EMPLOYEE BENEFITS

CLERK OF COURT AND COMPTROLLER

2023-2024

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.

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

Coverage	Carrier/Policy #	Phone	Website/Email
Medical Insurance	Blue Cross Blue Shield of Florida	Customer Service: (800) 830-1501	www.MyHealthToolkitFL.com
Health Advocacy	HealthAdvocate	Customer Service: (866) 799-2728	www.healthadvocate.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	Surgery Plus	Customer Service: (833) 709-2444	irc@surgeryplus.com
Telemedicine	Teladoc	Customer Service: (866) 789-8155	www.MyHealthToolkitFL.com
Dental Insurance	Ameritas Group #: 010-302084	Customer Service: (800) 487-5553	www.ameritas.com
Vision Insurance	EyeMed Group #: 1012764-2765	Customer Service: (866) 800-5457	www.eyemed.com
Flexible Spending Accounts	P&A Group	Customer Service: (800) 688-2611	www.padmin.com
Life Insurance	Mutual of Omaha Group #: GLUG-AJFS	Customer Service: (800) 877-5176	www.mutualofomaha.com
Voluntary Short and 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	Mutual of Omaha	Customer Service: (800) 877-5176	www.mutualofomaha.com
Diabetes Management Program	Kannact	Customer Service: (501) 200-5011	www.kannact.com/irc

Here's where to find...

WELCOME TO ENROLLMENT!

Indian River County 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 benefit plans. We understand that you may have questions about 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. This guide contains an overview of benefits. For additional information about the plans available to you, please see the summary plan description (SPD) at ircgov.com.

INTRODUCTION

The Indian River 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 under each benefit description heading 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 the employee is hired on April 11, then the effective date of coverage would be July 1.

Termination

If an employee separates employment from the Clerk, insurance will continue through the end of the 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 covered 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 other benefit 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 cause 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 the birth of a child) to request the appropriate changes to coverage. Late requests cannot be approved. As a result of a qualifying event, changes are effective on 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. The 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 will 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, (60 days for birth of a child) 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 Clerk'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 Clerk 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.

MEDICAL

(800) 830-1501
http://www.myhealthtoolkitfl.com/

BLUE CROSS BLUE SHIELD OF FLORIDA

Medical insurance is offered through Blue Cross Blue Shield of Florida 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 Blue Cross Blue Shield of Florida's customer service.

Blue Cross Blue Shield of Florida BlueOptions Plan

24 Payroll Deductions

	BlueOptions
Gold Eligible Employee	$55.00
Gold Employee + Family	$200.00
Silver Eligible Employee	$7.50
Silver Employee + Family	$103.75

Summary of Benefits and Coverage

A Summary of Benefits & 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: Lmciver@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.

Other Available Plan Resources

Blue Cross Blue Shield of Florida offers all enrolled members and dependents additional services and discounts through value-added programs. For more details regarding other available plan resources, please contact Blue Cross Blue Shield of Florida's customer service.

Locate a Provider

To search for a participating provider, log in to your My Health Toolkit account or call the number on the back of your membership ID card to speak to a customer service advocate.

Blue Cross Blue Shield of Florida BlueOptions Plan At-A-Glance

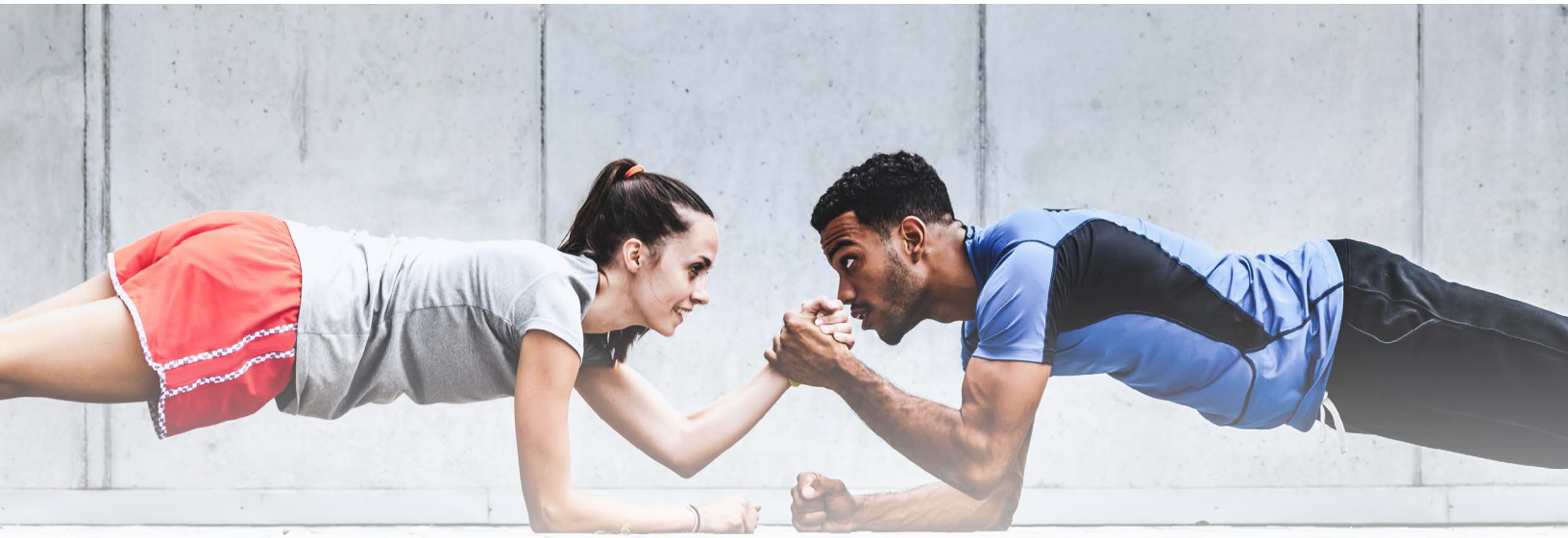
Product	BlueOptions	
Plan Number	Premier Silver Plan-05302	Premier Gold Plan-03559
Cost Sharing - Member's Responsibility		
Calendar Year Deductible (DED)	Single / Family	Single / Family
In-Network (INN)	$1,000 / $2,000	$600 / $1,200
Out-of-Network	$2,000 / $4,000	$1,200 / $2,400
Coinsurance (Member pays after Calendar Year DED)		
In-Network	30%	20%
Out-of-Network	40%	30%
Calendar Year Out of Pocket Maximum	Single / Family	Single / Family
In-Network	$6,000 / $12,000	$3,000 / $6,000
Out-of-Network	$8,000 / $16,000	$4,000 / $8,000
Medical / Surgical Care by a Physician		
Office Services		
In-Network Family Physician	$40 Copayment	$30 Copayment
In-Network Specialist	$65 Copayment	$50 Copayment
Out-of-Network	DED + 40%	DED + 30%
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 + 40%	DED + 30%
Convenient Care Center		
In-Network	$40 Copayment	$30 Copayment
Out-of-Network	DED + 40%	DED + 30%
Inpatient Hospital Facility PAD Per Admission		
In-Network	PAD $500 + DED + 30%	PAD $200 + DED +20%
Out-of-Network	PAD $1,000 + DED + 40%	PAD $400 + DED + 30%
Physician Services at Hospital		
In-Network	DED + 30%	DED + 20%
Out-of-Network	DED + 30%	DED + 20%
Radiology, Pathology and Anesthesiology Provider Services at Hospital		
In-Network	DED + 30%	DED + 20%
Out-of-Network	INN DED + 30%	INN DED + 20%
Preventive Services-Adult Wellness Services		
Office Services		
In-Network Family Physician / Specialist	No Charge	No Charge
Out-of-Network	40%	30%
Non-Hospital Services Freestanding Facility		
Clinical Lab (Blood Work): Quest**		
In-Network	No Charge	No Charge
Out-of-Network	DED + 40%	DED + 30%
X-rays (Independent Diagnostic Center)		
In-Network	$25 Copayment	$15 Copayment
Out-of-Network	DED + 40%	DED + 30%

Product	BlueOptions	
Plan Number	Premier Silver Plan-05302	Premier Gold Plan-03559
Outpatient Hospital Facility (per visit) (Surgical)		
In-Network	DED + 30%	DED + 20%
Out-of-Network	DED + 40%	DED + 30%
Emergency and Urgent Care		
Emergency Room Facility (per visit)		
In-Network	(Copayment Waived if Admitted) $500 Copayment + DED + 30%	(Copayment Waived if Admitted) $250 Copayment + DED + 20%
Out-of-Network	$500 Copayment + INN DED + 30%	$250 Copayment + INN DED + 20%
Urgent Care Centers		
In-Network	$40 Copayment	$30 Copayment
Out-of-Network	$40 Copayment	$30 Copayment
Ambulance		
In-Network	DED + 30%	DED + 20%
Out-of-Network	INN DED + 30%	INN DED + 20%
Advanced Imaging (MRI, MRA, PET, CT & Nuclear Medicine)		
Physician Office		
In-Network Family Physician or Specialist	30%	$200 Copayment
Out-of-Network	DED + 40%	DED + 30%
Independent Diagnostic Testing Center		
In-Network	30%	$200 Copayment
Out-of-Network	DED + 40%	DED + 30%
Outpatient Hospital Facility		
In-Network	DED + 30%	DED + 20%
Out-of-Network	DED + 40%	DED + 30%
Mental Health / Alcohol & Substance Abuse Services		
Inpatient / Outpatient Hospital Facility	PAD (Per Admission Deductible)	PAD (Per Admission Deductible)
In-Network	$500 PAD + DED + 30%	PAD $200 + DED + 20%
Out-of-Network	$1,000 PAD + DED + 40%	PAD $400 + DED + 30%
Specialist Visits		
In-Network	$60 Copayment	$45 Copayment
Out-of-Network	DED + 40%	DED + 30%
Prescription Drugs (RX Administered through RX Benefits)		
1X Calendar Year Deductible Per Person	$100 (must be met before Copayments apply)	N/A
Generic	$5 Copayment	$10 Copay
Preferred Brand Name	$65 Copayment	$50 Copay
Non-Preferred Brand Name	$95 Copayment	$75 Copay
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 Blue Cross Blue Shield of Florida.. When using a lab other than Quest, please be sure to confirm they are contracted with Blue Cross Blue Shield of Florida's BlueOptions Network prior to receiving services.

BlueCross BlueShield | Blue365

Included with the Medical Plan



HEALTHY LIVING IS JUST A DEAL AWAY

Join Blue365 and start saving today!

Blue365 gives you access to savings across all aspects of your life– including 20 percent off on Fitbit devices and over $800 off Lasik, discounts on healthy, organic meal delivery services like Sun Basket, and much more!

Register now for free to take advantage of Blue365. It's an online destination where participating members can find healthy deals and exclusive discounts, all you need is your Blue Cross and Blue Shield member card to get started.

Get started today at
www.Blue365Deals.com/register

Exclusive savings from

fitbit
GARMIN
SKECHERS
Hotels.com
American HEARING BENEFITS
SUN BASKET
KIND
eyeMed

KANNACT – DIABETES MANAGEMENT

(501) 200-5011

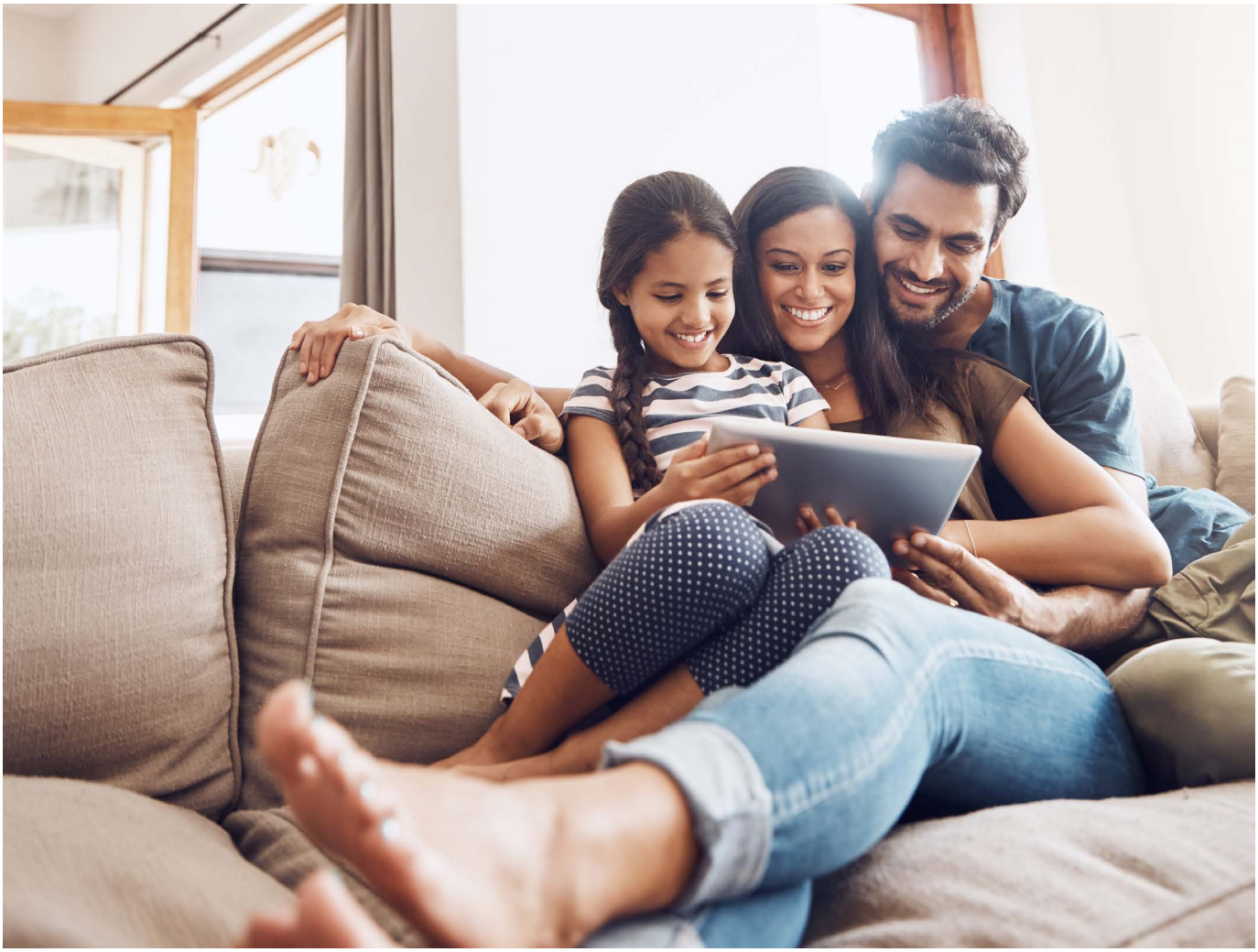
www.kannact.com/irc

Included with the Medical Plan

Expanded Program with added benefits!

Employees or covered dependent(s) who have been diagnosed with Type 2 Diabetes and are covered on the Clerk'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.



CANARX

Indian River County
Board of County Commissioners
ircgov.com

Included with the Medical Plan in addition to the RX plan.

SIGN UP TODAY

Receive a one-time $25 GIFT CARD for enrolling in the CANARX program with a qualifying prescription for a 90 day supply with 3 refills!

*Offer available to new program members only.

Medications FREE to your door!
See reverse for a full list of medications.

CANARX is a voluntary international mail order prescription program that is available to eligible employees, retirees and their dependents of Indian River County, FL.

Brand name medications, in the original factory-sealed manufacturers packaging, are delivered DIRECT TO YOUR DOOR from certified pharmacies in Canada, the United Kingdom and Australia. YOU PAY NOTHING thanks to the savings CANARX brings to your plan.

Getting started is super easy!

1. Check to see if a medication is offered. Call **1-866-893-6337** and speak with a CANARX representative or view the complete formulary and print enrollment material at **www.canarx.com** (WebID: **IRCMEDS**).
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit documentation (completed enrollment form, prescription and a copy of your photo ID).
4. Sit back and relax...medication will be mailed direct to your home within 4 weeks!

- **$0 Copay**
- **300+ FREE Brand Name Medications**
- **Easy, convenient refills**
- **Refills only, no "new to you" meds**
- **No additional costs**

For More Information

1-866-893-6337
www.canarx.com
WebID: IRCMEDS

August 2022

For More Information: Call 1-866-893-6337

ACTONEL 35MG
ACTONEL 150MG
ACTOPLUS 15MG-850MG
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%
ANORO ELLIPTA 62.5/25MCG
ARNUITY ELLIPTA 100MCG
ARNUITY ELLIPTA 200MCG
AROMASIN 25MG
ARTHROTEC 50MG
ARTHROTEC 75MG
ASACOL HD 800MG
ASMANEX TWISTHALER 110MCG
ASMANEX TWISTHALER 220MCG
ASTAGRAF XL 5MG
ATELVIA DR 35MG
ATROVENT HFA 20UG
AZILECT 0.5MG
AZILECT 1MG
AZOPT 1%
BANZEL 200MG
BEPREVE 1.5%
BEYAZ
BIJUVA 1MG-100MG
BIKTARVY 50MG-200MG-25MG
BINOSTO 70MG
BONIVA (G) 150MG
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
CLARINEX 5MG
CLIMARA PATCH 25MCG
CLIMARA PATCH 50MCG
CLIMARA PATCH 75MCG
CLIMARA PATCH 100MCG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT
20MCG/100MCG
COMTAN 200MG
DALIRESP 500MCG
DEXILANT DR 30MG
DEXILANT DR 60MG
DIFFERIN CREAM 0.1%
DIFFERIN GEL 0.3%
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
EDURANT 25MG
EFFIENT (G) 5MG
EFFIENT (G) 10MG
ELESTAT 0.05%
ELIQUIS 2.5MG
ELIQUIS 5MG
ELMIRON 100MG
ENABLEX 7.5MG
ENABLEX 15MG
ENTRESTO 24MG-26MG
ENTRESTO 49MG-51MG
ENTRESTO 97MG-103MG
EPIPEN 0.3MG
EPIPEN JR 0.15MG
EPIVIR / HBV 100MG
EVISTA 60MG
EXELON 4.6MG/24HR
EXELON 9.5MG/24HR
EXELON 13.3MG/24HR
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
FROVA 2.5MG
GENVOYA
GILENYA 0.5MG
GLUCAGEN HYPOKIT 1MG
GLYXAMBI 10MG/5MG
GLYXAMBI 25MG/5MG
IMITREX NASAL SPRAY 5MG
IMITREX NASAL SPRAY 20MG
IMITREX STATDOSE 6MG/0.5ML
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
JAKAFI 5MG
JAKAFI 10MG
JAKAFI 15MG
JAKAFI 20MG
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
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LESCOL XL 80MG
LEXIVA 700MG
LINZESS 72MCG
LINZESS 145MCG
LINZESS 290MCG
LOTEMAX GEL 0.5%
LOTEMAX OINT 0.5%
LOTEMAX SUSP 0.5%
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
MIRAPEX ER 0.375MG
MIRAPEX ER 0.75MG
MIRAPEX ER 1.5MG
MIRAPEX ER 2.25MG
MIRAPEX ER 3MG
MIRAPEX ER 3.75MG
MIRAPEX ER 4.5MG
MULTAQ 400MG
MYRBETRIQ 25MG
MYRBETRIQ 50MG
NAMENDA 10MG
NATAZIA 3/2-2/2-3/1MG
NEUPRO 1MG
NEUPRO 2MG
NEUPRO 3MG
NEUPRO 4MG
NEUPRO 6MG
NEUPRO 8MG
NEXIUM (G) 20MG
NEXIUM (G) 40MG
NEXIUM DR (G) 10MG
NEXLIZET 180MG-10MG
ODEFSEY 200MG-25MG-25MG
ORILISSA 150MG
ORILISSA 200MG
OSPHENA 60MG
OTEZLA 30MG
PAXIL CR (G) 12.5MG
PAXIL CR (G) 25MG
PRED FORTE 1%
PREMARIN CREAM
0.625MG/GM
PREZISTA 800MG
PRISTIQ 50MG
PRISTIQ 100MG
PROMETRIUM 100MG
PROTOPIC OINT 0.03%
PROTOPIC OINT 0.1%
QVAR REDIHALER 40MCG
QVAR REDIHALER 80MCG
RAPAMUNE 0.5MG
RAPAMUNE 1MG
RAPAMUNE 2MG
RELPAX 20MG
RELPAX 40MG
RENVELA (G) 800MG
RESTASIS MULTIDOSE 0.05%
RESTASIS VIALS 0.05%
RETIN A GEL (G) 0.025%
REXULTI 0.25MG
REXULTI 0.5MG
REXULTI 1MG
REXULTI 2MG
REXULTI 3MG
REXULTI 4MG
RINVOQ 15MG
RINVOQ 30MG
RYBELSUS 3MG
RYBELSUS 7MG
RYBELSUS 14MG
SAPHRIS 5MG
SAPHRIS 10MG
SEREVENT DISKUS 50MCG
SIMBRINZA 1%/0.2%
SINGULAIR GRANULES (G) 4MG
SOOLANTRA 1%
SPIRIVA 18MCG
SPIRIVA RESPIMAT 2.5MCG
STIOLTO RESPIMAT 2.5/2.5MCG
STRIVERDI RESPIMAT 2.5MCG
SUSTIVA 50MG
SYNAREL NASAL
SYNJARDY 5MG/500MG
SYNJARDY 5MG/1000MG
SYNJARDY 12.5MG/500MG
SYNJARDY 12.5MG/1000MG
TASMAR 100MG
TAZORAC CREAM 0.05%
TAZORAC GEL 0.05%
TAZORAC GEL 0.1%
TECFIDERA (G) 120MG
TECFIDERA (G) 240MG
TIVICAY 50MG
TOBREX OINT 0.3%
TRADJENTA 5MG
TRELEGY ELLIPTA
100-62.5-25MCG
TRELEGY ELLIPTA
200-62.5-25MCG
TRIBENZOR 20/5/12.5MG
TRIBENZOR 40/5/12.5MG
TRIBENZOR 40/5/25MG
TRIBENZOR 40/10/12.5MG
TRIBENZOR 40/10/25MG
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ 600-50-300MG
UCERIS 9MG
UROCIT-K 10MEQ
URSO 250MG
VECTICAL 3MCG/GM
VELPHORO 500MG
VESICARE (G) 5MG
VESICARE (G) 10MG
VIREAD (G) 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
XARELTO 2.5MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
XELJANZ 5MG
XELJANZ 10MG
XELJANZ XR 11MG
XIGDUO XR 5/1000MG
XIGDUO XR 10/500MG
XIGDUO XR 10/1000MG
XIIDRA 5%
YAZ 3/0.02MG
ZIAGEN (G) 300MG
ZIANA 1.2%-0.025%
ZOMIG NASAL SPRAY 5MG
ZOVIRAX CREAM 5%

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.

SURGERYPLUS

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

To learn more about SurgeryPlus, call (833) 709-2444 or email them at irc@surgeryplus.com

Included with the Medical Plan

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 Blue Cross Blue Shield of Florida 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 Blue Cross Blue Shield of Florida. Additionally, follow-up care such as physical therapy, durable medical equipment, and lab work will still be processed by the Blue Cross Blue Shield of Florida medical plan (subject to medical plan benefits) and necessary prescription drugs will be covered under RxBenefits through Express Scripts (subject to pharmacy plan benefits).

No Enrollment Necessary

If you are covered under the Clerk'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 Clerk 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 THROUGH TELADOC

Included with the Medical Plan

(866) 789-8155

http://www.myhealthtoolkitfl.com/

Quality Care...Anytime and Anywhere with 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 physicians 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!

Teledoc Copays:

General Medicine - $10 copay
Dermatology- $20 copay

Its Easy to Get Started

Register for Teladoc now -- don't wait till you are sick! Call (866) 789-8155 or start by logging in to www.MyHealthToolkitFL.com. Under the **Resources** tab, select **Teladoc**. This will take you to the Teladoc site. Your insurance information will appear so you can easily complete your registration.

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

HEALTH ADVOCACY

Included with the Medical Plan

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

HealthAdvocate™
Always at your side

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!

- Employee
- Spouse/ Domestic Partners
- Dependents
- Parents and Parents-in-law

Health Advocate

Customer Service: (866) 799-2728
Email: answers@HealthAdvocate.com
www.healthadvocate.com.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

(866) 799-2728

www.healthadvocate.com/members

Organization Name:Indian River County Government

HEALTH ADVOCATE

The Clerk provides a comprehensive Employee Assistance Program (EAP) 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

How Does Health Advocate Work?

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.

DENTAL INSURANCE

(800) 487-5553

www.ameritas.com

AMERITAS

The Clerk offers dental insurance 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.

24 Payroll Deductions

	LOW Option	HIGH Option
Employee	N/A	$0
Employee + spouse	$7.38	$16.86
Employee + child(ren)	$11.58	$23.68
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 that 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 services.

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 the member can begin earning rewards again the very next year. In addition, if an employee stays in the PPO network, the 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

	Classic (PPO) LOW Option		Classic (PPO) HIGH Option	
Network	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 & 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 (Amalagam 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 the previous page.
**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 a Class III, Major Restorative procedure. 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

The Clerk offers vision insurance 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.

(866) 800-5457

www.eyemed.com
Click on "Insight Network" to find a provider near you!

24 Payroll Deductions

	EyeMed
Employee	$0.00
Employee + spouse	$2.36
Employee + child(ren)	$2.63
Family	$5.09

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 (Fitting, Follow-up & 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)

The Clerk offers Flexible Spending Accounts (FSA) 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 daycare expenses, then an employee may benefit from participating in an FSA. An FSA allows an employee to set aside money from their paycheck for reimbursement of health care and daycare expenses an 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. The 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 $3,050. 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 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 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 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 daycare expenses. Qualified expenses include daycare 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 daycare 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.

4 WAYS TO SUBMIT YOUR CLAIMS

(800) 688-2611

www.padmin.com

P&A Group Mobile App

Download the mobile app and log into your account. Go to the menu and tap Upload Claim/Documentation to submit your claims.

QuikClaim from Your Smartphone

Capture a picture of your receipt or other supporting documentation of your eligible expense. Log into your account from your mobile device at www.padmin.com by selecting Account Login and follow the prompts on your screen.

Electronic Claim Upload from Your Computer

Submit claims directly online at P&A's website www.padmin.com by logging into your P&A account. Select Upload Claim/Documentation under Member Tools.

Fax or Mail a Paper Claim

Complete a claim form and fax or mail it to P&A Group. Claim forms are available when you log into your account at www.padmin.com.

FAX: (877) 855-7105
MAIL: P&A Group 17 Court St. Ste 500 Buffalo, NY 14202

When submitting a claim make sure to include proof of service/documentation (itemized receipt, etc).

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 Tax22.65% = 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."

BASIC LIFE AND AD&D INSURANCE

Basic Term Life and Accidental Death & Dismemberment

Basic Term Life and Accidental Death & Dismemberment (AD&D) insurance is offered through Mutual of Omaha to 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; however, you may be eligible to continue the insurance under a Portability Policy. Please contact Mutual of Omaha to request a portability form and for additional details.

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. The form will ask basic health history questions and will have to be approved prior to coverage becoming effective.

Voluntary Life & AD&D Rate Table

Rate Per $1,000 of Benefit

Age Bracket	Voluntary Life Rate
Under Age 25	$0.08
25-29	$0.08
30-34	$0.09
35-39	$0.12
40-44	$0.18
45-49	$0.29
50-54	$0.47
55-59	$0.81
60-64	$0.87
65-69	$1.49
70-75	$2.64
75+	$10.04

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.

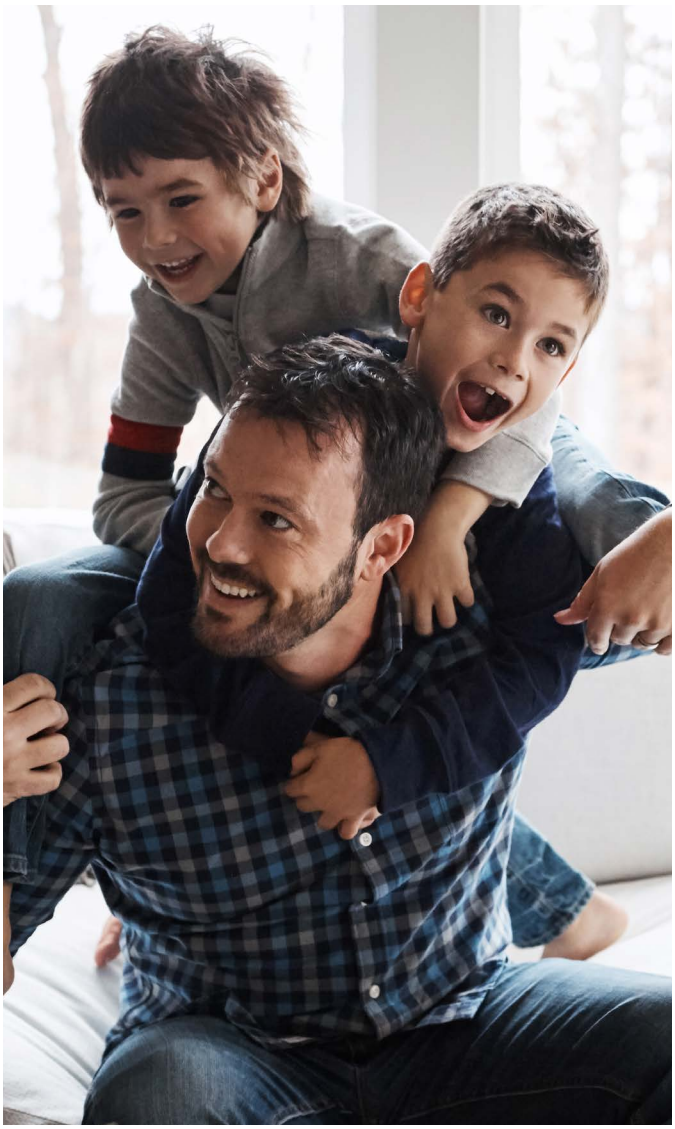
Child(ren) Life with AD&D Rates

The monthly rate per member is $0.74 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. Employees may update beneficiary information at any time throughout the year.

(800) 877-5176

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 SHORT-TERM DISABILITY

(800) 877-5176

www.mutualofomaha.com

MUTUAL OF OMAHA

The Clerk offers Voluntary Short Term Disability (VSTD) insurance through Mutual of Omaha to all eligible employees. The VSTD benefit pays an employee a percentage of earnings if the employee becomes disabled due to an accident or injury.

Benefit Summary	
Benefit Percentage	60%
Maximum Benefit	$1,500
Accident Elimination Period	7 days
Sickness Elimination Period	7 days
Zero Day Residual	Included
Own Job Definition	Loss of duties and earnings
Benefit Duration	13 weeks

Cost Summary

Monthly Rate (Per $10 of Weekly Benefit)	Premium Factor
$0.48	.0144

Example

	x	.0144	=	
Weekly Salary (=Annual Salary/52) max $2500		Premium Factor		Per Pay Period Premium

This plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/6 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 6 months of coverage, would not be covered.

LONG-TERM DISABILITY

(800) 877-5176

www.mutualofomaha.com

MUTUAL OF OMAHA

The Clerk offers Long Term Disability (LTD) insurance and a Voluntary LTD Buy-up option through Mutual of Omaha to all eligible employees. The LTD 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.

Long Term Disability (LTD) Plan Summary:

- Both LTD benefits pay 60% of monthly pre-disability earnings up to a monthly maximum benefit amount of $5,000.
- Both LTD benefits begin on the 91st day following the disabling event.
- The Clerk paid LTD is only a 2-year benefit. 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 LTD 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 Rate Table

Rate Per $100 Covered Payroll	
Age	Rates
Under 25	$0.03
25-29	$0.05
30-34	$0.06
35-39	$0.08
40-44	$0.10
45-49	$0.14
50-54	$0.21
55-59	$0.26
60-64	$0.30
65-69	$0.32
70-99	$0.33

Example

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

Buy-Up LTD Plan Maximum Benefit Period: If your disability begins at age 61 or less, the benefit will continue to age 65, your social security natural retirement age, or 3 years and 6 months, whichever is longest. If your disability begins after age 61, the maximum benefit period is reduced, depending on your age at disability. Please contact Mutual of Omaha for additional information.

VOLUNTARY ACCIDENT INSURANCE

(800) 877-5176

www.mutualofomaha.com

MUTUAL OF OMAHA

The Clerk offers Voluntary Accident Insurance through Mutual of Omaha to all eligible employees. This insurance offers financial protection by paying a cash benefit if you or an insured dependent are injured as a result of a covered accident.

Voluntary Accident Insurance Plan Summary

- To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined, and any child(ren) must be under age 26. For your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
- Coverage type: 24-hour (on and off-job)
- Express Benefit: $200

Benefits Amounts	
Initial Care & Emergency[1] - Most treatment/service required within 72 hours of accident; Once per accident per insured person	
Emergency Room	$300
Urgent Care Center	$225
Initial Physician Office Visit	$200
Ambulance	Up to $2,500
Specified Injuries[1,2]	
Fractures (Surgical / Non-surgical)	Up to $8,000 / Up to $4,000
Dislocations (Surgical / Non-surgical)	Up to $12,000 / Up to $6,000
Lacerations	Up to $1,000
Burns	Up to $20,000
Dental	Up to $400
Hospital, Surgical & Diagnostic[1,3]	
Admission	$2,500
Daily Confinement (Up to 365 days per accident)	$700 per day
ICU Confinement (Up to 15 days per accident)	$1,400 per day
Rehab. Facility Confinement (Up to 30 days per accident)	$200 per day
Surgical	Up to $2,500
Diagnostic	Up to $300
Follow-Up Care[1] - Treatment / service required within 365 days of accident; Medical device is once per accident per insured person	
Physician Follow-Up Office Visit	$150; Up to 6 per accident
Therapy Services	$150; Up to 6 per accident
Medical Device	$400
Prosthetic Device(s)	$1,250; Up to 2 per accident

1. Additional limitations apply 88 described in the certificate.
2. Fractures and dislocations require treatment within 90 days of accident, burns and lacerations within 72 hours of an accident, and dental care within 30 days. If an insured person sustains both a fracture and dislocation 88 the result of the same accident, the maximum amount payable is up to 200% of the amount payable for the injury with the highest applicable benefit amount.
3. Daily confinement must begin with 90 days of accident and ICU confinement within 30 days. Surgical treatment timeframes vary. If applicable, diagnostic services must be received within 90 days of accident. Except for confinement benefits, most benefits are payable once per accident per insured person. If any surgery occurs concurrently with an open reduction for a fracture or dislocation of the same bone or joint as a result of the same accident, only the highest applicable benefit is payable.
4. The principal sum for you and your spouse reduces by 50% when you reach the age of 70.

Benefits Amounts	
Additional Benefits[1] - Benefits are payable within 365 days of accident; Health screening benefit is payable once per calendar year	
Transportation (Up to 3 trips per accident)	$600 per trip
Lodging (Up to 30 nights per accident)	$200 per night
Childcare (Up to 30 days per accident)	$30 per day
Healthcare Screening	$50
Catastrophic Benefit[1,4] - Benefits are payable within 365 days of accident; Once per accident per insued person	
Principal Sum (PS)	You: $75,000; Spouse: $50,000; Child(ren): $20,000
Common Carrier Accidental Death	300% of PS
Transportation of Remains	Up to $5,000
Reasonable Modifications	Up to 10% of PS
Coma	25% of PS
Services	
Hearing Discount Program	The Hearing Discount program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-88-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

24 Payroll Deductions

Employee	$5.42
Employee + spouse	$7.95
Employee + child(ren)	$9.67
Family	$12.92

VOLUNTARY CRITICAL ILLNESS INSURANCE

(800) 877-5176

www.mutualofomaha.com

The Clerk offers Voluntary Critical Illness Insurance through Mutual of Omaha to all eligible employees. This insurance provides an employee with cash benefits if the employee or covered dependent suffers a covered event. This plan also comes with a health screening benefit of $50.00 payable once per calendar year for each insured person who has a health screening test performed while insurance is in effect for the insured person.

- To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined, and any child(ren) must be under age 26. For your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
- The premiums for this insurance are paid in full by you. Child insurance is automatic. A separate premium is not required.
- Maximum payout is 400% of the CI Principal Sum amount for each insured person.
- Health Screening Benefit: pays a flat, annual benefit of $50 for a health screening test.
- When you turn age 70, the original amount of insurance will reduce to 50% for both you and your spouse.
- There is no benefit waiting period.

24 Payroll Deductions

Age Band	$10,000	$20,000
<30	$0.80	$1.60
30-39	$1.40	$2.80
40-49	$3.00	$6.00
50-59	$6.30	$12.60
60-69	$13.25	$26.50
70-79	$24.70	$49.40
80-99	$34.00	$68.00

Coverage Guidelines	Minimum	Maximum	Guarantee Issue
For You Elect in $10,000 increments	$10,000	$20,000	$20,000
Spouse Elect in $10,000 increments	$10,000	100% of employee's CI Principal Sum, up to $20,000	$20,000
Child(ren) *benefit for each child	25% of employee's CI Principal Sum, up to $5,000		$5,000

Benefit Category	Condition	% of CI Principal Sum
Heart/Circulatory/Motor Function	Heart Attack, Heart Transplant, Stroke, ALS (Lou Gehrig's), Advanced Alzheimers, Advanced Parkinson's	100%
	Heart Valve Surgery, Coronary Artery Bypass, Aortic Surgery	25%
Organ	Major Organ Transplat/Placement on UNOS List, End-Stage Renal Failure	100%
	Acute Respiratory Distress Syndrome (ARDS)	25%
Childhood/Developmental *benefits only available to children	Cerebral Palsy, Structural Congenital Defects, Generic Disorders, Congenital Metabolic Disorders, Type 1 Diabetes	100%
Cancer	Cancer (Invasive)	100%
	Bone Marrow Transplant	50%
	Carcinoma in Situ, Benign Brain Tumor	25%

RETIREMENT PLANS

Florida Retirement System (FRS) (Mandatory)

The Clerk is a member of the Florida Retirement System (FRS) and pays a percentage of employees' salaries to FRS as shown below. Participation is mandatory and the employee has a choice of participating in one of two plans: the pension plan or the investment plan. Please go to www.myfrs.com or www.choosemyfrsplan.com to learn more.

Employment Class	Employee Pays	Employer Pays	Total Percentage
Regular Class	3.00%	13.57%	16.57%

457 and Roth 457 Deferred Compensation (Voluntary)

The Clerk offers a voluntary 457 Deferred Compensation Retirement Plan that offers you the opportunity to save for retirement and help supplement FRS and Social Security. You can join the plan at any time – not just during Open Enrollment – and contributions will be effective as of the first day of the month after you enroll. For example, if you enroll in September 2024, your first contribution will be made from the first payroll in October 2024.

The Plan offers a voluntary 457 Deferred Compensation Plan (contributions to this plan are made on a tax deferral, or pre-tax basis, so the money is not taxable until the employee takes a distribution). The Plan also offers a voluntary Roth 457 Deferred Compensation Plan (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).

Contact HR for more information or if you are interested in enrolling.

Please Note: Limits apply to all contributions made to the 457 Deferred Compensation Plan and Roth 457 Deferred Compensation Plan. Please consult a financial advisor or check the IRS website (http://www.irs.gov/retirement/article/0,,id=172437,00.html) for more information.

GLOSSARY OF TERMS

COPAYMENT: A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a PPO-type plan. In some cases, you may be responsible for coinsurance after a copay is made.

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

DEDUCTIBLE: A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits that require copays do not apply to the deductible. For example, if your plan's deductible is $1,000, you'll pay 100 percent of eligible healthcare expenses until you have met the $1,000 deductible. After that, you share the cost with your plan by paying coinsurance.

IN-NETWORK: A group of doctors, clinics, hospitals and other healthcare providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital or other provider that is not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays for those services.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

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.