EMPLOYEE BENEFIT HIGHLIGHTS

2024-2025

Contact Information

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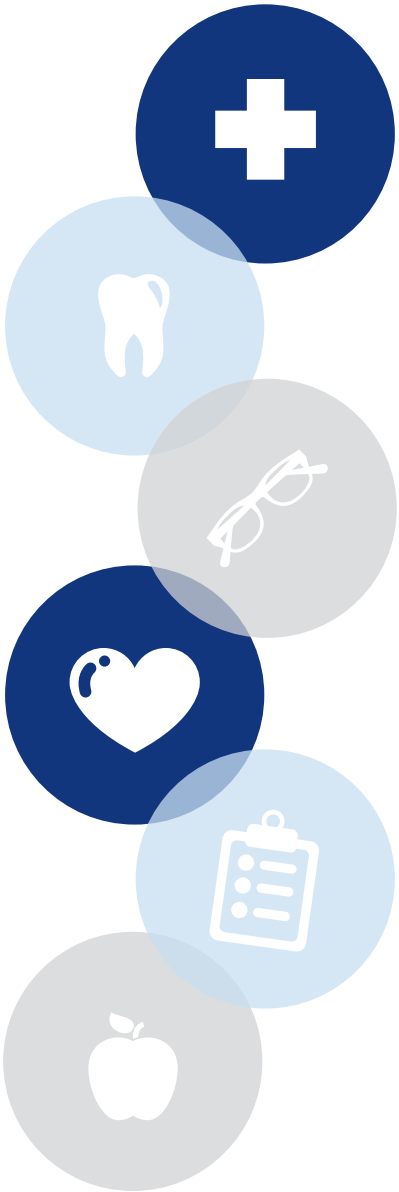
		Stephanee Phillips, Wellness Coordinator	Phone: (941) 764-4927 https://wellness.charlottecountyfl.gov Stephanee.Phillips@charlottecountyfl.gov
	**Online Benefit Enrollment**	Bentek Support	(888) 5-Bentek (523-6835) support@mybentek.com www.mybentek.com/charlottecounty
	**Medical Insurance**	Cigna Healthcare	Customer Service: (800) 244-6224 Onsite Cigna Representative: (941) 743-1388 www.mycigna.com
	**Mail-Order Pharmacy Program**	Elixir Pharmacies	Customer Service: (866) 909-5170 www.elixirsolutions.com
	**Telehealth**	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.mycigna.com
	**Health Reimbursement Account**	P&A Group	Customer Service: (716) 852-2611 www.padmin.com
	**Dental Insurance**	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	**Vision Benefit**	EyeMed	Customer Service: (866) 939-3633 www.eyemed.com
	**Flexible Spending Accounts**	P&A Group	Customer Service: (716) 852-2611 www.padmin.com
	**Employee Assistance Program**	Cigna Behavioral Health	Customer Service: (877) 622-4327 www.mycigna.com
	**Basic Life and AD&D Insurance**	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Voluntary Life Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	**Voluntary Short & Long Term Disability Insurance**	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	**Supplemental Insurance**	Aflac	Customer Service: (800) 992-3522 www.aflacgroupinsurance.com
	**Medicare Supplemental Insurance**	Valery Insurance Agency	Customer Service: (800) 330-8445
	COBRA Benefits	P&A Group	Customer Service: (716) 852-2611 www.padmin.com
	**Legal Insurance**	Legal Shield	Agent: Jim and Andrea Carroll Phone: (941) 235-1770
	**Employee Health Centers**	My Health Onsite	Customer Service: (941) 800-2005 Customer Service: (941) 764-0301 www.MyHealthOnsite.com/patient-access

Table of Contents



This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The County reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

CHARLOTTE COUNTY
FLORIDA

Introduction

The County is pleased to offer a comprehensive array of benefits including group insurance coverage, retirement savings plans, Employee Health Centers and wellness programs. Please refer to the County Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. For further explanation or assistance answering specific questions, please refer to the customer service phone number under each benefit description heading. General inquiries may be directed to Risk Management.

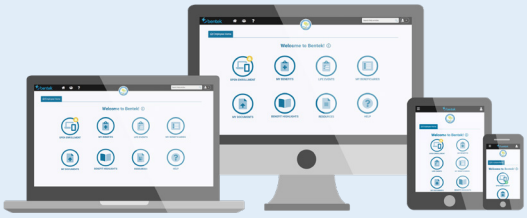
IMPORTANT NOTE

New Hires have two weeks from date of hire to complete the benefit election process.

Online Benefit Enrollment

The County provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Life Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report qualifying life events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/charlottecounty**

  Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com, Monday through Friday during regular business hours 8:30am - 5:00pm.

To access Bentek using a mobile device, scan code.

Core Benefits

Plan Coverages at Time of Hire

The County's health insurance plan consists of the following core benefits:

- ✓ Medical Insurance (including prescription drug coverage)
- ✓ Dental Insurance
- ✓ Vision Insurance
- ✓ Basic Term Life Insurance
- ✓ Accidental Death and Dismemberment Insurance
- ✓ Employee Assistance Program

Medical, dental and vision coverage is offered to all benefit-eligible employees as a package, however, employee can elect to opt-out of dental and/or vision and remain on the medical plan only (please note that this will not affect employee's deductions). Electing dependent coverage also entitles employee's dependent(s) to receive benefits with the exception of the Basic Life and Accidental Death and Dismemberment Insurance. The employee costs for these Core Benefits are payroll deducted under a pre-payment plan. Deductions are taken out the month before the effective date of coverage. For example, if the effective date is December 1, payroll deductions would be taken in November. There are 24 payroll deductions per year.

Employee will also be offered the following optional benefits that can be elected on a voluntary basis and payroll deducted:

- ✓ Short Term Disability Insurance
- ✓ Long Term Disability Insurance
- ✓ Flexible Spending Accounts (Medical & Dependent Care)
- ✓ Voluntary Term Life Insurance

Open Enrollment

The County's annual Open Enrollment period is the time of year employees may make changes to their benefit elections. These elections will be effective when the new plan year begins on October 1. During Open Enrollment, employees may:

- ✓ Change your Section 125 Tax Election
- ✓ Add Dependent(s)
- ✓ Remove Dependent(s)
- ✓ Apply for Short Term Disability
- ✓ Apply for Long Term Disability
- ✓ Apply for Voluntary Life Insurance
- ✓ Apply for Aflac Products

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

Other Coverage

If employee is covered by another medical insurance plan (example: an individual policy, as a dependent under a spouse's policy, military insurance, etc.) and employee wishes to decline the County's medical insurance plan, the County will reimburse employee $200 per month (considered taxable income). However, employee will still be enrolled in the Basic Life insurance and Accidental Death and Dismemberment insurance at no cost. To be eligible to receive this coverage rebate, employee must be under the age of 65 and not Medicare eligible. Employee must also provide proof of other medical insurance (example; certificate of insurance, copy of identification card or copy of current policy). Employee will be required to verify this information on an annual basis.

Coordination of Benefits

When both employee and spouse work for the County, each person may be covered by their employer's health plan, as well as the spouse's health plan. Coordination of benefits determines which group health care plan pays benefits first. The secondary health plan may then pay additional benefits. Health insurers follow a common set of guidelines to determine which plan pays first and which plan pays second for family members. The employee's group health care plan is always primary. If the employee is married, and both the employee and spouse cover dependent child(ren), the plan that covers the parent whose birthdate is first in the calendar year is usually primary for any dependent child(ren).

Other factors that may affect which plan pays first includes eligibility for Medicare, court decrees or custody arrangements, the length of time an employee is covered, and whether employee is active or a retiree. If both the employee and employee's spouse are both County employees, they may not be covered as both an employee and a dependent. Additionally employees may not cover child(ren) as dependent(s) of both employees.

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

Group Insurance Eligibility

The County's group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the County's health insurance plans if they are full-time employees or average 130 working hours a month, under the accepted measurement method elected under the Affordable Care Act. Coverage will be effective the first of the month following 30 days of employment. For example, if employee is hired on February 11, then the effective date of coverage will be April 1.

Separation of Employment

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

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child(ren) of the participant or the spouse. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A stepchild
- A 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 age 26. An over-age dependent may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Please see Taxable Dependents if covering eligible dependents over age 26.

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

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

Disabled Dependents

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

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group medical plan; and
- The dependent has been continuously insured

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

Taxable Dependents

Employee covering adult child(ren) under employee's medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Contact Risk Management for further details if covering an adult dependent child who will turn age 27 any time during the upcoming calendar year or for more information.

Annual Over-Age Dependent Audits

At the end of each year Risk Management will conduct an over-age dependent audit of all dependent children over the age of 26 that are on the plan. An employee who meets the criteria to keep an over-age dependent on the medical plan must complete an Over-Age Dependent Verification Form, and pay the appropriate post-tax premium. The form includes an affidavit whereby employees must sign verifying they understand; that any person who knowingly and with the intent to defraud or deceive any insurer by providing false or misleading information may result in denial of benefits, termination of coverage and/or disciplinary action (Fl Statute Ch 817.234(1)(b)(200).

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code 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(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, 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 Section 125 of the Internal Revenue Code. 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)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment.
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

IMPORTANT NOTES

If employee experiences a Qualifying Event, **Risk Management must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes may be effective the date of the Qualifying Event or the first of the month following the Qualifying Event. Newborns are effective on the date of birth. Qualifying Events will be processed in accordance with employer and carrier eligibility policy. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided as a supplement to this booklet being distributed to new hires and existing employees during the Open Enrollment period. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	Benefits Coordinator
Address:	Charlotte County Risk Management 18500 Murdock Circle #B-201, Port Charlotte, FL 33948
Phone:	(941) 743-1244
Email:	Jennifer.Bullistron@charlottecountyfl.gov
Enrollment Software – Bentek:	www.mybentek.com/charlottecounty

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Benefits Coordinator.

If there are any questions about the plan offerings or coverage options, please contact the Benefits Coordinator at (941) 743-1244.

Medical Insurance

The County offers medical insurance through Cigna Healthcare to benefit-eligible employees. The monthly costs for coverage are listed in the premium tables below. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) or contact Cigna's customer service.

An Open Access Plan (OAP) is a plan that allows members to access any in-network provider (physician, lab, hospital, etc.) anywhere in the United States of America. Unlike an HMO, members do not need to name a Primary Care Physician, or have referrals to see a specialist. Members who stay within the OAP network, are covered according to the plan benefits.

Medical Insurance – Cigna OAPIN Plan - Premiums

Monthly Cost - Includes Medical, Dental and Vision Coverage

Tier of Coverage	Employee Contribution	County Contribution	Total Monthly Rate
Employee Only	$26.00	$1,133.00	$1,159.00
Employee + Spouse	$286.00	$2,153.00	$2,439.00
Employee + Child(ren)	$249.00	$1,870.00	$2,119.00
Employee + Family	$315.00	$2,364.00	$2,679.00

Medical Insurance – Cigna OAPIN Plan - With Tobacco Premiums

Monthly Cost - Includes Medical, Dental and Vision Coverage

Tier of Coverage	Employee Contribution	County Contribution	Total Monthly Rate
Employee Only	$76.00	$1,133.00	$1,209.00
Employee + Spouse	$336.00	$2,153.00	$2,489.00
Employee + Child(ren)	$299.00	$1,870.00	$2,169.00
Employee + Family	$365.00	$2,364.00	$2,729.00

Premium Deductions

Medical, dental and vision coverage is offered to all benefit-eligible employees as a package, however, employee may elect to opt-out of dental and/or vision and remain on the medical plan only (please note that this will not affect the payroll deductions. Electing dependent medical coverage also entitles employee's dependent(s) to receive dental and vision benefits unless they opt-out of dental or vision coverage. Employee costs for benefits are payroll deducted under a pre-payment plan. Deductions are taken the month before the effective date of coverage. For example, if employee's effective date is December 1, payroll deductions would be taken in November. There are 24 deductions per year.

Tobacco User Premiums

Employees must request and complete a nicotine test at one of the Employee Health Centers during the Wellness Initiative Program period. Employees that do not complete the test will receive the "With Tobacco Premium". Employees who test negative for nicotine will qualify for a "With Tobacco Premium" waiver for the plan year. Additionally, employee that tests positive for nicotine but also completes a Tobacco Cessation Program will qualify for a waiver for the plan year. Any employee that DOES NOT complete the test or program by the required deadlines will receive the "With Tobacco Premium".

Other Available Plan Resources

Cigna offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please contact Cigna's customer service at (800) 244-6224, or visit www.mycigna.com.

Cigna Healthcare | Customer Service: (800) 244-6224 | www.mycigna.com

Telehealth

Cigna provides access to telehealth services as part of the medical plan. MDLIVE is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

This benefit is provided to all enrolled members. Registration is suggested and should be completed prior to using services. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with Telehealth, such as:

- ✓ Sore Throat
- ✓ Fever
- ✓ Rash
- ✓ Headache
- ✓ Cold And Flu
- ✓ Acne
- ✓ Stomachache
- ✓ Allergies
- ✓ UTIs And More

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for Urgent Care and ER visits. For further information please contact MDLIVE through Cigna.

Telehealth - MDLIVE	Services Cost Per Visit
Urgent Virtual Care	No Charge
Primary Care	$25.00 Copay
Specialty Care	$35.00 Copay

Cigna Healthcare
MDLIVE | Customer Service: (888) 726-3171 | www.mycigna.com

Cigna OAPIN Plan At-A-Glance

Network	Open Access Plus
Calendar Year Deductible (CYD)*	**In-Network**
Single	$500
Family	$1,000
Coinsurance	
Member Responsibility	0%
Calendar Year Out-of-Pocket Limit*	
Single	$1,500
Family	$3,000
What Applies to the Out-of-Pocket Limit?	Deductible and Copays (Includes Rx)
Physician Services	
Primary Care Physician *(PCP)* Office Visit *(No PCP Election Required)*	$25 Copay
Specialist Office Visit *(No Referral Required)*	$35 Copay
Maternity Visit *(Initial Visit Only)*	$35 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)***	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	0% After CYD
Outpatient Surgery in a Surgical Center	0% After CYD
Physician Services at Surgical Center	0% After CYD
Urgent Care *(Per Visit)*	$50 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	0% After CYD
Outpatient Hospital	0% After CYD
Physician Services at Hospital	0% After CYD
Emergency Room *(Per Visit: Waived if Admitted)*	$150 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	0% After CYD
Outpatient Services *(Per Visit)*	No Charge
Outpatient Office Visit	$35 Copay
Prescription Drugs *(Rx)*	
Generic	$15 Copay
Preferred Brand Name	$30 Copay
Non-Preferred Brand Name	$60 Copay
Mail Order Drug *(90-Day Supply)*	2x Retail Copay

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select **Open Access Plus** network.

Plan References

**Although the plan renews according to the fiscal year (Oct 1 - Sept 30) the deductibles and out-of-pocket limit accrue and reset on a calendar year basis.*

***Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.*

Important Notes

*Services recieved by providers or facilities **not** in the Open Access Plus network, will not be covered.*

Dental Insurance

Cigna Dental PPO Plan

The County offers dental insurance through Cigna Healthcare to benefit-eligible employees. A brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Cigna's customer service.

In-Network Benefits

The Dental PPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Cigna Total DPPO Network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Plan Year Deductible (PYD) and then coinsurance based on the plan's charge limitations.

Please Note: *Total DPPO dental members have the option to utilize a dentist that participates in either Cigna's Advantage Network or DPPO Network. However, members that use the Cigna Advantage Network will see additional cost savings from the added discount that is allowed using an Advantage Network provider. Members are responsible for verifying whether the treating dentist is an Advantage Dentist or a DPPO Dentist.*

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Cigna Total DPPO provider. Cigna reimburses out-of-network services based on what it determines as the Maximum Reimbursable Charge (MRC). The MRC is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between the Cigna's MRC and the amount charged by the out-of-network dental providers. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Plan Year Deductible

The Dental PPO plan benefits begin once each covered member satisfies a $50 deductible (waived for Class I services). The deductible is applied collectively for either in-network or out-of-network services or any combination of both. Once any three (3) covered members in a family each satisfy the $50 deductible, the deductible will be considered met for all covered members in the family.

IMPORTANT NOTE

The plan year deductible for the dental plan is October 1st through September 30th.

Plan Year Benefit Maximum

The maximum benefit (coinsurance) the Dental PPO plan will pay for each covered member is $1,500 for in-network and out-of-network services or combined. Diagnostic and preventive services will accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next plan year.

Cigna Healthcare | Customer Service: (800) 244-6224 | www.mycigna.com

Cigna Dental PPO Plan At-A-Glance

Network	Total Cigna DPPO	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Plan Year Benefit Maximum		
Per Member	$1,500	
Class I Services: Diagnostic & Preventive Care		
Oral Exam	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Cleanings		
X-rays *(Bitewing / Full Mouth)*		
Fluoride Treatments *(Restrictions Apply)*		
Sealants *(Restrictions Apply)*		
Space Maintainers		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% After PYD	Plan Pays: 80% After PYD *(Subject to Balance Billing)*
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Periodontal Services		
Oral Surgery		
Anesthetics		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After PYD	Plan Pays: 50% After PYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,500	
Benefit *(Dependent Children Up To Age 19)*	Play Pays: 50% Deductible Waived	

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select **Cigna Total DPPO** network.

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 previous page.*

Important Notes

- *Each covered family member may receive up to two (2) routine cleanings per plan year covered under the preventive benefit.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply*
- *Benefit frequency limitations may apply to certain services.*

Vision Insurance

EyeMed Vision Care Plan

The County offers vision insurance through EyeMed to benefit-eligible employees. A brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to EyeMed's summary plan document or contact EyeMed's customer service.

Please Note: *Vision coverage is included as part of the medical contribution.*

In-Network Benefits

The vision plan offers employees 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 choose to receive services from vision providers who do not participate in the EyeMed Insight network. When going out of network, the provider will require payment at the time of appointment. EyeMed will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

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

EyeMed | Customer Service: (866) 939-3633 | www.eyemed.com

Other Available Plan Resources

EyeMed.com

- Find an eye doctor.
- Get directions to the provider of choice.
- Schedule appointments.
- View or print member ID card.
- See current benefits eligibility and in-network benefit details.
- Get answers to commonly asked questions.

EyeMed Member App

The EyeMed app is like a personal assistant. Download and get the same helpful features that are found on eyemed.com – but with upgrades like the ability to save vision prescriptions, or schedule an exam and contact lens change reminders. Visit the Apple Store or Android Play Store and download the EyeMed app today.

EyeMed Vision Care Plan At-A-Glance

Network		Insight	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 copay	Up to $35 Reimbursement
Contact Lens Fit & Follow-Up	Standard Lens	Up to $40 Allowance	Not Covered
	Premium Lens	10% Off Retail Price	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		Covered at 100%	Up to $25 Reimbursement
Bifocal		Covered at 100%	Up to $40 Reimbursement
Trifocal		Covered at 100%	Up to $60 Reimbursement
Frames			
Allowance		Up to $200 Retail Allowance; Then 20% Off Balance Over $200	Up to $45 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		Covered at 100%	Up to $210 Reimbursement
Elective *(Lenses)*	Conventional	Up to $200 Allowance; Then 15% Off Balance Over $200	Up to $200 Reimbursement
	Disposable	Up to $200 Allowance; Plus Balance Over $200	Up to $200 Reimbursement

Locate a Provider

To search for a participating provider, contact EyeMed's customer service or visit www.eyemed.com. When completing the necessary search criteria, select **Insight** network.

Plan References

**Contact lenses are in lieu of spectacle lenses.*

Important Notes

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

Health Reimbursement Account

The County is providing employees who participate in the Wellness Initiative Program a Health Reimbursement Account (HRA) administered through P&A Group. HRA monies are not taxable, funded by the County and can be used for any qualified medical expense incurred, such as deductibles and coinsurance for physician services and hospital services.

HRA IRS Guidelines

HRA's must be funded solely by an employer. The contribution cannot be paid through a voluntary salary reduction agreement on the part of an employee. Employee is reimbursed tax free for qualified medical expenses up to a maximum dollar amount per coverage period. An HRA may be offered with other health plans, including Flexible Spending Accounts.

Employee may enjoy several benefits from having an HRA.

- ✓ Contributions made by the employer can be excluded from gross income.
- ✓ Reimbursements may be tax free if employee pays qualified medical expenses.
- ✓ Any unused amounts in the HRA can be carried forward for reimbursements in later years.

Distributions From an HRA

Generally, distributions from an HRA are paid to reimburse employee for qualified medical, dental or vision expenses incurred. The expense must have been incurred on or after the date employee enrolled in the HRA.

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

Health Reimbursement Account (HRA)	Flexible Spending Accounts (FSA)
✓ Employer funded account	✓ Employee funded account
✓ Enrollment is automatic if enrolled in medical plan	✓ Employee must enroll annually
✓ Funds are used for eligible medical expenses for employee and employee's dependent(s) who are enrolled in medical plan	✓ Funds are used for eligible medical, dental, vision & dependent care for employee and employee's qualified dependent(s)
✓ Unused funds accumulate and roll over each year	✓ Employees may carry over unused FSA funds into the next plan year.

If an employee has the HRA and also elects an FSA, FSA monies will be used first since they may be forfeited.

What are some examples of qualified expenses eligible for reimbursement?

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

Health Reimbursement Account *(Continued)*

The County will fund each employee's Health Reimbursement Account (HRA) if the employee (and dependent spouse covered on the plan) participate in the Wellness Initiative Program. This money is not taxable to employee and can be used to offset the cost of expenses incurred under the medical insurance plan. Examples of these expenses include deductible and copays for items such as doctor visits, inpatient hospital stays and prescription drugs that generate out-of-pocket cost to the employee. If both employee and eligible spouse participate in the program, each could earn the $500 incentive up to a maximum of $1,000 (single parent with children can earn a maximum of $750).

HRA Funding Allotment

- If both employee and eligible spouse participate in the program, each are eligible to earn the $500 incentive up to a maximum of $1,000 (single parent with children can earn a maximum of $750).
- Funds remain in account designated for employee until claimed for reimbursement.
- Employee will receive a debit card to pay for medical plan expenses. If provider does not accept debit card, the user will pay the cost for the incurred expense at the time of service and then claim reimbursement from the plan administrator.
- Reimbursement is not subject to income tax.
- Claims must be filed within 90 days after the end of the plan year in order to claim reimbursement.
- Unused funds roll forward for use in future years. When employee retires from the County, employee will be able to use remaining funds for qualified medical expenses. Employee must meet the FRS guidelines for retirement to be considered a retiree. If employee leaves County employment not due to retirement, any unused funds will remain with the County.

Distributions From an HRA

Generally, distributions from an HRA must be paid to reimburse employee for qualified medical, dental or vision expenses employee has incurred. The expense must have been incurred on or after the date employee is enrolled in the HRA. Keep all receipts in the event employee is asked to provide them.

Mobile App

Managing your benefit plans is easier than ever before with P&A Group's mobile app. Time-saving tools are quickly accessible with the tap of an icon, providing you with everything you need to manage your account(s) wherever, whenever. View account information, file claims and upload receipts using a smartphone camera. Visit the App Store (on Apple devices) or Google Play (on Android devices) and search "P&A Group" to get the app.

How to Login to My HRA Account?

1. Go to www.padmin.com and in the Login box make sure "Participant" is selected under User Type. Choose your Account Type and click "Go to Login".
2. Under My Benefits Account Login, enter your username and password and click "Submit". If you are a first time user, click the "First Time Logging In" link. You will be prompted to create a username and password for your account.
3. After you successfully logged into your account, your My Benefits Summary will be displayed. This shows a summary of every plan made available to you through your employer.

Rollover Guidelines

The 2024 plan year will end on December 31, 2024, however, employee will have an additional 90 days after the plan ends to submit claims to P&A Group for service dates from January 1, 2024 to December 31, 2024. Employee will not be able to use the debit card for these services; however employee may submit a claim manually through the online portal, toll free fax, email or mail. All rollover funds occur in April of the following year.

Please Note: *Employees should not use the card for services dated in old plan year as the services will be denied and a repayment request will be generated.*

P&A Group | Phone: (716) 852-2611 | www.padmin.com

Flexible Spending Accounts

The County offers Flexible Spending Accounts (FSA) administered through P&A Group. The FSA Plan Year is from January through December annually. FSA open enrollment period, will be held in December. Employee may elect to participate in either or both FSAs.

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

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,200. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical care expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

***Please Note:** The entire Health Care FSA election is available for use on the first day coverage is effective.*

Dependent Care FSA

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

Please note, if family annual income is over $20,000, this reimbursement option will likely save participant more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household.

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

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

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

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

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Employee may carry over up to $640 of unused Health Care FSA funds into the next plan year after plan year ends and all claims have been filed. Dependent Care funds cannot be carried over.
- When a plan year ends and all claims have been filed with the exception of the $640 rollover for the Health Care FSA, all unused funds will be forfeited and not returned.
- Employee can enroll in an FSA only during the Open Enrollment Period, a Qualifying Event, or a New Hire Eligibility Period.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as Federal law does not recognize them as a qualified dependent.

HERE'S HOW IT WORKS!

An employee earning $50,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $41.66 based on a 24 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$50,000	$50,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$49,000	$50,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $9,628	- $9,825
After Tax Expenses	- $0	- $1,000
Spendable Income	$39,372	$39,175
Tax Savings	**$197**	

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted via web, mobile app, mail or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants can request a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. P&A Group may request supporting documentations for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the P&A Group. If employee has a health care FSA, funds will be deducted first from the FSA until depleted and then from the HRA, when using the debit card.

- The amount employee has available is the balance on the P&A Card. Employee may use the P&A Card up to this amount, but never over. Employee may check available balance at www.padmin.com. Please keep P&A Card as it will be used again next plan year, or up to the expiration date on the card. When the expiration nears, a new card will automatically be ordered.
- If employee is close to reaching the balance on P&A Card, it will only allow employee to spend the funds remaining in the account. If the purchase exceeds the account balance, employee will need to pay the difference using another means of payment (i.e., out-of-pocket).
- If employee decides not to use the P&A Card, employee may submit a manual claim for reimbursement either by fax, email, mail, or online through the secure web form at www.padmin.com (while logged in) or through the P&A Group mobile app for iPhone or Android at any time during the plan year.

Rollover Guidelines

The 2024 plan year will end on December 31, 2024, however, employee will have an additional 90 days after the plan ends to submit claims to P&A Group for service dates from January 1, 2024 to December 31, 2024. Employee will not be able to use the debit card for these services; however employee may submit a claim manually through the online portal, toll free fax, email or mail.

Please Note: *Employees should not use the card for services dated in old plan year as the services will be denied and a repayment request will be generated.*

P&A Group | Phone: (716) 852-2611 | www.padmin.com

Employee Assistance Program

The County cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Cigna. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes three (3) face-to-face visits with a specialist, per person, per issue, per year, telephonic consultation, online material/tools and webinars. EAP offers counseling services on issues such as:

- ✓ Child Care Resources
- ✓ Legal Resources
- ✓ Grief and Bereavement
- ✓ Stress Management
- ✓ Depression and Anxiety
- ✓ Work Related Issues
- ✓ Adult & Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor/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/manager will not receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

To Access Services

Employee and family member(s) must register and create a user ID on www.mycigna.com to access EAP services.

Cigna Behavioral Health
Customer Service: (877) 622-4327 | www.mycigna.com | ID: CCBOCC

Basic Life and AD&D Insurance

Basic Term Life Insurance

The County provides Basic Term Life insurance for all eligible employees at no cost through New York Life. All full-time general employees are covered for a benefit amount of two (2) times base annual salary rounded to the next higher $1,000 to a maximum of $50,000.

Accidental Death & Dismemberment Insurance

The County also provides Accidental Death & Dismemberment (AD&D) insurance which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit and a partial benefit is also payable based on the schedule of benefits. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact New York Life's customer service.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

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

Beneficiary Designations

Events such as death, marriage, birth of a child, and divorce can drastically change a life. For these reasons, it is important to review Life insurance beneficiaries to make sure beneficiary designations are up to date. Employee may update beneficiary information at any time through Bentek, or may download the form on Connect at Work under "County Forms".

Always remember to keep beneficiary forms updated.
Beneficiary forms may be updated at anytime through Bentek.

New York Life Group Benefit Solutions
Customer Service: (800) 362-4462 | www.mynylgbs.com

Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible employee may elect to purchase additional Life insurance on a voluntary basis through New York Life. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages. Voluntary Life insurance offers coverage for employee, spouse or child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $200,000.**

- Units can be purchased in increments of $10,000, with a benefit maximum of $500,000, or not to exceed five (5) times annual salary.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of benefit amount at age 65
  - Reduces to 50% of benefit amount at age 70

2024-2025 Open Enrollment: Eligible employees have the opportunity during Open Enrollment to purchase or increase Voluntary Employee Life insurance up the Guaranteed Issue amount of $200,000 without Evidence of Insurability (EOI)

Voluntary Spouse Life Insurance

New Hires may purchase Voluntary Spouse Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $50,000.**

- Employee must participate in Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $5,000 to a maximum of $250,000, however, coverage cannot exceed 100% of the employee's approved Life insurance coverage amount.
- Spouse Life insurance coverage is subject to the same age reduction schedule as employee with coverage terminating at age 70.

2024-2025 Open Enrollment: Eligible employees have the opportunity during Open Enrollment to purchase or increase Voluntary Spouse Life insurance up the Guaranteed Issue amount of $50,000 without Evidence of Insurability (EOI)

Voluntary Life Insurance Rate Table

Monthly Premium

Age Bracket *(Based On Employee Age)*	Employee/ Spouse (Rate Per $1,000 of Benefit)
Under 35	$0.128
35-39	$0.156
40-44	$0.224
45-49	$0.337
50-54	$0.536
55-59	$0.862
60-64	$1.321
65-69	$2.240
70-74	$4.250
75+	$8.026
Child(ren)	$0.248

Please Note: *Spouse coverage terminates when the spouse reaches age 70*

Voluntary Dependent Child(ren) Life Insurance

- Employee must participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- Children from six (6) months to age 26 may be covered for a $10,000 benefit.
- Children from birth to six (6) months may be covered for a $500 benefit.

New York Life Group Benefit Solutions
Customer Service: (800) 362-4462 | www.mynylgbs.com

Voluntary Short Term Disability

The County offers Voluntary Short Term Disability (STD) insurance to all benefit-eligible employees through New York Life. The STD benefit pays a percentage of weekly earnings if employee becomes disabled due to a non-work related injury or illness. The premium is calculated based on weekly earnings; examples are illustrated in the Voluntary STD Premium Rate Table below. Employee's STD rate and benefit will be adjusted if salary fluctuates throughout the plan year.

Voluntary Short Term Disability (STD) Benefits

- STD provides 60% of weekly earnings, up to a maximum benefit of $1,000 per week.
- Employee must be disabled 29 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefit begins on the 30th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 22 weeks.
- Employee unable to return to work after 22 weeks will be automatically transitioned to Long Term Disability, if elected.
- The benefit amount will be offset by any other income received. Employee may not receive more than 60% total of all income combined.

Please Note: *If employee does not elect this coverage when initially eligible, employee will have to complete an Evidence of Insurability form if electing in the future. This form will ask basic medical history questions and must be approved by carrier prior to employee's coverage becoming effective.*

2024-2025 - Open Enrollment will not require EOI for enrollment

Voluntary STD Premium Rate Table

Annual Salary	Weekly Salary	Benefit Per Week	Monthly Premium
$15,000	$288.46	$173.08	$4.85
$20,000	$384.62	$230.77	$6.46
$25,000	$480.77	$288.46	$8.08
$30,000	$576.92	$346.15	$9.69
$35,000	$673.08	$403.85	$11.31
$40,000	$769.23	$461.54	$12.92
$45,000	$865.38	$519.23	$14.54
$50,000	$961.54	$576.92	$16.15
$55,000	$1,057.69	$634.62	$17.77
$60,000	$1,153.85	$692.31	$19.38
$65,000	$1,250.00	$750.00	$21.00
$70,000	$1,346.15	$807.69	$22.62
$75,000	$1,442.31	$865.38	$24.23
$80,000	$1,538.46	$923.08	$25.85
$86,667	$1,666.67	$1,000.00	$28.00

Voluntary Long Term Disability

The County offers Voluntary Long Term Disability (LTD) insurance to all benefit-eligible employees through New York Life. The LTD benefit pays a percentage of monthly earnings if employee becomes disabled due to a illness or injury. The premium is calculated based on monthly earnings; examples are illustrated in the Voluntary LTD Premium Rate Table below. Employee's LTD rate and benefit will be adjusted if salary fluctuates throughout the plan year.

Voluntary Long Term Disability (LTD) Benefits

- LTD provides 60% of monthly earnings up to a maximum benefit of $3,500 per month.
- Benefit payments will commence on the 181st day of disability.
- Benefits are payable to age 65 or are based on a reduced benefit duration if the employee is disabled on or after the age of 62.
- Benefits are payable for the first 24 months if employee is unable to perform own occupation. After 24 months employee is considered disabled if, solely due to injury or sickness, employee is unable to perform the material duties of any occupation for which employee is (or may reasonably become) qualified to perform.
- If employee returns to work part-time, a partial LTD benefit may be payable.
- The benefit amount will be offset by any other income received. Employee may not receive more than 60% total of all income combined.

Please Note: *If employee does not elect this coverage when initially eligible, employee will have to complete an Evidence of Insurability form if electing in the future. This form will ask basic medical history questions and must be approved by carrier prior to employee's coverage becoming effective.*

2024-2025 - Open Enrollment will not require EOI for enrollment

Voluntary LTD Premium Rate Table

Annual Salary	Monthly Salary	Benefit Per Month	Monthly Premium
$15,000	$1,250.00	$750.00	$7.88
$20,000	$1,666.67	$1,000.00	$10.50
$25,000	$2,083.33	$1,250.00	$13.13
$30,000	$2,500.00	$1,500.00	$15.75
$35,000	$2,916.67	$1,750.00	$18.38
$40,000	$3,333.33	$2,000.00	$21.00
$45,000	$3,750.00	$2,250.00	$23.63
$50,000	$4,166.67	$2,500.00	$26.25
$55,000	$4,583.33	$2,750.00	$28.88
$60,000	$5,000.00	$3,000.00	$31.50
$65,000	$5,416.67	$3,250.00	$34.13
$70,000	$5,833.33	$3,500.00	$36.75

Supplemental Insurance - Aflac

The County is now offering a variety of supplemental medical insurance products sponsored by Aflac. These benefits can help off-set copays, deductibles and out of pocket expenses incurred in the event of an accident or illness. Aflac pays cash benefits directly to the policyholder. These coverages may be purchased separately on a voluntary basis and premiums are paid through semimonthly payroll deductions. To learn more about these new plans, please meet with an enrollment counselor during Open Enrollment for a personal one-on-one presentation. Details regarding available plans and services are also available on Bentek.

Aflac Plan Features:

- All coverages for benefit-eligible and new hires employees are guaranteed-issue, meaning medical underwriting is waived.
- Employee may cover a spouse and/or dependent child(ren) regardless of participation level and coverage with other insurance carriers.
- Several plans qualify for pre-tax premium payroll deductions.
- Benefits are paid directly to policyholder.
- Coverage is portable (with certain stipulations). Employee can take it with them if employee changes jobs or retires.
- No age limit to enroll.

Aflac Core Benefits:

Group Accident Advantage Plus - 24-Hour High Plan
(Pre-tax Payroll Deduction)

- Pays cash benefits for expenses resulting from injuries on or off the job and pays in addition to any other insurance in force.
- Pays cash benefits fast for expenses that major medical may not cover, including: doctor visits, ambulance rides, ER visits, hospitalization, surgery, stitches, casts, medical appliances, and other medical expenses not covered by major medical insurance.
- Covers accidental fractures dislocations, lacerations burns, concussions, coma and much more.
- Accidental Death & Dismemberment benefit included.
- Annual Wellness benefit per covered policyholder, included.

Group Hospital Indemnity Plan 2 ***(Pre-tax Payroll Deduction)***

- Cash benefits for injuries and illness resulting in hospital admission, daily confinement and ICU confinement.
- Covers treatment services including, outpatient services, physician office visits, Telemedicine, major diagnostic exams, out of hospital Rx, ER visits and rehabilitation facility stays.
- Annual wellness benefit per policyholder annually, included.

Group Critical Illness with Cancer Plan ***(After-tax Payroll Deduction)***

- Guaranteed Issue lump sum benefit payable up to $30,000 for employee and $15,000 for spouse coverage.
- Provides cash when needed most that will help with treatment costs for covered critical illnesses and cancer.
- Cash flow to help pay bills so policyholder(s) can focus on recuperation instead of stressing over out of pocket expenses.
- Dependent child(ren) coverage at no additional cost.
- Annual wellness benefit per policyholder, included.
- Payable for the following covered illnesses:
  - Cancer *(Internal and Invasive)**
  - Heart Attack *(Myocardial infraction)*
  - Kidney Failure
  - Coronary Artery Bypass Surgery
  - Stroke
  - End Stage Renal Failure
  - Stem Cell Transplant
  - Major Organ Transplant
  - Bone Marrow Transplant

To get more information about individualized cost, please contact the Aflac agent.

Refer to online brochure for full limitation and exclusions.

Aflac Group Plans
Customer Service: (800) 433-3036 | www.aflacgroupinsurance.com

Aflac | Agent: Margaret Pearson
Phone: (561) 881-1964 | Fax: (561) 881-8872
Email: margaret_pearson@us.aflac.com

Retiree Benefits

Group Retiree Health Plan

The County's Group Retiree Health Plan will be provided by the insurance carrier(s) in force at the time of retirement and is subject to change if the County changes carriers, benefits or rates. All of the following requirements must be met in order for a County employee to be eligible for retiree insurance benefits (medical, dental & vision insurance).

- Employees must have a minimum of eight (8) years of service vested with the County in conjunction with the Florida Retirement System (FRS).
- The employee must be eligible to receive and/or be receiving benefits from the FRS.
- Retirement age of 55 or above must be attained (unless the employee has 30 consecutive years of service with the FRS/25 Years for High Risk employees).
- Having a job elsewhere is not a factor.

Health Insurance - Retiree Rates

Includes Medical, Dental and Vision Coverage

Tier of Coverage	Total Monthly Rate
Employee Only	$1,159.00
Employee + Spouse	$2,439.00
Employee + Child(ren)	$2,119.00
Employee + Family	$2,679.00

Supplemental Retiree Program

Supplemental Retiree Program is a subsidized program for eligible County retirees to assist in off-setting the cost of post-retirement medical insurance premiums. To be eligible, the retiree must be under 65 years of age and have a minimum of 20 years of full time service with the County. The plan participant must be collecting FRS monthly retirement benefits. The monthly supplement will be $10 for each year of service. Minimum of 20 years of service is required (20 yrs × $10 = $200 per month). **Time in the FRS "Drop" Program is not included in the calculation of this benefit.** The maximum monthly benefit is $300 per month. This supplement will be deducted from the retiree's medical insurance invoice on a monthly basis. If the retiree's medical insurance is not with the county, a check will be issued on a monthly basis payable to the retiree. Proof of other insurance is required annually. If the subsidy is greater than the premium, the difference is taxable.

The County's Retiree Supplement will cease when the retiree becomes eligible for Medicare. The retiree may continue coverage under the County's Group Retiree Health Plan but the Supplement will no longer be deducted from the premium.

IAFF Supplemental Benefit

Any IAFF retiree must be under 65 years of age to be eligible. Under age 65 retirees who are Medicare-eligible due to SSI are not eligible. Retirees over the age of 65, who are covered under Medicare or a Medicare Supplements are not eligible. Under age 65 retirees who are Medicare-eligible due to being on Social Security Disability for more than two years are also not eligible. At the time of retirement the IAFF employee must have completed 20 years of service with the Charlotte County Fire/EMS Department. The plan participant must be collecting FRS monthly retirement benefits. The monthly supplement is $20 per each year of service. Minimum of 20 years of service is required (20 yrs × $20 = $400 per month). **Time in the FRS "DROP" Program is not included in the calculation of this benefit.** The maximum monthly benefit is $600 per month. If retiree's medical insurance is not with the County, the subsidy will be direct deposited in the retirees bank account on a monthly basis. If retiree is covered under the County's medical insurance, the amount of the supplement will be deducted from the monthly invoice. Any overage due will be paid to retiree and will be handled on an individual basis.

Retiree Life Insurance

At retirement, if employee is age 55+ and has a minimum of eight (8) years of service with Charlotte County, they will have the opportunity to continue 50% of the amount of the term group Basic Life insurance currently in force while employed with Charlotte County. For example, if employee retires with $50,000 group Basic Life insurance in force, employee would be eligible to keep $25,000 at retirement.

Group Retiree Life insurance premiums are based on the current contract the County has in force and premiums are subject to change annually. Beneficiary forms may be obtained from Risk Management.

Premium Payments

Medical, dental and vision coverage is offered to all benefit-eligible retirees as a package, however, retiree may elect to opt-out of dental and/or vision and remain on the medical plan only (please note that this will not affect the total premium). Electing dependent medical coverage also entitles retiree's dependent(s) to receive dental and vision benefits unless they opt-out of dental or vision coverage.

COBRA Benefits

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a Federal law that provides employee the opportunity to continue existing group insurance coverage upon separation of service from the County. After electing health insurance benefits at New Hire Orientation, employee will be mailed an initial COBRA Notice which explains the COBRA rights as a County employee. Employee and covered dependent(s) may choose to elect COBRA if one (1) of the following qualifying events occurs:

- Termination of employment from the County, unless it was due to gross misconduct,
- A reduction of hours which would result in no longer meeting the eligibility requirements for coverage,
- In the event of death,
- In the event of divorce or legal separation,
- Becoming eligible for Medicare, or
- A child no longer meets eligibility requirements to be covered as a dependent.

Certain coverages may be continued for up to 18 months in the event of termination or up to 36 months for other qualifying events. Once a qualifying event is reported, employee or employee's covered dependent will be notified of the right to continue coverage and state the current COBRA premiums effective at that time. Employee and dependent(s) will have 60 days in which to elect COBRA coverage. This election period will end on the latter, 60 days from the qualifying event or, 60 days from the date the County notifies employee of COBRA rights.

Medical Insurance - COBRA Rates

*Medical includes Dental, Vision Coverage and the use of Employee Health Center

Tier of Coverage	Employee Monthly Premium	2% Admin Fee	Total Monthly Premium
Employee Only	$1,159.00	$23.00	$1,182.00
Employee + Spouse	$2,439.00	$49.00	$2,487.00
Employee + Child(ren)	$2,119.00	$42.00	$2,161.00
Employee + Family	$2,679.00	$54.00	$2,732.00

P&A Group | Phone: (716) 852-2611 | www.padmin.com

Medicare Supplemental Insurance

Medicare-eligible retirees and employees may want to consider United American Insurance Group Medicare Supplement as an alternative to electing group insurance coverage. The group Medicare Supplement is a Guarantee Issue and has low, affordable group rates. There are 10 plans to choose from including those with prescription drug coverage. Depending on employee's personal situation, a Medicare Supplemental Policy combined with current Medicare coverage may provide employee with an adequate, lower cost alternative; especially retirees and employees over the age of 65 who insure a spouse.

To learn more about Medicare Supplemental Insurance or to schedule a personal appointment, contact the Valery Insurance Agency by using the contact information provided below.

Valery Insurance Agency
Customer Service: (800) 330-8445 | www.valeryagency.com

Legal and Identity Theft Protection

Two (2) voluntarily benefits are available to employee and family member(s) from LegalShield that provide protection, security and peace of mind concerning identity theft and other legal issues that touch family's lives. These benefits are paid by employee through personal bank or credit card draft, with no long term commitment. (Payroll deduction is not available at this time.)

LegalShield

Advice on any legal issue - Talk to an attorney about any legal issue from the trivial to the traumatic. **Home** - Purchase, Refinance, Foreclosure, Landlord/Tenant; **Financial** - Collections, Warranties, Guarantees, Contracts; **Family Matters** - Divorce, Child Custody, Child Support; **Estate Issues** - Wills, Living Wills, Power of Attorney; **Auto** - Moving Violations, Accidents

IDShield

Monitor more of what matters - IDShield monitors employee's identity from every angle, not just Social Security; **Counseling** - identity specialists are focused on protecting employees 24 hours a day, seven (7) days a week; **Restore Identity** - IDShield provides participants with a top-notch internal team of U.S.-based, professionally-licensed private investigators who will work tirelessly on behalf of the covered members to fully restore their identity to pre-theft status, including pre-existing identity theft matters. **$3 million identity fraud protection** - The plan covers certain expenses and legal costs incurred as a result of a covered identity theft event.

Enrollment in these services covers employee, spouse or domestic partner, and dependent child(ren). See plan brochures or the dedicated website for more information and details. Rates vary depending on plans selected. To receive the discounted group rate, or have any questions, please contact our LegalShield Independent Associate, Jim Carroll.

LegalShield | Agent: Jim and Andrea Carroll
https://www.legalshield.com/info/charlottecounty | (941) 276-7412

Employee Health Centers

The Employee Health Centers (EHC) were established to provide County employees easy and cost-free access to the highest quality medical care for acute and chronic conditions. The EHC is available to individuals who are enrolled in the County's medical plan, including employee, spouse, child(ren) and retirees.

The EHC is administered by My Health Onsite, a third party vendor. Utilization is completely voluntary. All visits with Health Center staff are completely confidential and no personal health information is shared with the employer. Employee still has access to primary care providers, specialists, hospitals, and outpatient facilities through the County's medical plan with Cigna.

Why choose the Employee Health Center?

- ✓ No Copays
- ✓ Online scheduling with dedicated 20-minute appointments — no long stay in a waiting room!
- ✓ Many prescriptions dispensed onsite cost-free
- ✓ 100% confidential and HIPAA compliant

What services can be performed at the Health Center?

- ✓ Primary Care
- ✓ Acute Care & Urgent Care
- ✓ Prescription Dispensing
- ✓ Labs performed onsite — no trip to a separate facility!
- ✓ Digital X-Rays
- ✓ Stress Tests and EKGs
- ✓ Vital Health Profiles (VHP)
- ✓ Flu Shots & Pneumonia Shots

Please be advised that Physicians at the EHC do not have hospital rights and can't admit patients directly from the EHC.

Accessing the Employee Health Center

All employees, dependents and retirees on the County's medical plan have cost-free access to the EHC. Appointments are required for all primary care visits and are scheduled in 20-minute intervals. The medical staff will advise if a longer appointment is needed.

The EHC does not allow walk-ins, unless it is specifically announced (i.e., flu shots or tobacco test). Appointments are always needed. To contact the EHC with questions for a doctor or nurse, please call (941) 764-0301.

In all emergency situations, please call 911.

Registration

Register to use the Employee Health Centers

All patients with a unique valid email address should receive an email invitation from "no-reply@eclinicalmail.com" with the subject line: Patient Portal Access Information from My Health Onsite (MHO). **(Please check spam/junk folders)**

To access your New Patient Portal, simply follow instructions in the email sent which includes:

- Your User Name and Temporary Password

Validate access by using your "Date of Birth".

If you have not received the email invitation, please call (941) 800-2005 to update your email address.

Proxy Authorization

For patients younger than 18 or adults wishing to provide web portal access to another person, a Patient Portal Proxy Authorization Form must be completed to comply with regulatory requirements. The proxy form can be obtained at the Employee Health Center, Risk Management Department or downloaded from MHO's web site at the following URL: www.MyHealthOnsite.com/patient-access. The forms must be completed and turned into the Employee Health Center staff to establish web portal access for proxy accounts.

A proxy is when you allow a spouse, parent, or guardian access to another family member's medical records. This form gives permission to have someone else access your patient portal. It can be between spouses, adult dependents, guardians, or parents and minors between the ages of 13 – 17. The Proxy Authorization form is available at the Employee Health Centers. It is also available under Forms on Connect at Work, as well as Risk Management, Wellness at Work website, and the My Health Onsite website: www.MyHealthOnsite.com/patient-access.

How to Login

1. Go to www.MyHealthOnsite.com.
2. Click Login.
3. Select Patient Access.
4. Select the Patient Access Hyperlink to take you to the Patient Portal page.
5. On the Patient Portal page, Enter User Name and Password to log in to book, cancel or reschedule your appointment.

Please Note: *Each covered dependent must register with My Health Onsite and create an account.*

MY HEALTH ONSITE℠

Bob Pryor EHC Location – Port Charlotte

Bob Pryor Employee Health Center/My Health Onsite
1050 Loveland Blvd., Port Charlotte, FL 33980
(941) 800-2005 • (941) 764-0301
www.MyHealthOnsite.com/patient-access

Health Center Hours of Operation

Monday	8:00 a.m. - 7:00 p.m. *(closed 1:00 - 2:00)*
Tuesday	8:00 a.m. - 7:00 p.m. *(closed 1:00 - 2:00)*
Wednesday	8:00 a.m. - 7:00 p.m. *(closed 1:00 - 2:00)*
Thursday	8:00 a.m. - 7:00 p.m. *(closed 1:00 - 2:00)*
Friday	8:00 a.m. - 6:00 p.m. *(closed 1:00 - 2:00)*
Saturday	8:00 a.m. - 4:00 p.m. *(closed 12:30 - 1:00)*

Lab Hours

Monday	8:00 a.m. - 11:00 a.m.
Tuesday	7:00 a.m. - 10:00 a.m.
Wednesday	8:00 a.m. - 11:00 a.m.
Thursday	8:00 a.m. - 11:00 a.m.
Friday	8:00 a.m. - 11:00 a.m.

South County EHC Location – Punta Gorda

South County Employee Health Center/My Health Onsite*
514 E. Grace Street, Punta Gorda, FL 33950
(941) 800-2005 • (941) 764-0301
www.MyHealthOnsite.com/patient-access

Health Center Hours of Operation

Monday	8:00 a.m. - 7:00 p.m. *(closed 1:00 - 2:00)*
Tuesday	8:00 a.m. - 7:00 p.m. *(closed 1:00 - 2:00)*
Wednesday	8:00 a.m. - 7:00 p.m. *(closed 1:00 - 2:00)*
Thursday	8:00 a.m. - 7:00 p.m. *(closed 1:00 - 2:00)*
Friday	8:00 a.m. - 6:00 p.m. *(closed 1:00 - 2:00)*
Saturday	Closed

Lab Hours

Monday	8:00 a.m. - 11:00 a.m.
Tuesday	8:00 a.m. - 11:00 a.m.
Wednesday	8:00 a.m. - 11:00 a.m.
Thursday	8:00 a.m. - 11:00 a.m.
Friday	8:00 a.m. - 11:00 a.m.

***Please Note:** This location does not treat any workers compensation or occupational visits, nor do they have a x-ray machine.*

Employee Health Centers Services

Save Money - Use the Employee Health Centers

Prescription Medications

The EHCs dispense generic and brand name medications at no cost to patients. Health Center staff can prescribe medication for a variety of acute and chronic conditions. If the Health Center does not stock a prescribed medication, staff will provide a prescription to take to the local pharmacy and purchase through the Cigna medical plan.

Schedule an appointment with a staff provider today to review current prescriptions. Please Note: The Health Centers are not pharmacies. Member is required to meet with the medical staff before a prescription can be dispensed for employee or a dependent.

Brand Name Generics Available at the EHC

- ✓ Glucophage
- ✓ Mevacor
- ✓ Synthroid
- ✓ Prilosec Omeprazole *(Can often be substituted for Nexium)*
- ✓ Metformin
- ✓ Lovastatin
- ✓ Levothyroxine Sodium

FREE Medications Available

- ✓ Acid Reflux/Heartburn
- ✓ Allergy
- ✓ Anti-Depressants
- ✓ Diabetes
- ✓ Blood Pressure
- ✓ Cholesterol
- ✓ Antibiotics
- ✓ And Many More!

My Health Onsite Rx Mail-Order Program with Elixir

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

Employee Cost for 90-Day Supply

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

Elixir Pharmacy
Customer Service: (866) 909-5170 | www.elixirsolutions.com

Access Your Elixir Account:
User Name: ccbocc+(SSN) | BIN number: 009893 / PCN: CPLUS

Radiology/Imaging Referrals

The EHCs have an agreement with American Imaging and Akumin for County employees to obtain radiology services, at no cost. Some of the tests include CT scans, mammograms and bone density screenings. Employees may get a referral from an EHC physician, or they can bring a prescription from an outside provider for the referral.

Tobacco Cessation - Self Paced

Employee may be supported with an online program, educational material, and reading material and while working with a Health Coach to become tobacco free. The provider may also request the County to pay for Chantix.

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctors' names and addresses or prescription medications.

CHARLOTTE COUNTY
FLORIDA

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

https://www.mybentek.com/charlottecounty

RISK strategies | GEHRING GROUP
A RISK STRATEGIES COMPANY

3500 Kyoto Gardens Drive, Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970 | www.gehringgroup.com

To access benefit booklet, use a mobile device to scan code.

FINAL
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