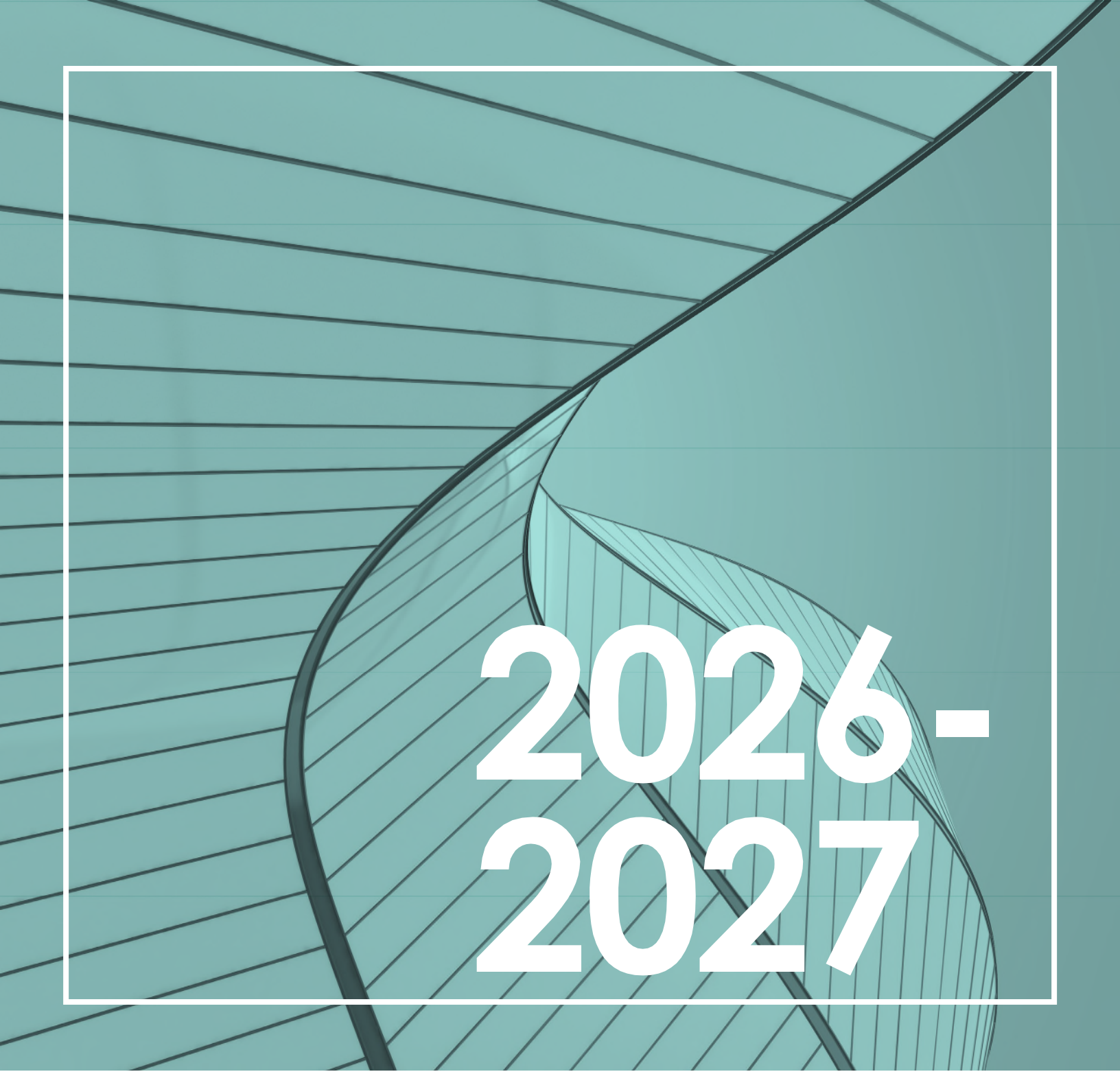


2026-2027

Employee **Benefits**

Clerk of Court and Comptroller

Contacts

Office	Contact	Phone	Email
Clerk of Court and Comptroller	Laura McIver	(772) 226-3101	Lmciver@indianriverclerk.com

Coverage	Carrier/Policy #	Phone	Website/Email
Medical Insurance	Blue Cross Blue Shield of Florida	Customer Service: (800) 830-1501	MyHealthToolkitFL.com
Employee Advocacy	Rightway	Advocacy: (305) 851-7310 Mon-Fri: 8 a.m. - 11 p.m. EST Sat/Sun: 9 a.m. - 5 p.m. EST Holidays: 9 a.m. - 3 p.m. EST	member.rightwayhealthcare.com
Pharmacy	Rightway RX BIN: 610862 RX PCN: RWRX RX GROUP: 50244	Rightway Pharmacy Customer Service: (888) 665-1678	member.rightwayhealthcare.com
International Pharmacy	CanaRx	Customer Service: (866) 893-6337	canarx.com WebID: IRCMEDS
Planned Surgery	Lantern (formerly SurgeryPlus)	Customer Service: (833) 709-2444	lanterncare.com
Telemedicine	Teladoc	Customer Service: (866) 789-8155	MyHealthToolkitFL.com
Dental Insurance	Ameritas Group #: 010-302084	Customer Service: (800) 487-5553	ameritas.com
Vision Insurance	EyeMed Group #: 1012764-2765	Customer Service: (866) 800-5457	eyemed.com
Life Insurance	Mutual of Omaha Group #: GLUG-AJFS	Customer Service: (800) 877-5176	mutualofomaha.com
Voluntary Short- & Long-Term Disability Insurance	Mutual of Omaha Group #: GLUG-AJFS	Customer Service: (800) 877-5176	mutualofomaha.com
Employee Assistance Program	Health Advocate	Customer Service: (866) 799-2728	healthadvocate.com/members
Supplemental Insurance	Mutual of Omaha	Customer Service: (800) 877-5176	mutualofomaha.com
Onsite Health Center	Marathon Health	Customer Service: (772) 874-3238	clients.marathon.health/indianrivercounty
Identity Theft	Norton LifeLock	Customer Service: (800) 607-9174	gendigital.com/us/en/partner/employee-benefits/premier-and-premier-plus/
Legal Insurance	ARAG	Customer Care Center: (800) 247-4184	araglegal.com/

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.

Here is where to find…

Contacts 2
Welcome To Enrollment! 3
Introduction....4
Group Insurance Eligibility....4
Qualifying Events and IRS Code Section 125....5
Qualifying Events and COBRA....6
Benefits Overview Videos....7
Employee Assistance Program (EAP) 8
Medical 9
Marathon Health Center 12
Nutrition Support 14
Rightway Pharmacy and Advocacy....15
CanaRX (IRCMeds)....18
Lantern (formerly SurgeryPlus) 19
Telemedicine through Teladoc 20
Dental Insurance....21
Vision Insurance....24
Basic and Voluntary Life/AD&D Insurance....26
Voluntary Short-Term Disability 28
Long-Term Disability 29
Voluntary Accident Insurance 30
Voluntary Critical Illness Insurance....32
Voluntary Hospital Indemnity Plan 33
Identity Theft....34
Legal Insurance....36
Retirement Plans....38
Glossary of Terms....38

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 benefits 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, visit the Human Resources website indianriver.gov/services/human_resources/staff_portal.

User: IRC

Password: IRCSTAFF

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 an employee's 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

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. Coverage becomes effective as of the first of the month following the notification of the life 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 becomes effective as of the first of the month following the notification of marriage, gain other coverage, loss of other coverage, or on the date of birth for instances of birth or adoption, subject to approval by Human Resources. The employee must notify Human Resources of the Qualifying Event within 30 days (60 days for birth of a child).
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.

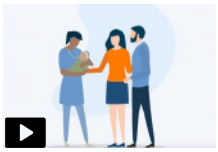
COBRA Continuation of Medical Coverage Benefits

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.

Benefits Overview Videos

Watch these videos below for more information on your benefits.

Qualifying Life Event



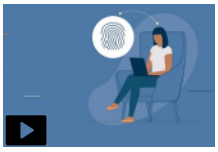
Critical Illness Insurance



Life and AD&D Insurance



Identity Protection



Prescription Drugs: Benefits Overview



Prescription Drugs: Tips to Manage Costs



Hospital Indemnity Insurance



Planned Surgery



Benefits Key Terms Explained



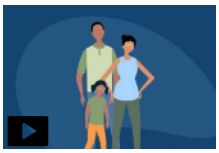
Disability Insurance



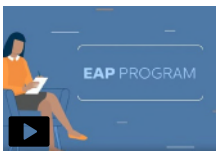
Accident Insurance



Vision Insurance



Employee Assistance Program



Employee Assistance Program (EAP)

HEALTH ADVOCATE

(866) 799-2728

healthadvocate.com/members

Organization Name: Indian River County Government

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.

Medical

(800) 830-1501
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 NetworkBlue Plan

24 Payroll Deductions

	NetworkBlue
Gold Eligible Employee	$68.75
Gold Employee + Family	$250.00
Silver Eligible Employee	$9.38
Silver Employee + Family	$129.69

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@indianriverclerk.com

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

Discounts

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.

Other Health Insurance Information

To access and manage your Other Health Insurance (OHI) information, log in to your Florida Blue member account. Navigate to My Plan & Benefits and select Health. Contact Florida Blue Member Services if you need assistance updating or verifying your OHI information.



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

Product	NetworkBlue	
Plan	Premier Silver Plan	Premier Gold Plan
Cost Sharing - Member's Responsibility Calendar Year Deductible (DED)		
In-Network (INN)	$1,500 / $3,000	$750 / $1,500
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	$4,000 / $8,000
Out-of-Network	$8,000 / $16,000	$6,000 / $12,000
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
In-Network Nutrition	$0 Copayment*	$0 Copayment*
In-Network Mental Health	$40 Copayment	$30 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%

**Prior Authorization required after 3 visits.*

Product	NetworkBlue	
Plan	Premier Silver Plan	Premier Gold Plan
X-rays (Independent Diagnostic Center)		
In-Network	$25 Copayment	$15 Copayment
Out-of-Network	DED + 40%	DED + 30%
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) $500 Copayment + DED + 20%
Out-of-Network	$500 Copayment + INN DED + 30%	$500 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	$40 Copayment	$30 Copayment
Out-of-Network	DED + 40%	DED + 30%
Prescription Drugs (RX Administered through Rightway)		
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)	2x Retail Copay	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 NetworkBlue Network prior to receiving services.*

Marathon Health Center

Included for medical plan enrollees. Clerk employees do not need to use PLT when visiting the Clinic for their own appointments.

Easy Access to Primary Care

Indian River County is pleased to offer Marathon Health to its employees, retirees, and covered family members who are enrolled in Indian River County's health plan. Marathon Health offers comprehensive primary care at no cost. It provides an easier, more convenient healthcare option for everything from screenings and prevention to chronic disease management and urgent care.
Marathon Health offers:

- More time with your provider
- 24/7 access to manage your care
- Same-day or next-day appointments for urgent issues
- Virtual appointments

We also offer a secure mobile app that you can use for easy appointment scheduling, communicating with your care team, medication refill requests, and much more.

Location:

960 37th Place, Suite 101
Vero Beach, FL 32960

Hours of Operation:

M-F: 7:00 a.m. – 6:00 p.m. (excluding observed holidays)

Contact:

(772) 874-3238

clients.marathon.health/indianrivercounty

For more information and to schedule an appointment, scan the QR code or visit clients.marathon.health/indianrivercounty



Marathon Health

Stop type 2 diabetes before it starts

1 in 3 adults in America has pre-diabetes, yet 8 in 10 adults with pre-diabetes don't know they have it.



Know your numbers

Two important screenings are fasting glucose (FG), which shows a single point in time and A1C, which shows an average over 3 months.

Normal blood sugar

- A1C less than 5.7%
- FG less than 100 mg/dl

Pre-diabetes

- A1C 5.7% - 6.4%
- FG 100 - 125 mg/dl

Diabetes

- A1C 6.5% or higher
- FG 126 mg/dl or higher

Schedule an appointment today by calling (772) 874-3238 or visit **my.marathon.health**

INDIAN RIVER COUNTY FLORIDA

13

Source: cdc.gov/diabetes/prevention/about-prediabetes.html

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Nutrition Support Available to Indian River County

Expert Nutrition Guidance at Little to no Cost **Included for medical plan enrollees.**

Whether you are looking to build healthier habits, manage your weight, or receive specialized support for a medical condition, nutrition services are available through your medical plan. Start by understanding the type of support you may need, then choose how you want to access care.

1. What Type of Nutrition Support Do You Need?

Preventive Nutrition Counseling

For members looking for general nutrition guidance to support overall health and wellness.

Common support includes:

- Healthy eating habits
- Weight management
- Heart-healthy nutrition
- Disease prevention
- General wellness support

Cost to You: First 3 visits each year: $0.
Additional visits: Standard Primary Care Physician (PCP) cost share applies.

Medical Nutrition Therapy (MNT)

For members with qualifying medical conditions who need specialized nutrition treatment from a dietitian.

Common support includes:

- Diabetes
- Kidney disease
- Celiac disease
- Obesity
- Other physician-diagnosed conditions

Cost to You: First 3 visits each year: $0.
Additional visits: $0 with prior authorization approval.

Coverage for additional visits is subject to medical necessity review and prior authorization requirements.

2. Choose How You Want to Access Services

Fay Nutrition

Virtual appointments with Registered Dietitian Nutritionists (RDNs).

- One-on-one nutrition counseling
- Weight management support
- Chronic condition support
- Flexible virtual appointments

Get Started:
Enroll at faynutrition.com/find. Hit "Get started" then "Let's go". Next select Blue Cross Blue Shield exactly as it appears on your insurance to check your coverage instantly. When prompted, use booking code HBBW8Z, choose a provider, and schedule an appointment.

Nourish Nutrition

Insurance-covered virtual nutrition counseling with licensed dietitians.

- Personalized nutrition plans
- Ongoing coaching and support
- Counseling for a variety of health goals

Get Started:
Enroll at nourish.com. Hit "Get started" then "Let's go". Next select Blue Cross Blue Sheild and enter your insurance information manually or upload your card and to check your coverage instantly. Then choose a provider, and schedule an appointment.

Teladoc Nutrition

Virtual nutrition guidance available through Teladoc.

- Convenient online access
- Healthy eating and wellness guidance
- Access through the Teladoc platform

Get Started:
Call (866) 789-8155 or visit MyHealthToolkitFL. Under Resources, select Teladoc to complete registration and access nutrition services.

Not sure where to start? Preventive counseling may be a good fit for general wellness goals. Medical Nutrition Therapy may be appropriate if you have a qualifying medical condition. For questions about eligibility, participation, or cost share, contact the carrier or member services using the information shown in this benefits guide.

rightway™

Rightway is your guide to better health.

Rightway is a service that guides you through a better healthcare experience. We provide you with unlimited access to a health guide, a trusted advocate who can answer your medical and pharmacy questions and take care of actions for you.



Included for medical plan enrollees.

RIGHTWAY HELPS YOU WITH YOUR HEALTHCARE NEEDS...

The Rightway app is a single source where you can view your benefits information, find a doctor in your area, and connect with your dedicated health guide who can answer your questions and take care of actions for you.

Your health guide can:

- Find you the best doctor and make an appointment.
- Assess your symptoms and figure out next steps.
- Provide upfront pricing for medical visits.
- Explain your bill and dispute a charge if something looks off.

AND IMPROVES YOUR PHARMACY BENEFITS EXPERIENCE

Rightway is your pharmacy benefit provider. When you go to pick up your prescription, you will use your Rightway ID card — it's always handy in the app. In between visits, your health guide is there to answer questions and provide ongoing support.

Your health guide can:

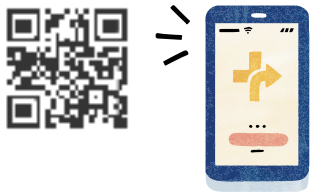
- Explain your coverage and help you find the most affordable option.
- Discuss your medications and advise on how to manage any possible side effects.
- Help with prior authorizations, specialty medications, refills, or mail delivery.

HOW RIGHTWAY WORKS

Our healthcare experts have your specific benefits information and know how to get you the highest-quality care and prescription medication at the best price.

START USING RIGHTWAY

Connect with your health guide through the Rightway app on your mobile phone. To download the app, scan the QR code below with your mobile phone camera.



Download the Rightway app to get started today.

Download on the App Store

GET IT ON Google Play

rightway™

Welcome to a better pharmacy experience.

If you're enrolled in a covered medical plan, you have pharmacy benefits through Rightway. Rightway is a pharmacy benefits manager with a human-first approach.



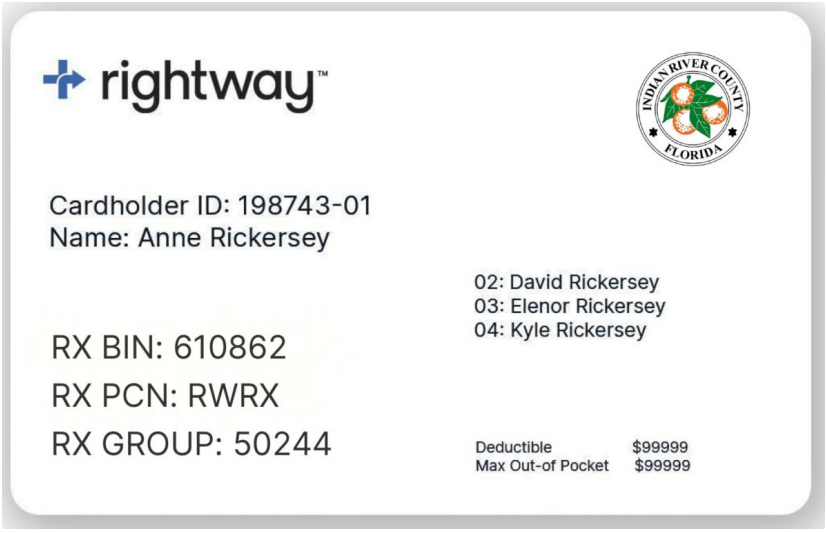
Included for medical plan enrollees.

Who is Rightway?

Rightway will manage your pharmacy benefits. This means we are the service that covers your prescriptions and helps you get your prescriptions filled at the pharmacy of your choice. We also provide 24/7 support with real people to answer any questions, explain your coverage and find ways to lower your out-of-pocket costs.

Your benefits.

When picking up your prescriptions, show your prescription ID card. Your Rightway information will be on your ID card and in the Rightway app.



Have questions? Let's connect.

- Email us: rwrx@rightwayhealthcare.com
- Visit us online: joinrightway.com/rx

Want to learn more? For more information scan the QR code with your phone or visit us at: joinrightway.com/rx

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rightway™

Using a mail-order pharmacy with Rightway.

Included for medical plan enrollees.

RIGHTWAY GIVES YOU OPTIONS FOR EASY PRESCRIPTION DELIVERY

With Rightway, you can have your medicine delivered to your home. We work with Mark Cuban Cost Plus Drugs and Walgreens Mail Service to make this simple and convenient. Chat with our pharmacy team in the Rightway app for personalized assistance.

Mark Cuban CostPlus Drug Company

Walgreens Mail Service

HOW TO GET STARTED

SET UP YOUR MAIL-ORDER ACCOUNT

Log in to your Rightway account to sign up with Walgreens or Cost Plus Drugs and transfer your prescription.

CHOOSE A SERVICE

Pick the partner that works best for your needs. The availability of specific medications and copay amounts may vary.

GET YOUR DELIVERY

Your prescription will arrive at your home or preferred address. You can even sign up for automatic refills to keep things simple.



Log in to your Rightway account to get started.

Go to the “Coverage” tab in the app to find “Mail Order Pharmacy”.

Download on the App Store

GET IT ON Google Play

NOT SURE WHICH OPTION IS BEST FOR YOU?

Our pharmacy team is here to help.

CHAT: Log in to your Rightway account to send us a message.
CALL US AT: 888-665-1678

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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

Lantern (formerly SurgeryPlus)

To learn more about Lantern, call (833) 709-2444

Included for medical plan enrollees.

The Lantern benefit is included at no additional cost to you when you are enrolled in one of the County's group medical plans. Lantern is a comprehensive benefit that provides access to a premier **Center of Excellence** 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 Lantern, you can choose to use either the group medical plan through Blue Cross Blue Shield of Florida OR to use Lantern. **When using Lantern, you will not have any deductible, copays, or coinsurance.** The Lantern 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 Rightway (subject to pharmacy plan benefits).

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 Lantern at (833) 709-2444 and you could save thousands of dollars.

Save Money

If you choose to use the Lantern 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
Lantern will recommend at least three of the best fitting surgeons for your individualized needs.



Scheduling
Lantern will book appointments, transfer medical records and manage logistics.



Advocacy
Lantern will listen and anticipate your surgery-related needs.



Follow-up
Lantern will work to ensure your complete satisfaction.

Telemedicine through Teladoc

(866) 789-8155
myhealthtoolkitfl.com

Included for medical plan enrollees.

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!



Teladoc Copays:

General Medicine – $10 copay
Dermatology – $20 copay
Nutrition - $0 copay
Mental Health - Gold Plan - $30 copay / Silver Plan - $40 copay

It's 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 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
- Talk to a therapist or psychiatrist 7 days a week (7 a.m. to 9 p.m. local time)
- Nutrition
- Upload images of a skin issue online and get a custom treatment plan within two days (i.e. Eczema, Acne, Rashes, and more)
- Other minor health issues and more

Dental Insurance

(800) 487-5553
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

	Classic (PPO)	
Plan	**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.**

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 & Preventive				
Routine Oral Exam (2 per year)	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 (2 per year)				
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 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.

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.

Vision Insurance

(866) 800-5457

eyemed.com

Click on "Insight Network" to find a provider near you!

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.

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



Basic Life and AD&D Insurance

(800) 877-5176
mutualofomaha.com/life-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.

(800) 877-5176
mutualofomaha.com
/life-insurance

Voluntary Life & AD&D Rate Table

Rate Per $1,000 of Benefit	
Age Bracket	**Voluntary Life & AD&D 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
70-74	$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.

Example

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

Voluntary Short-Term Disability

(800) 877-5176
mutualofomaha.com
/disability-insurance

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)		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
mutualofomaha.com
/disability-insurance

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 based on the salary amount at the time of Open Enrollment.

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	$0.04
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.

The LTD Buy-Up benefit may provide limited additional value for employees enrolled in the FRS Pension Plan because LTD payments are reduced by certain disability income sources, including FRS Disability Retirement benefits. The LTD Buy- Up is not a benefit payable through your SSNRA. LTD benefits are subject to offsets, which may include FRS Disability Retirement benefits, Social Security Disability benefits, workers' compensation benefits, and other disability-related income as defined by the policy. These offsets can reduce the amount payable under the LTD plan. The LTD Buy-Up would only be a good option for employees in the FRS Investment Plan.

Voluntary Accident Insurance

(800) 877-5176
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	$400
Urgent Care Center	$325
Initial Physician Office Visit	$200
Ambulance	Up to $2,500
Specified Injuries[1,2]	
Fractures (Surgical / Non-surgical)	Up to $12,000 / Up to $6,000
Dislocations (Surgical / Non-surgical)	Up to $12,000 / Up to $6,000
Lacerations	Up to $1,500
Burns	Up to $25,000
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)	$300 per day
Surgical	Up to $5,000
Diagnostic	Up to $400
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	$175; Up to 6 per accident
Therapy Services	$150; Up to 6 per accident
Medical Device	$400
Prosthetic Device(s)	$1,750; 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)	$300 per night
Childcare (Up to 30 days per accident)	$40 per day
Healthcare Screening	$50
Catastrophic Benefit[1,4] - Benefits are payable within 365 days of accident; Once per accident per insured person	
Principal Sum (PS)	You: $100,000; 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 (888) 534-1747 or visit amplifonusa.com/mutualofomaha to learn more.

2026-2027 Payroll Deductions

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



Voluntary Critical Illness Insurance

(800) 877-5176
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, Sudden Cardiac Arrest, Heart Transplant, Stroke, ALS (Lou Gehrig's), Advanced Alzheimers, Advanced Parkinson's, Permanent Paralysis, Coma, Complete loss of Sight, Speech, hearing and Multiple Sclerosis	100%
	Heart Valve Surgery, Coronary Artery Bypass, Aortic Surgery	50%
Organ	Major Organ Transplant/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	100%
	Skin Cancer	$500/year

Voluntary Hospital Indemnity Plan

The Clerk offers Voluntary Low and High Hospital Indemnity plans through Mutual of Omaha for covering out-of-pocket expenses and extra bills that occur.

(800) 877-5176
mutualofomaha.com

Benefits	Low Plan Amounts	High Plan Amounts
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.	
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or child(ren) to be eligible for coverage, you must elect coverage for yourself.	
Premium Payment	The premiums for this insurance are paid in full by you.	
Hospital Admission & Confinement	Admission benefits are payable up to a combined total of 2 days per policy year and are not payable on the same day; Confinement benefits are payable up to a combined total of 90 days per policy year unless otherwise noted and are not payable on the same day as Hospital/ICU admission benefits.	
Hospital Admission	$500 per admission	$1,000 per admission
Daily Hospital Confinement	$100 per day	$150 per day
ICU Admission	$1,000 per admission	$2,000 per admission
Daily ICU Confinement	$200 per day	$300 per day
Daily Newborn Nursery Care Confinement	(Up to 2 days per policy year) $75 per day	
Additional Benefits		
Health Screening Benefit	(1 time per insured per calendar year; up to 6 per family per calendar year) $50	
Express Benefits	(1 benefit per hospital admission) $100	(1 benefit per hospital admission) $150

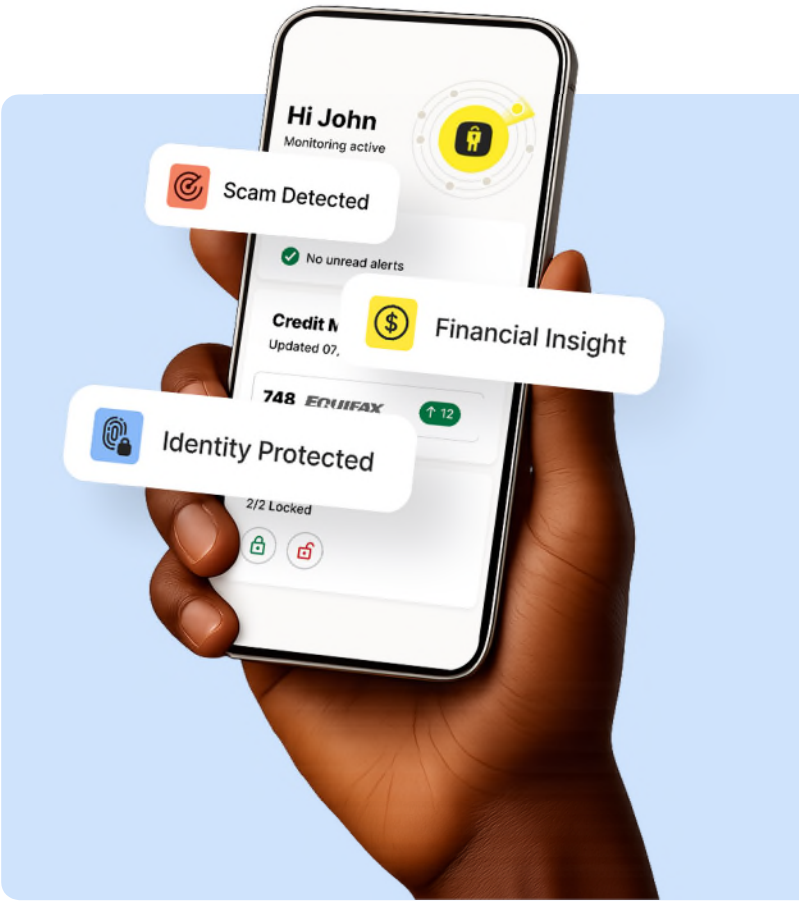
Voluntary Low Hospital Payroll Deductions	
	Low Plan
Employee	$6.21
Employee + spouse	$14.29
Employee + child(ren)	$8.57
Family	$17.15

Voluntary High Hospital Payroll Deductions	
	High Plan
Employee	$10.36
Employee + spouse	$23.81
Employee + child(ren)	$14.29
Family	$28.58

norton™
LifeLock Benefit Solutions

Take Back Control of Your Identity

Your personal data is everywhere— from doctor's offices to mobile apps. Norton LifeLock Benefit Plans help prevent fraud, block scams, monitor activity, and strengthen your financial wellbeing.



Get Protection Now

Protect Your Well-Being from Every Angle

Fraud Detection
Monitor identity and finances to detect identity fraud early.

Identity Restoration
Get peace of mind with expert help if your identity is compromised.

Threat Prevention
Block scams and cyberthreats to protect your data and devices.

Enhanced Privacy
Remove your personal details from data broker sites and enjoy a safer, more private internet experience.

Financial Insights
Gain financial insights into your credit, spending, and income.
Available this Winter

Scam Detection
Built-in AI assistant helps you navigate suspicious websites and SMS messages, and offers advice if you think you're being scammed.

Already a member?
Don't forget to cancel your existing membership just prior to your benefit effective date by calling **800-607-9174.**

* Feature availability subject to change.
No one can prevent all cybercrime or prevent all identity theft. We do not monitor all transactions at all businesses.
Copyright © 2025 Gen Digital Inc. All rights reserved. Norton LifeLock Benefit Solutions is part of Gen–a global company dedicated to powering Digital Freedom through its trusted consumer brands including Norton, Avast, LifeLock, MoneyLion and more.

norton™
LifeLock Benefit Solutions

Pricing Only Employees Get

Enroll Today!

Find Out More

Benefit Plans are 60% less than the retail equivalent.

Norton.com/PremPremierPlus

	Employee Only	Employee + Family
Premier	$4.00	$7.49
Premier Plus	$6.25	$10.74

Pricing displayed is: Semi-Monthly

You get this (and so much more)

	Premier	Premier Plus
Identity & Credit Monitoring[1] We monitor for new accounts being opened in your name and for key changes to your credit file at three of the leading credit bureaus and alert you to potential fraud.	✓ 3B[2]	✓ 3B[2]
Identity Restoration Support If your identity is compromised, a US-based Identity Restoration Specialist will personally handle your case and help restore your identity.	✓	✓
Device Security w/ Secure VPN Protects your mobile devices, tablets, and computers from hackers and vulnerable websites in addition to keeping your browsing private.	✓ 5 devices family gets 10	✓ 10 devices family gets unlimited
Genie Scam Detection AI-powered alerts help detect and navigate suspicious texts, emails, and calls in real time. Offers advice if you think you're being scammed.	✓	✓
Cyber Crime Insurance[3] For cyber attacks is available for up to $50,000 in addition to the LifeLock Million Dollar Protection Package. Includes coverage for Cyber Extortion, Social Engineering Scams, Cyber Bullying[4], and Digital Currency Crime.		✓
Financial + Credit Insights Empowers you with valuable insights into your finances, guiding you on the path to greater, more insightful, financial well-being.	✓	✓

1-Credit features require setup, identity verification and sufficient credit history by TransUnion and/or Equifax. Credit monitoring features may take several days to activate after enrollment.

2-The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.

3-Reimbursement and Expense Compensation, each with limits of up to $1 million for Benefit Essential, Premier, and Premier Plus, and up to $50,000 for LifeLock Benefit Junior ($25,000 reimbursement coverage and $25,000 fraudulent withdrawals). All plans include up to $1 million in coverage for lawyers and experts. Cyber Crime Insurance, if applicable, covers up to $50,000 for covered expenses per Plan. All benefits are issued and covered by third party partners. Policy terms, conditions, and exclusions at: gendigital.com/legal.

4-Cyber Bullying Coverage is not available to residents in New York.

Indian River County

Legal Insurance from ARAG

Legal Insurance

Be protected when legal happens.

How Legal Happens in Your Life

Legal issues can come up at any time. And facing them alone can be overwhelming when you're not sure what to do. A legal insurance plan from ARAG® provides access to experienced network attorneys and trusted resources for a wide range of legal needs like the examples below.

Protecting Your Growing Family

- Create a pre-marital agreement before your wedding.
- Add your newborn child to your will.

Managing Your Home, Protecting Your Assets

- Your neighbor's ugly fence is on the property line.
- Your landlord won't ffx the heater.

A Place to Turn During Life's Challenges

- You get caught speeding.
- Your dog bites a neighbor.

Protection As a Consumer

- The mechanic botches your car repair.
- Your dream vacation gets canceled with no refund.

Financial Challenges

- Your ID was stolen on vacation.
- You can't get out of debt.

Plus 100+ more ways to use your plan!

How Does ARAG Legal Insurance Protect?

When the unexpected happens, having legal insurance can provide you with protection and peace of mind.

Work with a network attorney and attorney fees are paid in full for most covered matters.

We help connect you with attorneys – many who average 20+ years of experience.

Save thousands of dollars, on average, for legal matters by avoiding costly legal fees.

Address your covered legal situations with a network attorney who is only a phone call away.

Use DIY Docs® to create, edit and save legal documents online, like a will, trust or power of attorney, using state-speciffc, attorneyreviewed templates.

Your network attorney can help throughout your legal matter, including preparing and reviewing legal documents, offering legal advice and representing you in court.

[1]ARAG Stress Research Study, general consumers and members with known legal issues, October 2022.

Using Your Legal Plan Is Easy

When you face a legal issue, getting help from ARAG is simple.

To get started, you can go online, use the ARAG Legal app or call Customer Care.

Answer a few questions to confirm your coverage and receive information on network attorneys who can help with your legal matter.

Then, meet with a network attorney virtually, over the phone or in person.

What Does It Cost?

ARAG legal insurance provides affordable coverage with more than 100+ ways to use your plan for both simple and complex legal issues, benefiting you and your family.

UltimateAdvisor®

$7.29 semi-monthly

UltimateAdvisor Plus™, which offers you even more legal protection and additional services.

$9.39 semi-monthly

To compare plans and find the best option for you, scan the QR code.

Want More Information?

Scan the QR Code to learn more about the specific coverages your plan provides – and much more.

Or, visit ARAGlegal.com/myinfo and enter Access Code: 19436irc

Or, call ARAG at 800-247-4184

Create Your Estate Plan from the Comfort of Your Couch

Take greater control of your legal needs with tools – included with your plan for no additional cost – designed to make creating important documents easy.

DIY Docs® lets you create customized legal documents, like a will, trust or power of attorney, at your own pace using state-specific, attorney-reviewed templates. You'll answer a series of guided questions to build documents tailored to your needs. Edit and save your work online, then download your completed document when you're ready.

Plus, Demand Letters help you draft professional letters for common disputes – like landlord or tenant issues, warranty concerns or disagreements with a neighbor. Use a guided prompt to create your letter and request citations to relevant laws or ordinances to support your case.

Limitations and exclusions apply. Depending upon a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, contact us.

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2026 Plan Information Rev 6/25 200333

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 myfrs.com or choosemyfrsplan.com to learn more.

Employment Class	Employee Pays	Employer Pays	Total Percentage
Regular Class	3.00%	13.59%	16.59%

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.

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 (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.



https://indianriver.savings.workingadvantage.com/

Notes





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.