/5/12.5MG TRIBENZOR 40/5/25MG TRIBENZOR 40/10/12.5MG TRIBENZOR 40/10/25MG TRILEPTAL (G) 600MG TRINTELLIX 5MG TRINTELLIX 10MG TRINTELLIX 20MG TRIUMEQ 600-50-300MG TUDORZA PRESSAIR 400MCG TWYNSTA 40/5MG TWYNSTA 40/10MG TWYNSTA 80/5MG TWYNSTA 80/10MG ULORIC 80MG UROCI-K 10MEQ URSO 250MG VAGIFEM 10MCG VECTICAL 3MCG/GM VENTOLIN HFA 90MCG VESICARE 5MG VESICARE 10MG VIIBRYD 10MG VIIBRYD 20MG VIBRYD 40MG VIREAD 300MG VIVELLE-DOT 25MCG VIVELLE-DOT 37.5MCG VIVELLE-DOT 50MCG VIVELLE-DOT 75MCG VIVELLE-DOT 100MCG VRAYLAR 1.5MG VRAYLAR 3MG VRAYLAR 4.5MG VRAYLAR 6MG VYTORIN 10/10MG VYTORIN 10/20MG VYTORIN 10/40MG VYTORIN 10/80MG WELCHOL 625MG WELCHOL PACKET 3.75G WELLBUTRIN XL (G) 300MG XADAGO 50MG XADAGO 100MG XARELTO 2.5MG XARELTO 10MG XARELTO 15MG XARELTO 20MG XELJANZ 5MG XELJANZ XR 11MG XIGDUO XR 5/1000MG XIGDUO XR 10/500MG XIGDUO XR 10/1000MG XIIDRA 5% YASMIN 28 YAZ 3/0.02MG ZOMIG (G) 2.5MG ZOMIG NASAL SPRAY 5MG ZOVIRAX CREAM 5%
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NOTE: Medication names appearing with (G) are available in a Generic version from your local or U.S. mail order pharmacy. This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.



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The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.