Escambia County
EMPLOYEE BENEFITS SUMMARY **2019**

Escambia County Board of County Commissioners
Human Resources Department
221 Palafox Place, Suite 200
Pensacola, FL 32502
850-595-3000
myescambia.com

Welcome to Escambia County

The Board of County Commissioners provides its employees with a salary and benefits package that allows us to attract and retain the best-qualified employees available. You are a most valued member of the BCC team, and we will continue to strive to improve your benefits and working conditions so we may all provide our citizens with the best customer service in the state. The Employee Benefits Summary is a quick reference resource that provides an overview of our benefit programs. Please take a few minutes to review the booklet. The booklet provides you with current information on the county programs such as policy overview, telephone numbers, contact information, policy numbers and premiums for the current year, as well as comparisons between similar benefits.

For more detailed information on these programs, please review the policies or Plan Documents, which can be located in the Human Resources Division, Benefits Section. If you have any questions or need assistance, please call the Benefits Office at 595-4767, 4682, 3682 or 4681. The Benefits staff is available from 8 a.m. to 5 p.m., Monday through Friday, located on the second floor of the Escambia County Governmental Center Building. Please call and make an appointment.

You may also visit myescambia.com/employee-resources for current information about your benefits, along with other useful Human Resources information.

Your Board of County Commissioners

The county is governed by the Escambia Board of County Commissioners. Escambia County is divided into five districts with one county commissioner elected from each district to serve a four-year term as the legislative and policy-setting body of Escambia County as established under Section 125 of the Florida Statutes. Commissioners are chosen in partisan elections by voters from the districts in which they live.

Left to right: Commissioner Jeff Bergosh, District 1; Commissioner Doug Underhill, District 2; Commissioner Lumon May, District 3 (Chairman); Commissioner Robert Bender, District 4; Commissioner Steven Barry, District 5 (Vice Chairman)

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Employee orientation

myescambia

myescambia.com/HR

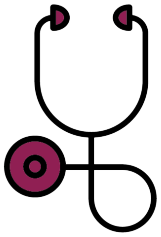
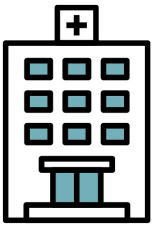
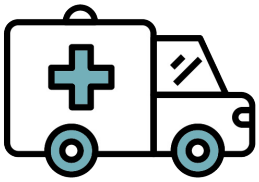
This 2019 Employee Benefits Summary does not guarantee benefits and is intended only to provide general information. This is not a contract. A complete description can be reviewed in the Plan Documents detailing coverage available in the HR Benefits Office or myescambia.com/benefits. Please keep this booklet to reference 2019 benefits.

Index/Information

Page	Benefit	Carrier/Vendor	Policy No.	Phone #	Website/Contact
	Cobra	WageWorks		877-452-6272	cobrabenefits.wagework.com
25	Deferred Compensation Plan	ICMA		866-328-4672	Adam Ferguson aferguson@icmarc.org icmarc.org
19	Dental	Delta Dental	1440	800-521-2651	deltadentalins.com
23	Employee Assistance Program (EAP)	Behavioral Health System		800-245-1150	behavioralhealthsystems.com
9	Escambia County Health Clinic	Concentra		850-595-0328 850-595-1949	2257 N. Baylen St. Pensacola, FL
14-16	Flexible Spending/ Dependent Care Account (DCA/FSA)	Lockard & Williams		850-516-7043	Kenny Anderson kanderson.benefits@gmail.com
14-16	Flexible Spending Accts./Health Care Reimbursement	Lockard & Williams		850-516-7043	Kenny Anderson kanderson.benefits@gmail.com
	Florida Blue Retail Center			850-202-4150	Cordova Commons 1680 Airport Blvd. Pensacola, FL
31	Florida Retirement System (FRS)	Florida Retirement System		1-844-377-1888	www.myfrs.com
31-34	FRS Pension			1-866-446-9577	www.myfrs.com
31-34	FRS Investment	Florida Retirement System Financial Planners		1-866-446-9577	www.myfrs.com
	Health Care Savings (HSA) Account	HSA Bank		800-357-6246	hsabank.com
14	IRS Section 125 Plan	Lockard & Williams		850-516-7043	Kenny Anderson kanderson.benefits@gmail.com
26	Life and AD&D Insurance	The Standard	75440.0001		standard.com
25	Long Term Disability Insurance	Madison Life	33420	800-627-3660	nis@sif.com
10-13	Medical	Florida Blue	97035	800-664-5295	floridablue.com

Page	Benefit	Carrier/Vendor	Policy No.	Phone #	Website/Contact
17-18	Medicare Advantage & Medicare Part D, Plan F Rx	Florida Blue			
20	Vision	Humana	748596	800-865-3676	humana.com
Voluntary Insurances					
30		AFLAC		850-473-9400, Ext. 5	Holly Butcher holly_butcher@us.aflac.com aflac.com
30		Allstate		850-453-0088	Milton McNease mcnease@mcneaseassociates.gccoxmail.com
30		Colonial Life and Accident Insurance Co.		800-245-1150	Wayne Rimmer wayne.rimmer@colonialife.com coloniallife.com
25	Deferred Compensation	ICMA		866-328-4672	Adam Ferguson aferguson@icmarc.org icmarc.org
25	Deferred Compensation	Nationwide		850-512-0085	Chris Witlock whitloc@nationwide.com nrsforc.com
30	Legal and Legal Shield	Pre-Paid Legal		800-725-7988	Rebecca Smith rjsmith@smithterry.com
25	Deferred Compensation	Trans America		850-393-1513	Michael R. Montee mmontee@signatorfn.com
25	Deferred Compensation	Valic		850-477-4014	Tim Schossow timothy_schossow@valic.com aigvalic.com

Where Should I go for Care?*

	Why would I use this care center?	What type of care would they provide?	What are the costs & time considerations?
 **Doctor's Office**	You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide preventitive and routine care, manage your medications and refer you to a specialist, if necessary.	✓ Routine checkups ✓ Immunizations ✓ Preventive services ✓ General health management	• Often requires a co-payment and/or coinsurance. • Normally requires appointment • Little wait time with scheduled appointment.
 **Escambia County Employee Clinic**	You can't get to your doctor's office, but your condition is not urgent or an emergency. The Escambia County Employee Health Clinic is dedicated to providing episodic, acute, and preventive health care for eligible employees, dependents and retirees. *Unfortunately the clinic is not able to see participants enrolled in Medicaid or Medicaire Part B.	✓ Common illnesses ✓ Injuries (strains, back pain, etc.) ✓ Minor wound care ✓ Routine immunizations ✓ Minor infections ✓ Screenings (cholesterol, glucose and blood pressure) ✓ Skin complaints (minor burns, rashes, boils, etc.)	• Free for active employees and family members who are enrolled in county-sponsored Blue Options 1352 or 1552. • Employees & family members who have provided proof of health insurance through another source or if they have the county's Health Saving Account can access the clinic with a $20 co-pay.
 **Urgent Care Center**	You may need care quickly, but it is not an emergency, and your primary care physician may not be available. Urgent care centers offer treatment for non-life threatening injuries or illnesses.	✓ Strains, sprains ✓ Minor broken bones (finger, etc.) ✓ Minor infections ✓ Minor burns ✓ X-rays	• Often requires a co-payment and/or coinsurance usually higher than an office visit. • Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first.
 **Emergency Room**	You need immediate treatment of a very serious or critical condition. The ER is for the treatment of life-threatening or very serious conditions that require immediate medical attention. Do not ignore an emergency. If a situation seems life threatening, take action. Call 911 or your local emergency number right away.	✓ Heavy bleeding ✓ Large open wounds ✓ Sudden change in vision ✓ Chest Pain ✓ Sudden weakness or trouble talking ✓ Major burns or broken bones ✓ Spinal injuries ✓ Severe head injury ✓ Difficulty breathing	• Often requires a much higher co-payment and/or coinsurance. • Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

***This is a sample list of services and may not be all-inclusive. Costs and time information represent averages only and are not tied to a specific condition or treatment. Your out-of-pocket costs will vary based on your plan.**

Escambia County employee

BENEFIT HIGHLIGHTS

Available **benefits**

- HEALTH
- DENTAL
- VISION
- LONG-TERM DISABILITY
- VOLUNTARY LIFE INSURANCE

HEALTH SAVINGS ACCOUNT

partially funded by county

TUITION REIMBURSEMENT PROGRAM

up to $2,400 per fiscal year

EMPLOYEE FITNESS CENTERS

four locations in the county

EFFECTIVE DATES: First of the month after working **30** days

Other **benefits**

- LEAVE DONATION PROGRAM
- FLEXIBLE SPENDING ACCOUNTS
- EMPLOYEE CLINIC
- HEALTH CARE OPT-OUT PROGRAM

RETIREMENT

County employees are members of the Florida Retirement System, which offers two retirement programs: a traditional pension plan and an investment plan. Visit MyFRS.com for details.

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? want **more** info?

Visit **myescambia.com/benefits** or contact Human Resources at **595-3000**.

NOTE: This is only a broad summary of some benefits. Employees should contact HR for details about specific plans and benefits.

Eligibility for Coverage

Employees who are full time or part-time with Escambia County and works at least 30 hours per week are eligible for our benefits once they have completed the waiting period. Benefits are effective on the first day of the month following 30 days of full-time employment.

Dependent Eligibility

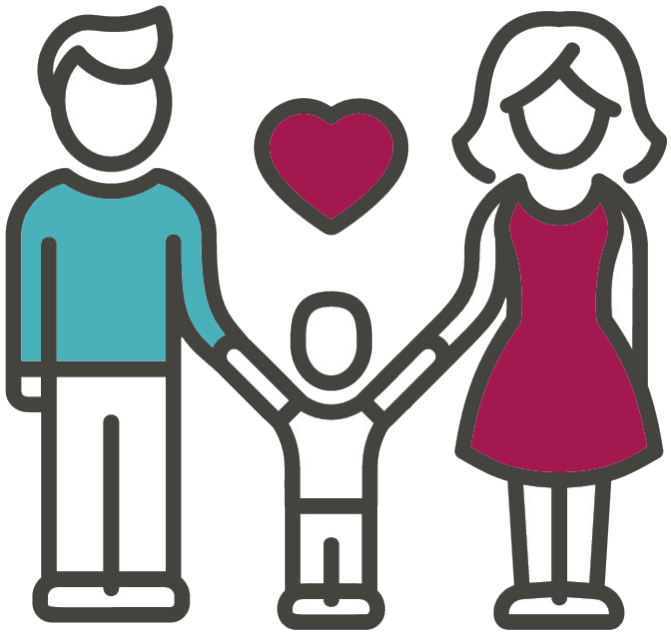
If you are eligible for benefits, you may also cover your eligible dependents including:

1. Your spouse under legally valid existing marriage (Ex-spouses are not eligible dependents even if coverage is court ordered.)
2. Medical, dental and vision plans - Your natural, newborn, adopted, foster, or step-child(ren) (or a child for whom you have been court appointed as legal guardian or legal custodian) until the end of the calendar year in which the child reaches age 26.
    a. A handicapped dependent child is eligible to continue coverage, beyond the limiting age of 26, as a covered dependent if the child is incapable of self-sustaining employment and chiefly dependent upon you for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 26th birthday.
3. Life insurance - Your unmarried child from live birth through age 20 (through age 24 if a registered student in full-time attendance at an accredited education institution). Eligibility will terminate on the child's birthday.
4. The newborn child of a covered dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child unless the eligible employee becomes the legal guardian of the child.

Dependent Eligibility Verification Process

The county has an annual process to verify coverage eligibility for dependents 26 years of age. For dependents covered under medical, dental and/or vision the county will contact to see if the child is a handicapped dependent. Otherwise, the child will be removed from the plan at the end of the plan year.

Note: It is your sole responsibility as the covered employee to establish that a child meets the applicable requirements for eligibility. Generally, eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an eligible dependent.



The Cost of Your Benefits

Escambia County pays the full cost of many of your benefits; you share the cost for others. You pay the full cost for any voluntary benefits you elect.

Benefit	Who Pays	Tax Treatment
Medical Coverage	Escambia County & You	Pre-Tax
Dental Coverage	Escambia County & You	Pre-Tax
Vision Coverage	You	Pre-Tax
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	Escambia County	Pre- or Post-Tax
Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance	You	Pre- or Post-Tax
Disability Coverage	You	Post-Tax
Qualified Benefits (FSA, DCA)	You	Pre-Tax
Deferred Compensation Plan	You	Pre-Tax
Florida Retirement System	Escambia County & You	Pre-Tax
Voluntary Insurance Plans	You	Pre- or Post-Tax

Notes

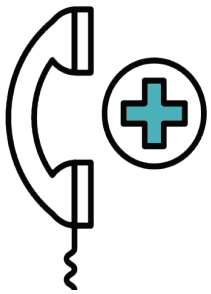
- **Spouses who are both employees of Escambia County cannot double cover each other on any plan.**
- **If you are an active employee with a dependent on our plan who has Medicare, this plan will typically be primary to Medicare. You should inform your health care provider of all plans that you or your dependents have.**
- **The Affordable Care Act requires your employer to provide you and the IRS with a report regarding you and your dependent(s)' health plan participation for each tax year. Form will be mailed in accordance with IRS renewal each year. Please keep your address updated in EFIN to ensure all benefit information is sent to your most current address.**

Escambia County Clinic Information

The Escambia County Employee & Family Health Clinic provides health care solutions for all county employees, retirees and their families.* The clinic provides a range of health and wellness services such as treatment for illness, wellness education programs and much more. The clinic is free for active employees and family members who are enrolled in county-sponsored Blue Options 1352 or 1552. Employees and family members who have provided proof of having health insurance through another source (complete a current insurance validation form; valuation of coverage with a copy of health care card) or if they have the county's Health Saving Account can have access to the clinic with a $20 co-pay.

*Retirees and their dependents enrolled in Medicare Part B or Medicaid are not eligible for the clinic.

Health clinic location: 2257 N. Baylen St., Pensacola
Appointments: Call 595-1949 or 595-0328
Hours: Monday: 7 a.m. to 6 p.m.
Tuesday: 8 a.m. to 1 p.m.
Wednesday-Friday: 8 a.m. to 5 p.m.
Saturday: 8 a.m. to 1 p.m.
Sunday: Closed



A healthier way to develop a better you.

The Employee Health Clinic is fully dedicated to providing episodic, acute, and preventive health care for eligible employees, dependents and retirees.

Health Clinic Services

- **Common illnesses –** including sore throat, sinus infections, colds, allergies, asthma and flu earaches, headaches, minor gastrointestinal complaints and more.
- **Injuries –** including back pain, sprains, arthritic symptoms, and strains (non work-related)
- **Minor wound care –** including cleaning, dressing, splinter removal, simple sutures and suture removal, and tetanus vaccine, as needed
- **Skin complaints –** including but not limited to rashes, itching boils, lumps, minor burns, minor sunburn and wart removal, insect bites and fungal infections
- **Minor infections –** including urinary tract symptoms and conjunctivitis of the eye
- **Routine immunizations –** Ault immunizations for influenza and Td/Tdap.
- **Laboratory tests –** (Physician discretion, not primary care orders)
- **Blood pressure, glucose and cholesterol screening**
- **Health Education –** including coaching and fitness programming, weight management and smoking cessation.

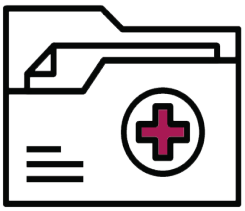
Wellness Centers

The county has established four Wellness Centers (gyms) for employees to utilize. These centers are available during various times of the day. The centers are unmanned, so employees need to be safe and maintain the cleanliness of the centers. There are Wellness Centers at the following locations:

- Central Office Complex, 3363 West Park Place, second floor
- Ernie Lee Magaha Government Building, 221 Palafox Place, second floor
- Public Safety Building, 6575 N. W St.
- Road Department, 601 Highway 297A

You must present your county badge to use the wellness centers.

Medical Insurance



The county offers a choice of medical plan options: You choose the plan that meets your needs and those of your family. For additional plan information, please refer to your official Summary Plan Comparison/plan summary/documents.

Health Insurance Opt-Out Program

If employees have health insurance coverage elsewhere, they may "opt-out" of health insurance through the BCC and receive a $200 payment every month in 2018. To receive these payments employees must provide proof of coverage and complete an opt-out agreement. **Note:** Employees that are TRICARE participants and employees who are eligible for Medicare will not be eligible for the benefit due to prohibitions of such payments by the Department of Defense and the Centers for Medicare and Medicaid Services, respectively.

You may only enroll into the plan during an annual open enrollment period as determined by the Escambia County Board of County Commissioners or during a "special enrollment period" within 30 days of a qualifying event.

Participants are also eligible for the Health Insurance Replacement Plan. This plan provides $10,000 additional life insurance for a total of $50,000 basic life insurance paid by the county and a dental discount of $12.98 per month on any dental coverage.

If you are covered under the county's group health plan in any manner, such as a spouse or dependent of a current employee or retiree, you are not eligible to receive the subsidy.

For complete program details and conditions, please see the opt-out agreement. Employees considering or participating in the opt-out program must provide proof of other health insurance and sign the opt-out agreement **each year.**

Medical Insurance Summary

Plan Provisions	BlueOptions Plan 1552		BlueOptions Plan 1352		BlueOptions 1168/1169	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Annual Deductible	$500/$1,500		$750/$2,250		$2,100/$4,200	$4,200/$8,400
Coinsurance (member responsibility)	20%	40%	20%	40%	0%	
Out of Pocket Max (per person/per family)	Includes DED, coinsurance, co-pay excludes RX		Includes DED, coinsurance, co-pay excludes RX		Includes DED, coinsurance, co-pay excludes RX	
	$2,000/$6,000		$3,000/$9,000		$2,100/$4,200	$8,400/$16,800
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Professional Provider Services						
Office Services						
Family Physician	$15	DED + 40%	$20	DED + 20%	DED	DED
Specialist	$30	DED + 40%	DED + 20%	DED + 40%	DED	DED + 20%
Providers Services at Hospital and ER (Family Physician/Specialist)	DED + 20%	In-network DED + 20%	DED + 20%	In-network DED + 20%	DED	In-network DED (no coins)
Allergy Injections (Family Physician/Specialist	$10/$10 copay	$10/$10 copay	$10/$10 copay	$10/$10 copay	DED	DED + 20%
E-Office Visit Services (Family Physician/Specialist)	$10/$10 copay	DED + 40%	$10/$10 copay	DED + 40%	DED	DED + 20%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center (Specialist)	DED + 20%	DED + 40%	DED + 20%	DED + 40%	DED + 20%	DED + 20%
Preventive Care						
Preventive Care Adult, Child, Well woman (Family Physician/Specialist)	$15/$30	40% no DED	20%/20% no DED	40% no DED	$0	20% no DED
Colonoscopies (Routine) Age 50+ then Frequency Schedule Applies	$0	$0	$0	$0	$0	$0
Mammograms (routine & Dx)	$0	$0	$0	$0	$0	$0

Plan Provisions	BlueOptions Plan 1552		BlueOptions Plan 1352		BlueOptions 1168/1169	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Emergency/Urgent/Convenient Care						
Ambulance Maximum (per day)	DED + 20%	In-network DED + 20%	DED + 20%	In-network DED + 20%	DED	In-network DED (no coins)
Convenient Care Center	$15	DED + 40%	$20	DED + 40%	DED	DED + 20%
Emergency Room Facility Services	$100 +20%	$100 +20%	$100 +20%	$100 +20%	DED	DED
Urgent Care Center	$30	DED + 40%	DED +20%	DED + 40%	DED	DED
Facility Services/Hospital Surgery/ICL/IDTF						
Ambulatory Surgery Center	$100	DED + 40%	$100	DED + 40%	DED	DED + 20%
Independent Clinical Lab	$0	DED + 40%	$0	DED + 40%	DED	DED + 20%
Independent Diagnostic Testing Facility - X-rays and AIS (Includes Physician Services)						
Advanced Imaging Services (AIS)	$100	DED + 40%	$100	DED + 40%	DED	DED +20%
Other Diagnostic Services	$100	DED + 40%	$100	DED + 40%	DED	DED +20%
Inpatient Hospital (per admit)	Opt. 1 & 2: DED + 20%	Opt. 1 & 2: DED + 20%	Opt. 1: $750/Opt. 2: $1,250	DED + 40%	Opt. 1: $500/Opt. 2: $1,000	DED + 40%
Inpatient Rehab Maximum	30 days	30 days	30 days	30 days	30 days	30 days
Outpatient Therapy and Spinal Manipulations BPM	35 visits; includes up to 26 spinal manipulations	35 visits; includes up to 26 spinal manipulations	35 visits; includes up to 26 spinal manipulations			
Outpatient Hospital (per visit)	Opt. 1: $150 Opt. 2: $250	$350	Opt. 1: $150 Opt. 2: $250	$350	Opt. 1 & 2: DED	Opt. 1 & 2: DED + 20%
Therapy at Outpatient Hospital	Opt. 1: $150 Opt. 2: $250	$350	Opt. 1: $150 Opt. 2: $250	$350	Opt. 1 & 2: DED	Opt. 1 & 2: DED + 20%

Continued on next page

Medical Insurance Summary, continued

Plan Provisions	BlueOptions Plan 1552		BlueOptions Plan 1352		BlueOptions 1168/1169	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Mental Health and Substance Abuse						
Inpatient Hospitalization	Opt. 1 & 2: $0	40% (No DED)	Opt. 1 & 2: $0	40% (No DED)	Opt. 1 & 2: DED	Opt. 1 & 2: DED (no coins)
Outpatient Hospitalization	Opt. 1 & 2: $0	40% (No DED)	Opt. 1 & 2: $0	40% (No DED)	Opt. 1 & 2: DED	Opt. 1 & 2: DED + 20%
Provider Services at Hospital and ER (Family Physician/Specialist)	$0	$0	$0	$0	DED	Opt. 1 & 2: DED (no coins)
Physician Office Visit (Family Physician/Specialist)	$0	40% (No DED)	$0	40% (No DED)	DED	DED
Emergency Room Facility Services (per visit)	$0	$0	$0	$0	DED	In-network DED (no coins)
Provider at locations other than Hospital & ER (Family Physician/Specialist)	$0	40% (No DED)	$0	40% (No DED)	DED	In-network DED (no coins)
Other Special Services and Locations						
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech Massage Therapies and Spinal Manipulations	35 visits		35 visits		35 visits	
Outpatient Rehab Therapy Center	DED + 20% coinsurance	DED + 40% coinsurance	DED + 20% coinsurance	DED + 40% coinsurance	DED	DED + 20% coinsurance
Outpatient Hospital Facility Services (per visit)	Opt. 1: $150 Opt. 2: $250	$350	Opt. 1: $150 Opt. 2: $250	$350	DED	DED + 20% coinsurance
Durable Medical Equipment	DED + 20%	DED + 40%	DED + 20%	DED + 40%	DED	DED + 20% coinsurance
Home Health Care (PBP Max) 20 Visits	DED + 20%	DED + 40%	DED + 20%	DED + 40%	DED	DED + 20% coinsurance
Skilled Nursing Facility (PBP Max) 60 Days	DED + 20%	DED + 40%	DED + 20%	DED + 40%	DED	DED + 20% coinsurance
Hospice	DED + 20%	DED + 40%	DED + 20%	DED + 40%	DED	DED + 20% coinsurance
Prescription Drugs						
Retail Prescription (30-day supply) Generic Brand Preferred Brand Non-Preferred	$15 $30 $50	50% co 50% 50%	$15 $30 $50	50% 50% 50%	100% after deductible	50% 50% 50% (after DED)
Mail Order (90-day supply) Generic Brand Preferred Brand Non-Preferred	$40 $75 $125	50% 50% 50%	$40 $75 $125	50% 50% 50%	100% after deductible	50% 50% 50% (after DED)

Flexible Spending Accounts

A Flexible Spending Account, or FSA, (Health Care Reimbursement) Plan is a tax-saving alternative offered though your employer under Section 125 of the Internal Revenue Code. The FSA is designed to reimburse you for eligible out-of-pocket medical costs. Specifically, the FSA reimburses for out-of-pocket expenses not covered under you medical, dental, and/or vision plans.

Pre-tax - Section 125

The IRS allows you to have certain insurance premiums deducted from your pay before taxes are calculated and deducted. This allows tax savings on the insurance premiums you have deducted from each paycheck. In addition, employees can participate in health care reimbursement and dependent care reimbursement. **You are required to elect to participate in these plans each year.**

Once you have made your election for the plan year, you will not be allowed to make any changes unless you have a qualifying event, or QE. The definition of a QE is provided in Changing your Coverage During a Plan Year section.

About Flexible Spending Accounts (Health Care Reimbursement)	
General	An employer-sponsored program funded by employee pre-tax contributions as part of a cafeteria plan that reimburses the employee for qualified medical expenses. The plan allows carryover of up to $500 to next plan year; any other funds are forfeited. Employees have 60 days (March 1) after the end of the plan year to file for expenses which were incurred the previous plan year.
Eligible Family Members	Only employees can receive reimbursements. However, employees can be reimbursed for dependent* expenses, including adult children who have not reached age 27 by the end of the tax year. Employees or dependents are not required to be covered on eligible plans to make claims under this plan. ***Must be claimed as dependents on income tax filing.**
Contribution Limits	2018 annual limit of $2,600 per IRS
Distribution of Funds	Use debit card or file paper claim forms
Order of Payment	1. Insurance plan(s) 2. FSA if applicable
Plan Changes	Only allows mid-year election changes due to qualified events and other plan provisions
Expense Substantiation	Required

FSA info continued on next page

Flexible Spending Accounts, continued

How long do I have to submit claims to the FSA?

Reimbursement is not allowed for claims that were incurred prior to the plan's effective date, or after the termination date of participation in the FSA plan. You have until March 1 to submit for reimbursement expenses which were incurred while you were an eligible participant of the plan.

What if my situation changes during the year?

The election you make at the beginning of each plan year is binding until the next enrollment period. It is always better to underestimate than to overestimate with an FSA plan. For those who resign or are terminated during the plan year: any amounts payroll deducted for your FSA are non-refundable. Our plan allows up to $500 of unused funds at the end of the plan year to carry over to the next year; any amount over $500 will be forfeited. Once you authorize a payroll deduction to your FSA, you may not cancel or change that election until the next enrollment period unless you experience a family status change (qualifying event) as defined in this booklet. When one of these changes occurs, employees must request a reallocation of their spending account within 30 days of the change in status.

Account Type	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pre-tax contribution to healthcare	$2,000	$0
Federal and Social Security taxes	$11,701	$12,355
After tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses and taxes	$36,299	$35,645
Tax savings with Medical and/or Dependent Care FSA	$654	N/A

Dependent Care Account (DCA)

The Dependent Care Flexible Spending Account, or DCA, pays expenses such as day care services and after school care for children under age 13. An eligible dependent may include stepchildren, adopted children, foster children or grandchildren (legal custody or guardianship). Eligible dependents are additionally defined as those who are physically or mentally unable to care for themselves, such as a disabled spouse, child or elderly parents who live with you. Eligible dependents must be claimed as an exception on your tax return. Expenses must be incurred to allow you or your spouse to work, look for work, or attend school full-time; and can only be reimbursed up to the amount currently available in your account. Any money that you elect to set aside in a flexible spending account for a given Benefit Period may be used only for eligible expenses you incur for services received during that Benefit Period. So it's very important that you plan carefully when deciding on how much to allot in your DCA.

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Dependent Care FSA	Dependent care expense (such as day care, after school programs or elder care programs) so you and your spouse can work or attend school full-time.	You may elect to contribute up to $5,000 ($2,500 if married and filing separate tax returns) during the plan year into your DCA.	Reduces your taxable income

How long do I have to submit claims to the DCA?

You have until March 1 to submit claims against your plan year account.

What is the difference between the Federal Child and Dependent Care Tax credit tax credit or using a DCA?

The amount of benefits received through the Dependent Care Account must be subtracted from the child and dependent care expenses used to calculate the child and dependent care tax credit. The choice between taking the federal child and dependent care tax credit or using a Dependent Care Account depends, largely, on your income level and your amount of work-related dependent care.

How Medicare Works

This information is provided as a courtesy to Escambia County employees. For the most up-to-date information, please visit **medicare.gov.**

What is Medicare?

Medicare is health insurance for people who are age 65 or older, under 65 with certain disabilities, or any age with end-stage renal disease (permanent kidney failure).

The 4 Types of Medicare

A Medicare Part A

Medicare Part A helps cover inpatient care in hospitals skilled nursing facilities, and hospice and home health care. Generally there is no monthly premium if you qualify and paid Medicare taxes while working.

B Medicare Part B

Medicare Part B helps cover medical services like doctors' services, outpatient care and other medically necessary services that Part A doesn't cover. You need to enroll in Medicare Part B and pay a monthly premium determined by your income. Many people also purchase a supplemental policy, such as a Medigap plan, to handle any Part A & B coverage gaps.

C Medicare Part C

Medicare Advantage Plans - also known as Medicare Part C - are combination plans managed by private insurance companies approved by Medicare. They are typically a combination of Part A, Part B and sometimes Part D coverage, but must cover medically necessary services. These plans have discretion to assign their own copays, deductibles and coinsurance.

D Medicare Part D

Medicare Part D is prescription drug coverage and is available to everyone with Medicare. It is a separate plan provided by private Medicare-approved companies, and you must pay a monthly premium.

Getting Started with Medicare

Medicare sends you a questionnaire about three months before you're entitled to Medicare coverage. Your answers to these questions, including whether you have group health insurance through an employer or family member, help Medicare set up your file and make sure your claims are paid correctly.

If your health insurance or coverage changes at any time after submitting the questionnaire, call the Medicare Coordination of Benefits Contractor at 800-999-1118 to update your file.

Once you start Medicare, you should schedule a free preventive visit within the first 12 months to assess your current health status and provide a health road map for the future.

Also, create an account on **medicare.gov** to access your information and keep track of claims. If you want your family or friends to be able to call Medicare on your behalf, fill out authorization forms to allow them to do so.

Coordination of Coverage

If you have Medicare and another type of insurance, the question of who should pay first can be tricky. For example, generally a group health plan would pay before Medicare, but there are several exceptions. Contact the number above for specific answers for your situation, or visit **medicare.gov** for additional information.

Medigap Coverage (also called "supplemental insurance")

Generally, when you buy a Medigap policy, you must have Medicare Part A and Part B in place. You will have to pay the monthly Medicare Part B premium. In addition, you will have to pay a premium to the Medigap insurance company. A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan does not cover. If you are in the Original Medicare Plan and have a Medigap policy, then Medicare and your Medigap policy will pay both their shares of covered health care costs. An example of where to buy supplemental insurance would be AARP or through USAA. You can find many great companies offering this supplemental insurance by visiting **www.medicare.gov/find-a-plan/questions/medigap-home.aspx**.

Dental Coverage

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your health. For additional plan information please refer to your official plan summary/documents.

The county offers a dental plan utilizing the Delta Dental network of dentists and specialists.

	High Option		Low Option	
Plan Provisions	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Annual Deductible (Individual/Family)	$75/$150 family		$75/$150 family	
Annual Maximum Benefit (per person)	$1,250		$1,000	
***Diagnostic and Preventive Care:** Includes oral evaluations, cleanings, and bitewing X-rays	0%	0%	0%	0%
Basic Services: Includes fillings, periodontics, scaling and root planning, and oral surgery	80%	80%	80%	80%
Major Services: Includes crowns, bridges, and full and partial dentures	60%	60%	50%	50%
Orthodontia: Adults and Children	Lifetime maximum up to $750		Lifetime maximum up to $500	

*No deductible applies to these services and is not part of the annual maximum benefit

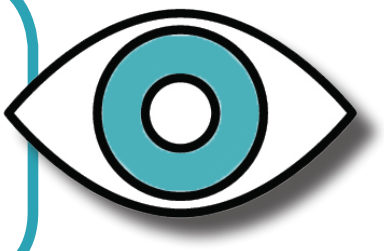
- Two Diagnostic and Preventive Care visits per year.
- Out-of-Network is paid Usual, Customary and Reasonable (UCR), and you may be responsible for dentist fees above the UCR.

Vision Coverage

The county offers the Humana Vision Care Plan that covers routine eye exams and also pays for all or a portion of the cost of glasses or contact lenses. Humana also provides a vision Lasik discount. For additional plan information, please refer to your official plan summary/document.

Plan Provisions	In-Network	Out of Network
Exam	$10 co-pay	Up to $35 allowance
Frequency • Exam • Lenses • Frames	12 months 12 months 24 months	12 months 12 months 24 months
Frames	Covered 100% within the $50 wholesale allowance	Up to $45 of retail allowance
Lenses • Single vision • Bifocal • Trifocal	$15 co-pay $15 co-pay $15 co-pay	Up to $15 allowance Up to $40 allowance Up to $60 allowance
Contact Lenses • Medically necessary • Elective in lieu of glasses	100% Up to $150 allowance	Up to $150 allowance
Lasik Provides three types of discounts - see official plan summary for details		

For employees who have health care coverage, they also receive a discount through Blue365, which includes 10-40% off frames, lenses, eye exams, contacts and more. The discount is through Davis Vision and the Group Name is BLUE365. To locate the discount, go to www.floridablue.com - go to member discount, then click the "I Agree" button, click the right arrow to find Personal Care/Davis Vision and View now.



Employee Premiums Per Pay Period
January - December 2018

Health Insurance - Blue Option 1352

Coverage Levels	Total Monthly County Contribution	EE Cost Non-Tobaco	EE Cost Tobacco
Employee	$610.17	$15.75	$40.75
Employee & Spouse	$1,452.96	$104.53	$129.53
Employee & Children	$1,307.84	$93.49	$118.49
Employee & Family	$1,889.01	$129.29	$154.29

Health Insurance - Blue Option 1552

Coverage Levels	Total Monthly County Contribution	EE Cost Non-Tobaco	EE Cost Tobacco
Employee	$659.36	$36.72	$61.72
Employee & Spouse	$1,570.10	$152.64	$177.64
Employee & Children	$1,413.28	$148.73	$173.73
Employee & Family	$2,040.59	$215.71	$240.71

Coverage Levels	Total Monthly Contribution HSA 1168/1169	EE Cost HSA 1168/1169 Non-Tobacco	EE Cost HSA 1168/1169 Tobacco
Employee	$491.17	$0.00	$25.00
Employee & Spouse	$1,169.59	$49.81	$74.81
Employee & Children	$1,052.79	$45.15	$70.15
Employee & Family	$1,520.06	$63.80	$88.80

Health Saving Account - $600 Employer Contribution

The county gives employees electing the Health Saving Account $600 employer contribution into the employee's HSA Bank account. The county or the appointing authority pays the $600 up front at the beginning of the plan year. New hires receive a prorated amount determined by the insurance eligibility date. Administrative fees are paid by the agency on a monthly basis for employees. Setup fees are only for new accounts and are a one-time fee of $20 paid by the appointing authority.

Dental Insurance

Coverage Levels	Total Monthly Premium for Low Option	EE Cost for Low Option	EE Cost for Low Option with HIR	Total Monthly Premium for High Option	EE Cost for High Option	EE Cost for High Option with HIR
Employee	$22.90	$2.50	$0	$26.25	$6.49	$0.00
Employee & Spouse	$39.62	$10.89	$4.40	$45.45	$15.96	$9.47
Employee & Children	$39.66	$10.90	$4.41	$45.48	$15.97	$9.48
Employee & Family	$61.89	$15.49	$9.00	$70.34	$21.97	$15.48

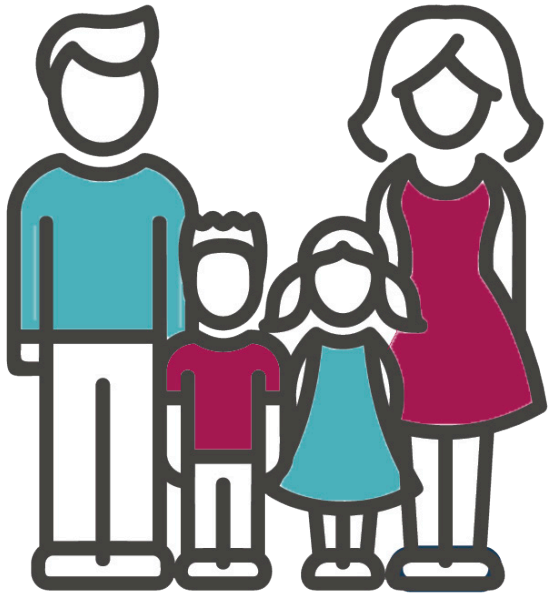
Vision Insurance

Coverage Levels	EE Montly Premiums (deducted once per month, second paycheck of the month)
Employee	$5.44
Employee & Spouse	$10.87
Employee & Children	$10.32
Employee & Family	$16.28

Employee Assistance Program

The county provides an Employee Assistance Program (EAP), where employees and their family members are eligible to receive up to three confidential counseling sessions a year, at no cost, from Behavioral Health Systems. An EAP can help with a variety of personal or family problems including:

- **Marital/family issues**
- **Child guidance**
- **Alcoholism and drug abuse**
- **Stress management**
- **Depression**
- **Grief and loss**
- **Legal issues**
- **And much more**



The EAP professionals at Behavioral Health Systems provide confidential evaluations, short-term counseling and referrals for any employee or eligible family member.

Anything over three sessions is coordinated with the employee's health insurance.

Mental Health

Mental health, behavioral health or substance abuse services

	Services	What You Will Pay In Network	What You Will Pay Out of Network	Limitations, Exceptions and Other Important Info
BlueOptions 1352/1552	Outpatient Services	No charge	40% coinsurance	None
	Inpatient Services	No charge	Physician office: No charge Hospital: 40% coinsurance	Prior authorization may be required. Your benefits/ services may be denied.
BlueOptions 1168/1169	Outpatient Services	Deductible	Physician office: Deductible Hospital: Deductible + 20% coinsurance	None
	Inpatient Services	Deductible	In-network deductible	Prior authorization may be required. Your benefits/ services may be denied.

Employee Leave

Annual Leave Donation Program

The program is to assist full-time employees who have been employed for at least six months and have loss of income when faced with a serious illness or injury to himself/herself or an immediate family member. The Annual Leave Donation Program allows employees to voluntarily transfer accrued Annual Leave or PTO hours to another qualified employee who has exhausted all other paid leave.

Annual Leave Incentive Plan

Any eligible employee may request to sell Annual Leave or PTO for cash payment in lieu of taking time off. An employee may sell a minimum of 8 hours and a maximum determined by the BCC of Annual Leave or PTO per fiscal year, as long as 240 hours remain after the Annual Leave/PTO is sold.

The payout of Annual Leave/PTO shall be contingent upon availability of funds, at the BCC's discretion.

Holidays

All employees shall have holidays with pay each year based on the published Holiday Schedule. Subject to the approval of the County Administrator, one holiday may be exchanged for another, and special holidays with pay may be granted, provided the total number of holidays is kept equitable among all employees.

Sick Leave

Sick Leave is not to be considered a right which an employee may use at his discretion, but is a privilege not to be abused. The purpose of Sick Leave is to assist the employee during an illness or injury. Sick leave shall not be credited in advance. Sick Leave accrual begins on the date of regular employment and ends on the date of separation.

Sick Leave Pool

Membership in the Sick Leave Pool is open to all eligible employees on a voluntary basis. The following criteria must be met:

- **Must be a full-time BCC employee**
- **Must have a minimum of 100 hours of unused Sick Leave/PTO or ELB**
- **Must contribute 12 hours of Sick Leave or PTO/ELB to the pool**

The employee must complete an Application for Membership and submit it to Human Resources where it must be approved before the donation can be made.

Long Term Disability (LTD)

The goal of the disability plan is to provide you with income replacement should you become disabled and unable to work due to non-work-related illness or injury. The county offers eligible employees disability income benefits via payroll deduction. You many choose when the benefits begin after a 90 or 180 day waiting period. This is called your elimination period.

You will be paid an amount according to the option you elect under our present plan until you can return to work or up to the age of 65. Should you qualify for Social Security or State Retirement Disability, the amount you would receive from these government plans would act as an offset against the amount you receive from your LTD Plan. This plan provides a minimum benefit of $100 per month, regardless of other income you may receive during disability (Social Security, or State Retirement Disability) until age 65. Should you never qualify for these government plans, then your LTD would pay until age 65.

You have four options to determine the percentage of income you would receive if you become disabled due to injury or sickness (after your elimination period has been reached) from 40% up to 60% of your gross income to a maximum of $5,000 a month.

You have an option to purchase additional coverage at a low monthly price. If your family cannot function without a percentage of your income for 180 days, you can choose to lower your out-of-work time or elimination period from 180 days to 90 days for the 50% (only) of your gross income.

You can choose any one of the options provided, or you can waive the coverage.

Premium costs for LTD are based on your salary, which is updated annually at the beginning of the calendar year. The Human Resources Division has a simple worksheet to determine the monthly cost of your options. You will also need to fill out an Evidence of Insurability Form to increase your percentage of coverage or decrease the elimination period.

Deferred Compensation

Employees are eligible to enroll in voluntary Deferred Compensation Plan(s) (457). Deferred Compensation is an arrangement which permits you to authorize a portion of your salary to be withheld and invested in group variable annuity contracts for payment to you at a later date. State Retirement and Social Security may not be enough to cover all your needs, depending on when you plan to retire. Deferred Compensation is a voluntary contribution made by you to supplement retirement planning needs. Neither the contributed amount nor any investment earnings are subject to current federal and (in most cases) state income taxes until the deferred income plus earnings are distributed to you. These distributions are generally taken at retirement when you may be in a lower tax bracket. Per IRS guidelines, retired special risk personnel may be able to elect a withdrawal of up to $3,000 once per calendar year, tax free, to pay for their health insurances premiums. Please contact your plan provider for more information. Provider information is in the index of this booklet.

Life and AD&D Insurance

Vendor: Standard Insurance Company **Group Number:** 754403-A

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment.

The county provides Basic Life (Term Life) and AD&D Insurance to all eligible employees, at no cost to you, in the amount of $40,000. Employees (except Medicare & Tricare) that do not elect health care coverage are eligible to elect an additional $10,000 of life insurance coverage for no additional cost.

Employees have an option to purchase Supplemental Life Insurance in $10,000 increments up to $300,000.

Employees have two options to purchase Dependent Life insurance:

Option 1 Employees have the option to purchase Dependent Life Insurance for their spouse ($5,000) and children ($2,000) for $1.49 per month.

Option 2 Employees have the option to purchase spouse Dependent Life Insurance, up to $150,000. Any election over $30,000 requires a medical review.

Child coverage is available for $2,000 for $1.06, $5,000 for $2.15 or $10,000 for $3.30 (per month).

Employees must choose between Option 1 and Option 2. Two employees working for the county are ineligible to cover each other on Dependent Life Insurance. One parent can only cover children of the dual county employees. Children may remain on the Dependent Life Insurance until the age of 20, unless they are full-time students, in which case the coverage will stop on their 25th birthday.

Employees have the option to continue or convert their life insurance at termination or retirement.

Coverage is reduced by 50 percent when employees reach age 70. Premiums on the life insurance matrix for 70+ reflect this reduction.

For life insurance premiums, please see the next page.

Life Insurance Matrix

Monthly Costs: Employee Supplemental Life and AD&D

Age	Employee Rates										
	$1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
Less than 30	$0.148	$1.48	$2.96	$4.44	$5.92	$7.40	$8.88	$10.36	$11.84	$13.32	$14.80
30-34	$0.158	$1.58	$3.16	$4.74	$6.32	$7.90	$9.48	$11.06	$12.64	$14.22	$15.80
35-39	$0.178	$1.78	$3.56	$5.34	$7.12	$8.90	$10.68	$12.46	$14.24	$16.02	$17.80
40-44	$0.248	$2.48	$4.96	$7.44	$9.92	$12.40	$14.88	$17.36	$19.84	$22.32	$24.80
45-49	$0.338	$3.38	$6.76	$10.14	$13.52	$16.90	$20.28	$23.66	$27.04	$30.42	$33.80
50-54	$0.488	$4.88	$9.76	$14.64	$19.52	$24.40	$29.28	$34.16	$39.04	$43.92	$48.80
55-59	$0.778	$7.78	$15.56	$23.34	$31.12	$38.90	$46.68	$54.46	$62.24	$70.02	$77.80
60-64	$1.128	$11.28	$22.56	$33.84	$45.12	$56.40	$67.68	$78.96	$90.24	$101.52	$112.80
65-69	$1.788	$17.88	$35.76	$53.64	$71.52	$89.40	$107.28	$125.16	$143.04	$160.92	$178.80
70+	$6.288	$31.44	$62.88	$94.32	$125.76	$157.20	$188.64	$220.08	$251.52	$282.96	$314.40

Age	Employee Rates									
	$110,000	$130,000	$150,000	$170,000	$190,000	$200,000	$230,000	$250,000	$270,000	$300,000
Less than 30	$16.28	$19.24	$22.20	$25.16	$28.12	$29.60	$34.04	$37.00	$39.96	$44.40
30-34	$17.38	$20.54	$23.70	$26.86	$30.02	$31.60	$36.34	$39.50	$42.66	$47.40
35-39	$19.58	$23.14	$26.70	$30.26	$33.82	$35.60	$40.94	$44.50	$48.06	$53.40
40-44	$27.28	$32.24	$37.20	$42.16	$47.12	$49.60	$57.04	$62.00	$66.96	$74.40
45-49	$37.18	$43.94	$50.70	$57.46	$64.22	$67.60	$77.74	$84.50	$91.26	$101.40
50-54	$53.68	$63.44	$73.20	$82.96	$92.72	$97.60	$112.24	$122.00	$131.76	$146.40
55-59	$85.58	$101.14	$116.70	$132.26	$147.82	$155.60	$178.94	$194.50	$210.06	$233.40
60-64	$124.08	$146.64	$169.20	$191.76	$214.32	$225.60	$259.44	$282.00	$304.56	$338.40
65-69	$196.68	$232.44	$268.20	$303.96	$339.72	$357.60	$411.24	$447.00	$482.76	$536.40
70+	$345.84	$408.72	$471.60	$534.48	$597.36	$628.80	$723.12	$786.00	$848.88	$943.20

Monthly Costs: Spouse Supplemental Life and AD&D

Age	Spouse Rates						
	$1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000
Less than 30	$0.146	$1.46	$2.92	$4.38	$5.84	$7.30	$8.76
30-34	$0.156	$1.56	$3.12	$4.68	$6.24	$7.80	$9.36
35-39	$0.176	$1.76	$3.52	$5.28	$7.04	$8.80	$10.56
40-44	$0.246	$2.46	$4.92	$7.38	$9.84	$12.30	$14.76
45-49	$0.336	$3.36	$6.72	$10.08	$13.44	$16.80	$20.16
50-54	$0.486	$4.86	$9.72	$14.58	$19.44	$24.30	$29.16
55-59	$0.776	$7.76	$15.52	$23.28	$31.04	$38.80	$46.56
60-64	$1.126	$11.26	$22.52	$33.78	$45.04	$56.30	$67.56
65-69	$1.786	$17.86	$35.72	$53.58	$71.44	$89.30	$107.16
70+	$6.286	$31.43	$62.86	$94.29	$125.72	$157.15	$188.58
Age	**Spouse Rates**						
	$70,000	$80,000	$90,000	$100,000	$110,000	$130,000	$150,000
Less than 30	$10.22	$11.68	$13.14	$14.60	$16.06	$18.98	$21.90
30-34	$10.92	$12.48	$14.04	$15.60	$17.16	$20.28	$23.40
35-39	$12.32	$14.08	$15.84	$17.60	$19.36	$22.88	$26.40
40-44	$17.22	$19.68	$22.14	$24.60	$27.06	$31.98	$36.90
45-49	$23.52	$26.88	$30.24	$33.60	$36.96	$43.68	$50.40
50-54	$34.02	$38.88	$43.74	$48.60	$53.46	$63.18	$72.90
55-59	$54.32	$62.08	$69.84	$77.60	$85.36	$100.88	$116.40
60-64	$78.82	$90.08	$101.34	$112.60	$123.86	$146.38	$168.90
65-69	$125.02	$142.88	$160.74	$178.60	$196.46	$232.18	$267.90
70+	$220.01	$251.44	$282.87	$314.30	$345.73	$408.59	$471.45

Changing Your Coverage (Qualifying Life Event) During the Plan Year

Under certain circumstances, employees are permitted to make mid-year plan changes if the requested change results from a qualified event as defined by the IRS. Please contact benefits to request the change **within 30 days** of one of the events listed below (contact Benefits to request the change):

Marital Status

A change in marital status includes marriage, death of a spouse, divorce or annulment.

Change in Number of Dependents

A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid change in the status.

Gain or Loss of Dependents' Eligibility Status

An event that causes an employee's dependent to satisfy or cease to satisfy coverage eligibility requirements under an employer's plan may include change in age, student, marital or employment status.

Open Enrollment Under Other Employer's Plan

You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and:

- The other employer's plan has a different period of coverage or
- The other employer's plan permits mid-year election changes.

Judgment/Decree/Order

If a judgment, decree or order from a divorce, annulment or change in legal custody requires that you provide health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for the dependent child and only if the other individual actually provides the coverage.

Medicare/Medicaid

Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.

Family and Medical Leave Act

Employees taking FMLA leave may make election changes under the special rules relating to changes in elections.

Questions?

Contact the county Benefits Office at **595-3000** for more information about changing your coverage during the plan year.

Voluntary Insurances

The county provides employees the opportunity to buy, payroll deduct, and flex other types of insurances through Colonial Life, AFLAC, or Allstate. A list of products each company provides is listed below. If you have any questions, please contact the representative for the respective company. Contact info is listed in the index of this booklet.

Voluntary Insurance Products Offered to County Employees

Insurance Type	AFLAC	AllState Workplace	Colonial Life
Accident Plan	✓	✓	✓
Annuities			
Cancer Plan	✓	✓	✓
Critical Illness		✓	✓
Dental Plan	✓		
Hospital Indemnity Plan	✓	✓	
Hospital Intensive Care Plan	✓	✓	
Hospital Sickness Indemnity Plan	✓		
Quality of Life (life insurance, critical & chronic)			
Short Term Disability	✓	✓	✓
Special Health Event (heart attack, stroke, etc.)	✓	✓	
Term Life Insurance	✓	✓	✓
Universal Life Insurance		✓	✓
Vision Plan	✓		
Whole Life Insurance	✓		
Worksite Term Life	✓		
Medical Bridge (Gap Plan)			✓
Supplemental Health Plan		✓	
Heart Stroke		✓	

Pre-Paid Legal

The county provides employees the opportunity to buy through payroll deduction legal and identity theft protection through LegalShield. For additional information, please contact Rebecca Smith or Ken Terry at 800-729-7998 or rjsmith@smithterry.com.

Florida Retirement System

This information is provided for informational purposes only. Please visit myfrs.com for details.

County employees are members of the Florida Retirement System (FRS). As of July 1, 2011, the county and employees share in the contribution toward retirement. Presently, the employee must pay 3 percent toward the contribution unless you are participating in DROP or if you are a re-employed retiree who is not eligible for renewed membership. Employees cannot elect not to pay their contribution to the FRS unless they are participating in DROP or they are re-employed, then the county pays the entire retirement contribution. Currently, FRS offers two retirement programs: (1) a traditional pension plan and (2) an investment plan. An employee who has any FRS service credit prior to July 1, 2011 and not considered a reemployed retiree is vested in the Pension Plan upon completion of six years of FRS service. If you start work in the FRS system after July 1, 2011, you are vested upon completion of eight years of FRS service in the Pension Plan. In the Investment Plan, you are vested upon completion of one year of FRS service.

Initial Election

Senate Bill 7022, enacted during the 2017 regular legislative session, extended the initial election period and changed the default membership for most FRS members whose initial election period is effective on or after Jan. 1, 2018.

- The initial election period after the month of hire has been extended from five calendar months to eight calendar months.
- Members in the Special Risk Class will continue to default to the Pension Plan. Members in all other membership classes will default to Investment Plan membership when no active election is made.
- Default membership resulting from no active elction being made is based on the membership class covering the position at the end of the eight months after the month of hire.

Choosing Your FRS Plan

As a county employee, you have a choice of two retirement plans: the **FRS Pension Plan** and the **FRS Investment Plan.** The FRS has made it easy to enroll, no matter which plan you choose.

New employees:

- Visit **www.MYFRS.com** to access and print the EZ FRS Enrollment Form, or call the toll-free MyFRS Financial Guidance Line at **1-866-446-9377**, option 4.
- You may also view the FRS's 15 minute **"New Hire Video"** available on the website or through the Human Resources Office. This video showcases the differences between the two plans and is designed to help you better understand your choices.
- Ernst & Young Financial Planners or Division of Retirement counselors are available to explain the plans and answer your questions. To speak to a planner or counselor, call the toll-free MyFRS Financial Guidance Line at **1-866-446-9377** (TTY 1-88-429-2160 for hearing impaired).
- Access is also available to the online Choice Service at **www.MyFRS.com**, where you can compare an estimate of projected benefits under both plans using various scenarios. Please use these free resources and make an informed choice for your future.

FREE Financial Planners

Ernst & Young Financial Planners are available from 9 a.m. to 8 p.m. ET, Monday-Friday.

Divisions of Retirement counselors are also available at no cost.

FRS Website

Utilize the free services available at **www.MyFRS.com.**

Use your PIN and Social Security Number to access your account.

FRS Workshops

Attend a workshop on retirement, investing or estate-planning offered free by FRS.

Check the schedule on MyFRS.com or ask Human Resources for more information.

MyFRS Financial Guidance Line

1-866-9377
TTY: 1-888-429-2160 (hearing impaired)

Call this toll-free line to speak to a planner or counselor and to get more information about FRS.

Second Election

At any time during your total active career (once you've made your initial plan selection), you can change your mind and return to the FRS Pension Plan or move into the FRS Investment Plan by using your one-time second election. Depending on which plan you're changing to, there could be an out-of-pocket cost to you. To make your second election, visit **www.MyFRS.com** to access and print the Second Election Retirement Plan Enrollment Form. Your second election will be effective the first day of the month following the month that FRS receives your enrollment form. If you're going to terminate employment, your second election enrollment form must be received and processed by FRS prior to your termination date. You may wish to do an annual review to determine if your current plan is still best for you or whether you should use your second election to change plans. You can do so by calling the MyFRS Financial Guidance Line to discuss the plans with an Ernst & Young financial planner.

FRS Pension Plan

The FRS Pension Plan is a defined benefit retirement plan. The FRS employer and employee make contributions to the plan. If an employee worked in the FRS system prior to July 1, 2011, they are vested for benefits under this plan after completing six years of creditable service. Unreduced or normal retirement income benefits are available once the participant has completed six years of creditable service and is age 62, or has completed 30 years of service, regardless of age. If an employee started working in the FRS system after July 1, 2011 an unreduced or normal retirement income benefit is available once the participant has completed eight years of creditable service and is age 65 or completed 33 years of service, regardless of age for all FRS classes of employee except Special Risk.

If a Special Risk employee worked in the FRS system prior to July 1, 2011, they must be:

- Vested and be age 55, or
- Have 25 years of special risk service (which may include military service) and be age 52, or
- Have 25 years of special risk service, regardless of age, or
- Have 30 years of any creditable service, regardless of age.

If an employee enrolled in the FRS on or after July 1, 2011 to qualify for normal retirement, they must be:

- Vested and be age 60, or
- Have 30 years of special risk service (which may include military service) and be age 57, or
- Have 30 years of special risk service, regardless of age, or
- Have 30 years of any creditable service, regardless of age.

FRS Pension Plan continued on next page

Florida Retirement System, continued

The participant's retirement under the FRS Pension Plan is guaranteed based on a formula that includes age, FRS membership class, years of FRS service, and average final compensation. At retirement, participants may select from one of the four lifetime retirement options: 1) Life only; 2) Life only with10 year survivor benefit starting from retirement date); 3) Life with lifetime survivor benefit; and 4) JLife with 1/3 reduction upon death of either member.

Cost-of-Living Increase: After you retire, you may receive an annual cost-of-living increase beginning in your July benefit payment each year. The July benefit is payable on the last working day of July. The cost-of-living increase is 3 percent for FRS Pension Plan retirements effective prior to August 1, 2011. The cost-of-living increase for FRS Pension Plan retirements effective on or after August 1, 2011 will be the sum of their pre-July 2011 service credit divided by the total service credit at retirement multiplied by 3 percent. FRS Pension Plan members initially enrolled on or after July 2, 2011, will not have a COLA after retirement.

FRS Investment Plan Program Highlights Include:

- **Participants are vested after one year of FRS creditable service.**
- **The participant's account is portable. Upon termination of employment, participants can choose to leave their balance invested in the FRS Investment Plan, or elect a distribution as described on the previous page.**
- **Participants direct where their money is invested among the available investment funds.**
- **Participants assume the investment risks.**
- **Participants do not have a guaranteed retirement income.**
- **Participants generally can change their investment fund selection(s) daily, although there are some trading restrictions.**
- **Participants are not eligible for participation in DROP.**

Deferred Retirement Option Program (DROP)

The Deferred Retirement Option Program (DROP) is available to all FRS Pension Plan members who are eligible for normal retirement. DROP is not available for FRS Investment Plan participants. Eligible members must choose to enter DROP within 12 months of first meeting the qualifications, and may participate in DROP for up to 60 months. Under DROP, you actually retire from the FRS, selecting your retirement benefit option under the FRS Pension Plan and establishing a future termination date with the county not to exceed 60 months from the date of entering DROP. Employees going into DROP will receive compounded monthly interest at an annual rate of 1.3% on their DROP. The cost of living will be based on the rules provided in the section talking about FRS Pensions.

Upon termination of DROP, you will receive your DROP benefits in one of three ways: 1) lump sum paid directly to you, 2) direct rollover to an eligible IRA or other eligible qualified account, or 3) a combination of 1 and 2. As of July 1, 2005, DROP participants (former and current) are allowed to roll over their DROP accumulation into the FRS Investment Plan. This option allows participants to take advantage of the low-cost investment products offered in the Investment Plan. More information is provided on www.MyFRS.com. Calls are also accepted at 1-866-446-9377, option 1.

Q&A: Florida Retirement System DROP

What happens if I do not terminate my employment at the end of my DROP period?

If you do not terminate at the end of your DROP period, your DROP application is voided and your DROP participation is retroactively canceled. FRS Pension Plan membership and service credit will be re-established.

How do I know if DROP is more beneficial to me than remaining in the Pension Plan and earning additional service credit or changing to the FRS Investment Plan?

You should review your anticipated FRS benefits under both FRS plans before entering DROP. You can call the toll-free MyFRS Financial Guidance Line at 1-866-446-9377 and speak to one of the financial planners from Ernst & Young or to one of the retirement counselors at the Division of Retirement to get estimates of benefits from both plans, as well as guidance on which plan may be best for you. For the hearing impaired, the TTY line is available at 1-888-429-2160.

Will I be able to contribute to my voluntary retirement account if I participate in DROP?

Yes. Participation in DROP does not prohibit you from making elective contributions to your retirement plan.

Do my benefits from FRS grow or remain constant if I enter DROP?

Your FRS benefits will grow each year by 3% based on the income option you select upon entering DROP.

Retirement Incentive Program

The Retirement Incentive Program allows BCC employees to retire upon their first, second, or third year of eligibility. An employee would receive a one-time payment of 15% of their annual gross salary if they retire in their first eligible year, 10% if they retire in their second eligible year, and 5% if they retire in their third eligible year. Employees in DROP are not eligible for the Retirement Incentive Program.

FRS Telephone number for the following sections: 1-844-377-1888

Calculations Section - Calculating retirement benefits and estimates of benefits, and contributions required to purchase various types of creditable service.

Enrollment Section - Enrolling agencies and members in the FRS and Social Security; processing changes in beneficiaries.

Contributions Section - Receiving and balancing monthly payroll reports from FRS employers.

Retired Payroll Section - Issuing retirement benefit payments and retirement contribution refunds.

Survivor Benefits Section - Paying of retirement benefits to survivors and beneficiaries; processing beneficiary changes after retirement.

Annual & Enrollment Notices

Grandfathered Health Plan Disclosure

This group health plan believes BlueOptions Plans #1168, #1169, #1352, and #1552 are "grandfathered health plans" under the Patient Protection and Affordable Care Act, (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

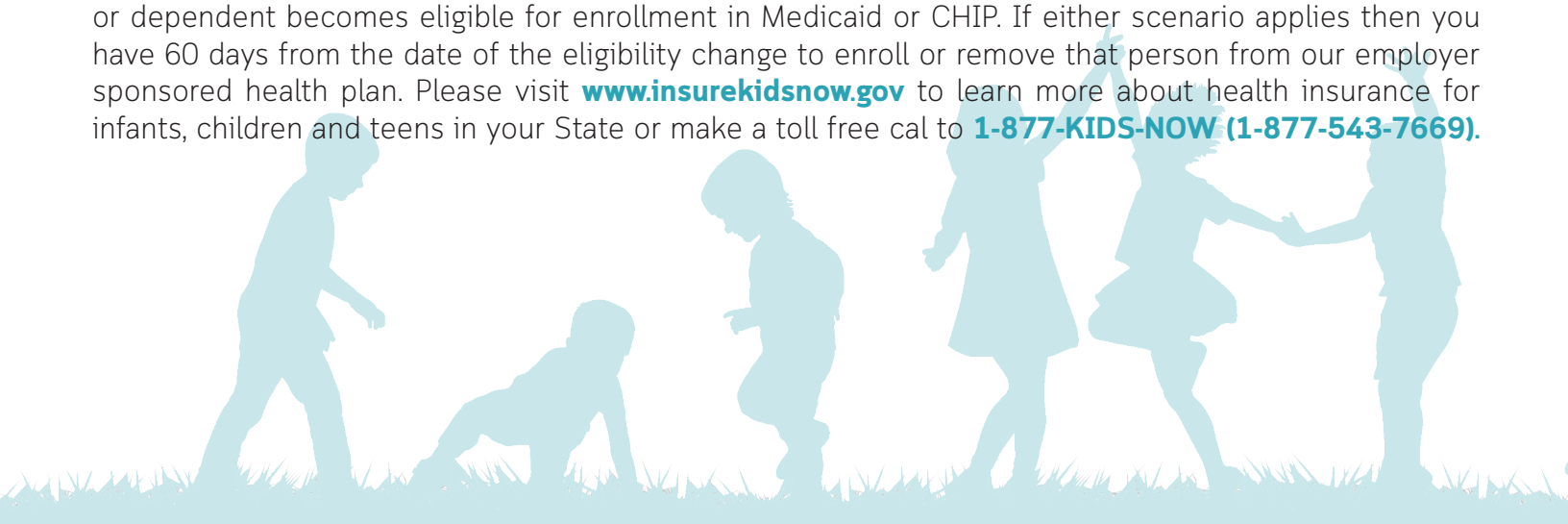
Questions regarding which protections apply and which protections do not apply to grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the Human Resource Department at **850-595-4681**. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov.**

Affordable Care Act (ACA) - Healthcare Reform Exchange Notice

Under ACA, large employers are responsible to provide eligible employees with coverage that meets the affordability and actuarial value rules set by the our government. The plans offered by your employer meet these standards. You will receive a separate notice with specific information. As a result, you and/or your dependents may not be eligible for a federal or state subsidy when applying for coverage in the Healthcare Marketplace.

Children's Health Insurance Program

CHIP (Children's Health Insurance Program) offers a special 60-day enrollment period to add or remove dependents from coverage in our group health plan under two scenarios: 1) The employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility. 2) The employee or dependent becomes eligible for enrollment in Medicaid or CHIP. If either scenario applies then you have 60 days from the date of the eligibility change to enroll or remove that person from our employer sponsored health plan. Please visit **www.insurekidsnow.gov** to learn more about health insurance for infants, children and teens in your State or make a toll free cal to **1-877-KIDS-NOW (1-877-543-7669)**.



The Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act, or WHCRA.

Genetic Information Nondiscrimination Act (GINA) of 2008

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

HIPAA – Privacy Act Legislation

The Health Plan and your healthcare carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007

Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including Social Security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine which plan pays first - Employer plan or Medicare/Medicaid./SCHIP for those employees covered under a government plan and an employer sponsored plan.

Annual & Enrollment Notices, continued

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract provides.

Mental Health Parity and Addiction Equity Act (MHPAEA)

MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for either mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA 96 required parity with respect to aggregate lifetime and annual dollar substance use disorder benefits. Thus, under MHPAEA, group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

Michelle's Law

Michelle's Law, an amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC). This law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitle to the same level of benefits during medically necessary leave of absence as the child had before taking the leave, If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.