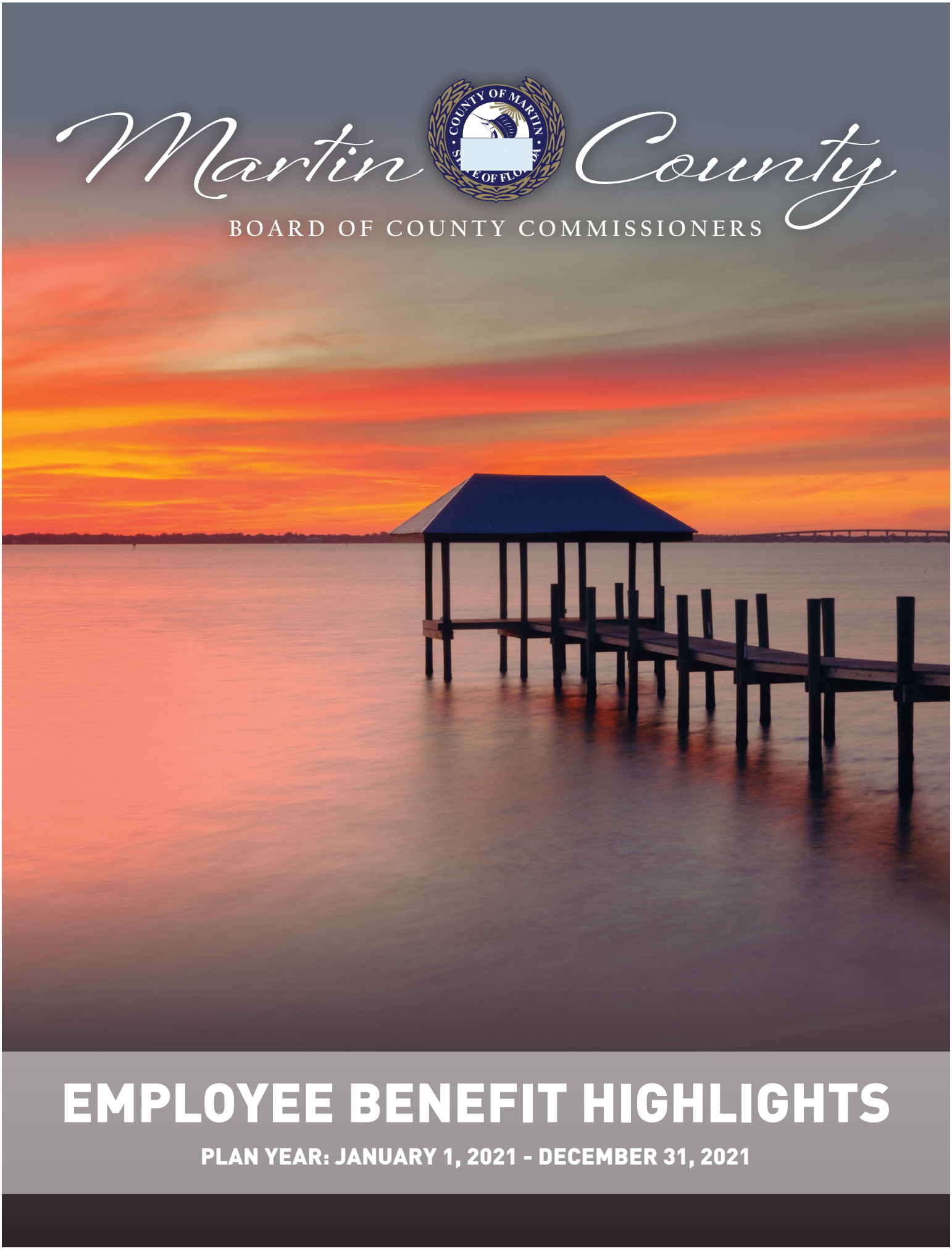
Indian River County Survey on Employee Health Clinics 2020	Responding Agency: Gehring Group on behalf of Martin County BOCC
Contact: Sheila O'Sullivan - 772-226-1377 sosullivan@ircgov.com	Contact: Brandie LaFave
Purpose: We are evaluating the different types of employee clinics that various agencies have implemented to evaluate whether implementing a clinic would be beneficial and cost effective.	Please provide responses below and provide any details and comments that may assist us in evaluating clinic options.
Your Health Plan Participant Count:	1,463 employees / 3,275 members
HISTORY	
Are you self-insured for your health insurance?	Self-Insured
Please provide the employer's monthly contribution towards the various health plan options.	EE Only $501.06 EE+Family $1,290.21
Please provide the employee's monthly contribution toward the various health plan options.	EE Only $131.60 EE+Family $329.36
What motivated your agency's decision to pursue a clinic? What were the main drivers?	Flatten healthcare trendline and added member benefit
Please list the goals you were hoping to accomplish when implementing a clinic. Employee benefit enhancement? Cost savings? Wellness program? Access to care?	All the above
How did you determine your organization was ready to implement a clinic?	Sufficient seed money in reserves and self funded medical plan
IMPELEMENTATION PROCESS	
How long did it take from the decision to implement to go live?	About 10 months
Describe the implementation process.	After the finalist was selected, the following was implemented by the clinic administrator and BOCC: 1. Staff recruitment 2. Medical supplies ordered 3. Prescription formulary and supplies ordered (based off medial carrier utilization reports) 4. Facility Build out 5.Communication materials created and distributed 6. Health assessment appointments scheduled with members 7. Staff training 8. Eligibility files tested with benefits administration tool (Bentek)
What resources did you need? Did you use an outside consultant to assist you?	The BOCC partnered with the benefits consultant, the Gehring Group
What were the start up costs?	Roughly $30k in start up costs + estimated $1.2 million in 1st year costs
Which department oversees the clinic and how many staff are allocated in support of employee benefits and the employee clinic?	Human Resources & Executive Staff
Describe your communication plan to your members?	Mailers, emails, educational seminars
What challenges did you face and what would you do differently? Describe lessons learned related to implementation?	Initial member engagement is a challenge and very important to receive proper return on investment. It is recommended that incentives such as premium reductions or subsidies be tied into initial health assessment utilization to build client - physician relationships.
CLINIC MODEL	
When was the clinic implemented?	2010
Describe your clinic model. Number of clinic locations, number and type of clinic staff, days and hours of operations, and services provided.	1 dedicated location for BOCC members + other locations shared by general public and other constitutionals. There is a mix of physician, NP, and MA's staffed at clinic. Hours of operation: Monday: 7:30 a.m. - 5 p.m. Tuesday: 7:30 a.m. - 5 pm Wednesday: 7:30 a.m. 5 p.m. Thursday: 7:30 a.m. - 5 p.m. Friday: 7:30 a.m. - 5 p.m. Saturday: 9 a.m. - 1 p.m. Services include family medicine, limited emergency services, acute and chronic condition management, lab draws, x-rays, prescription dispensing, wellness programs, and workers compensation / occupational health.
Who is/are your vendor partner(s)?	Employee Wellness / Treasure Coast Urgent Care / Treasure Coast Primary Care
Who is eligible to visit the clinic and what is the number of eligibles?	Active Employee's, Dependents and Retiree's who are enrolled in our medical plan
What is the member cost for a clinic visit?	No cost
How is the clinic funded and what are the annual costs?	The clinic is included in the health insurance premium equivalents and annual cost is roughly $1.7 million
How are the clinic expenses verified and paid?	Member eligibility verified through Bentek eligiblity files
Describe any member incentives or well being strategies associated with the clinic.	$0 cost to the member to visit clinic or fill prescription
Please describe any innovations or programs running in the clinic that are working well.	
Please indicate if you have any plans to expand or reduce clinic services in the future.	No plans to reduce services
OUTCOMES	
How many of your members are participating in the clinic? Please express as both as a number and percent of total eligibles.	3200 members are eligible to receive services. The County shares with the Sheriff and City of Stuart as well which would add additional lives. The appointment slots are shared and historically the County exceeds it allotment which is accomodated. We target 85% of appointment slots and we typically use 100-110%.
Please describe any metrics you have established to determine clinic outcomes.	Historical review of # of professional office visits; professional office visit costs; total # of prescriptions filled at wellness center & medical plan; prescription costs; emergency & urgent care utilization and costs; admissions; and claims cost per employee/retiree per month; trend history to determine claims avoidance vs. average cost of employee health center to determine the ROI.
What reporting do you receive to demonstrate outcomes?	NavMD Data Analytics
Please describe success/outcomes that are noteworthy.	18% reduction of professional office visits; 3% reduction in professional office visit costs; 15% reduction in the number of prescriptions; 9% reduction in prescription costs. Not to mention the amount of lives that have been saved.
Describe employee satisfaction with the clinic. Have you conducted employee surveys related to the clinic, if so please summarize overall employee sentiments related to the clinic.	Employee satisifcation is typically positive and favorable.
Describe how the clinic has met the initial clinic goals stated above. How have you quanitified success as it relates to your upfront goals.	Prior to opening in 2010 claims trend was 9-10% and since claims trend remained flat for several years resulting in multiple years of no premium increases.
Is there anything you would change or do differently if you had it to do it over again?	Built our own facility.

Indian River County Survey on Employee Health Clinics 2020	Responding Agency: Gehring Group on behalf of Martin County BOCC
Contact: Sheila O'Sullivan - 772-226-1377 sosullivan@ircgov.com	Contact: Brandie LaFave
Please share any additional information that you believe would be helpful to us as we evaluate the possibility of pursing an employee clinic.	
Medication	
Does the clinic provide medications through the clinic? If so, what are the member copays? If you offer medications with no copays, how was the list of "free" medications determined?	Yes, prescriptions on the formulary are at no cost to the members
How did you evaluate which medications to offer through the clinic? What was the main reason you offer medications through the clinic?	Utilization reports from Florida Blue are used to analyze which prescriptions should be included in the formulary. At this time, only generics are included in the formulary and they must be at a lower cost than what is seen through the health plan to be utilized. Shelf life, storage criteria, and doctor recommendations are also taken into consideration.
Is the cost of medications to the employer's plan, less than the cost through the traditional pharmacy benefit? What data was used to make this determination?	Yes, utilization and financial reports are used to analyze this
What is the annual cost to the employer's plan of offering the medications through the clinic?	Annual pass through prescription costs through the clinic is under $300k.
Do you medications expire and have to be disposed of without being dispensed to members?	Yes however the clinic administrator is in charge of prescription management to avoid this



EMPLOYEE BENEFIT HIGHLIGHTS

PLAN YEAR: JANUARY 1, 2021 - DECEMBER 31, 2021

Have you taken advantage of the

Martin County Employee Wellness Center

Located in the Monterey Medical Center at 1050 Monterey Road, Suite 101 in Stuart

Services are FREE! • Exclusively YOURS! • Wait times are MINIMAL!

The Employee Wellness Center (EWC) is available to provide the care you and your family need for all non-emergency illnesses. These services are available at no cost for employees and their dependents enrolled under the County's medical plan. Schedule an appointment with the medical staff to learn more about the Employee Wellness Center.

On-Site X-rays and Labs

If an outside doctor orders blood work for you, simply bring the lab slip to the Employee Wellness Center and we will take care of drawing the blood.

On-Site Prescription Dispensing

The Employee Wellness Center stocks widely used generic medications at no cost. However, you will be required to schedule a visit with one of the medical providers before a prescription will be dispensed.

NEW EXTENDED HOURS!

HOURS OF OPERATION						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:30 a.m. - 5 p.m.*	7:30 a.m. - 5 p.m.*	7:30 a.m. - 7 p.m.	7:30 a.m. - 5 p.m.*	7:30 a.m. - 5 p.m.*	9 a.m. - 1 p.m.	Closed*

*The Urgent Care facility is open to the general public and employees from 5pm - 6pm during the week and from 8am - 2pm on Sundays.

Call or log on (click on the Patient Portal tab) to schedule your appointment today!

(772) 872-7304 or www.employeewell.com

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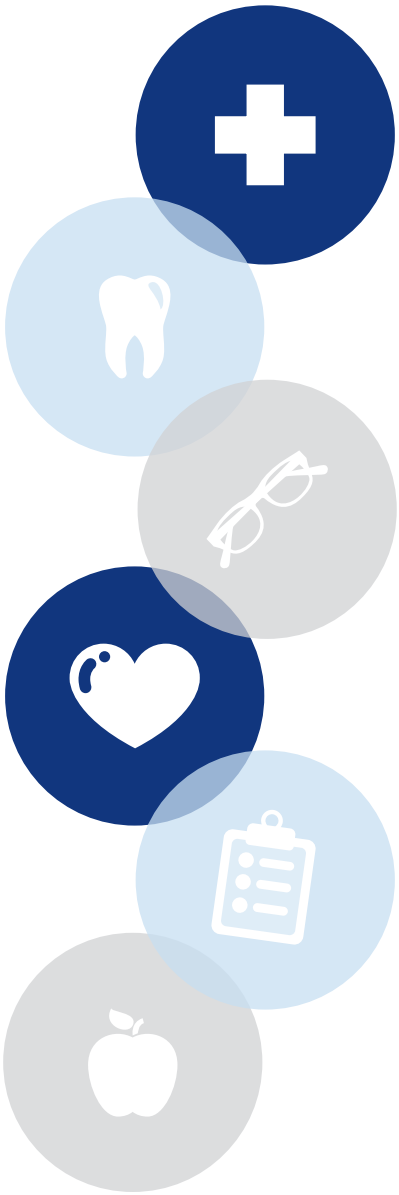


This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The Martin County Board of County Commissioners reserves the right to amend, modify or terminate the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

Contact Information

	Board of County Commissioners	Matthew Graham Director of Human Resources	Phone: (772) 221-1320 Email: mgraham@martin.fl.us
		Sara Walker Human Resources Manager	Phone: (772) 221-1455 Email: swalker@martin.fl.us
		Heather Dayan Human Resources Manager	Phone: (772) 463-2885 Email: hdayan@martin.fl.us
		Ashley Collier Human Resources Generalist	Phone: (772) 463-2855 Email: acollier@martin.fl.us
	Clerk and Comptroller	Stephanie Glasser Human Resources	Phone: (772) 463-3264 Email: sglasser@martinclerk.com
	Tax Collector	Judy Friend Human Resources	Phone: (772) 223-7932 Email: jfriend@mctc.martin.fl.us
	Property Appraiser	Daina Takacs Director of Operations	Phone: (772) 288-5711 Email: daina.takacs@pa.martin.fl.us
	Payroll *(Board, Clerk & Supervisor of Elections)*	Kerry Sees, CPP Payroll Manager	Phone: (772) 288-5988 Email: ksees@martinclerk.com
	Martin County Employee Benefits Contact	Brandie LaFave Benefits Specialist	Phone: (772) 320-3029 | Fax: (772) 223-2168 Email: blafave@martin.fl.us
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) www.mybentek.com/martincounty
	Medical Insurance	Florida Blue Group Number: 91221	Customer Service: (800) 664-5295 www.floridablue.com
	Prescription Drug Coverage & Mail-Order Program	Express Scripts Pharmacy	Customer Service: (866) 230-7261 www.express-scripts.com
	Telehealth	Teladoc	Customer Service: (800) 835-2362 www.Teladoc.com
HRA	**Health Reimbursement Account**	BenefitsWorkshop	Customer Service: (888) 537-3539 www.benefitsworkshop.com/martincounty
	Dental Insurance	Florida Combined Life Group Number: 247L66	Customer Service: (888) 223-4892 www.floridabluedental.com
	Vision Insurance	Humana Group Number: VS3145	Customer Service: (877) 398-2980 www.humana.com
FSA	**Flexible Spending Accounts**	BenefitsWorkshop	Customer Service: (888) 537-3539 www.benefitsworkshop.com/martincounty
	Basic Life and AD&D Insurance	The Standard Group Number: 642407	Customer Service: (800) 247-6888 www.standard.com
	Long Term Disability Insurance	The Standard	Customer Service: (800) 247-6888 www.standard.com
	Employee Assistance Program	New Directions	Customer Service: (800) 624-5544 eap.ndbh.com
	Supplemental Insurance	Aflac	Agent: Karen Zabaglo | Phone: (772) 284-3210 Email: karen_zabaglo@us.aflac.com Agent: Loire Lucas | Phone: (772) 708-5931 Email: loire_lucas@us.aflac.com
	Legal & Identity Theft Plan	Legal Shield	Agent: Steve Baker | Phone: (321) 613-0037 Email: sb@legalshieldassociate.com
	Cobra	**BenefitsWorkshop**	Customer Service: (888) 537-3539 www.benefitsworkshop.com/martincounty

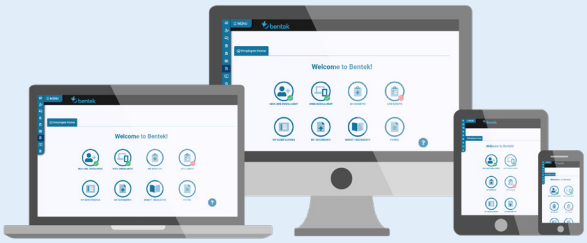
Introduction

The Martin County Board of County Commissioners provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of these options as a convenient reference. Please refer to the County's Personnel Policies, applicable Union Contracts and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs, and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact the Martin County Employee Benefits Specialist.

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/martincounty**
- ✓ 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 Employee Benefits Center online, log on to:
www.mybentek.com/martincounty

Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*

Group Insurance Eligibility

The County's group insurance plan year is January 1 through December 31.

Employee Eligibility

Employees are eligible to participate in the County's insurance plans if they are working a minimum of 30 hours per week. Coverage will be effective the first of the month following 30 calendar days of employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 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 spouse. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to the age of 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, Dental, and Vision Coverage: A dependent child may be covered through the end of calendar year in which the child turns age 26.

Disabled Dependents

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

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (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 the Benefits Specialist if further clarification is needed.

Documentation Requirements

All dependents must have an established legal relationship to the employee to be covered under the benefit program. The types of documentation accepted are as stated in the table below.

Employee with dependents enrolled in the group insurance plan are advised that they will be required to comply with this process or may jeopardize maintaining continued coverage for such dependents.

Dependent Relationship	Documentation Required
Spouse	• Copy of legal government issued marriage certificate, Social Security card,
Dependent Child(ren) Under Age 26	• Copy of State issued birth certificate(s) **OR** copy of legal guardianship court documents listing the employee as legal guardian. • **AND** Social Security card.
Step-Child(ren) Under Age 26	• Copy of State issued birth certificate(s), Social Security card, • **AND** copy of State issued marriage certificate.
Child(ren) under Legal Guardianship, Custody or Foster Care Under Age 26	• Copy of court documents showing legal guardianship **OR** legal custody **OR** foster care placement.
Child(ren) Adopted or in the process of Adoption Under Age 26	• Copy of court documents of the legal adoption showing relationship to and placement in the employee's house **OR** Adoption Certificate.

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Flexible Spending Accounts 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 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, **the Benefits Specialist must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. 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. 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. Cancellations will be processed at the end of the month. In the event of death, coverage terminates the day following the death. Employees may be required to furnish valid documentation supporting a change in status or "Qualifying Event."

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 Specialist
Address:	2401 SE Monterey Rd. Stuart, FL 34996
Phone:	(772) 320-3029
Email:	blafave@martin.fl.us
Website URL:	www.mybentek.com/martincounty

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 Specialist.

If there are any questions about the plan offerings or coverage options, please contact the Benefits Specialist at (772) 320-3029.

Medical Insurance

The County offers medical insurance through Florida Blue to benefit-eligible employees. The monthly costs for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plan, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Florida Blue's customer service.

Medical Insurance – Florida Blue – BlueOptions Plan

Monthly Premiums

Tier of Coverage	Employee Cost	Employer Cost
Employee Only	$142.26	$541.64
Employee + Family	$356.04	$1,394.72

Please Note: *Payroll deductions include dental insurance coverage*

Florida Blue | Customer Service: (800) 664-5295 | www.floridablue.com
Group Number: 91221

Dental Plan Premium

The County offers all benefit-eligible employees medical and dental coverage as a "bundled" package. However, employee may elect to opt-out of the dental plan and remain on the medical plan only. In order to opt-out of the dental coverage, employee will be required to waive this election in Bentek.

Please Note: if a participant elects to opt-out of the MCBOCC's sponsored dental plan payroll deduction will remain the same. There will not be a decrease in premium.

Other Available Plan Resources

Florida Blue offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please log on to www.floridablue.com or contact Florida Blue's customer service.

Blue365

Blue365 is provided automatically at no additional cost and offers access to discounted products and services at participating providers. Members can log on to www.floridablue.com to learn more about these programs or call (800) 664-5295.

- ✓ Fitness club memberships, exercise footwear and apparel
- ✓ Vision care, glasses, and contact lenses
- ✓ Hearing care and aids
- ✓ Alternative medicine
- ✓ Elder care advisory services
- ✓ Hotel rooms and travel information
- ✓ Weight loss management

Telehealth – Teladoc

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

The benefit is provided to all enrolled members. Registration is required and should be completed ahead of time. 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
- ✓ Headache
- ✓ Stomachache
- ✓ Fever
- ✓ Cold and Flu
- ✓ Allergies
- ✓ Rash
- ✓ Acne
- ✓ UTI's 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 Teladoc.

Teladoc | Customer Service: (800) 835-2362 | www.teladoc.com

Florida Blue – BlueOptions Plan At-A-Glance

Network	BlueOptions	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$500	$1,500
Family	$1,500	$4,500
Coinsurance		
Member Responsibility	20%	50%
Calendar Year Out-of-Pocket Limit		
Single	$3,000	$6,000
Family	$6,000	$12,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$25 Copay	50% After CYD
Specialist Office Visit	$50 Copay	50% After CYD
Telehealth – Teladoc	No Charge	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	No Charge	50% After CYD
X-rays	$50 Copay	50% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD	50% After CYD
Outpatient Surgery in Surgical Center	$50 Copay	50% After CYD
Physician Services at Surgical Center	$50 Copay	50% After CYD
Urgent Care *(Per Visit)*	$65 Copay	$65 Copay after CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After CYD	50% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD	50% After CYD
Physician Services at Hospital	$100 Copay	$100 Copay
Emergency Room *(Per Visit)*	$300 Copay	$300 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	$500 Copay	50% Coinsurance
Outpatient Services *(Per Visit)*	$25 Copay	50% Coinsurance
Outpatient Office Visit	$25 Copay	50% Coinsurance
Prescription Drugs *(Rx)*		
Generic	$15 Copay	50% Coinsurance
Preferred Brand Name	$30 Copay	50% Coinsurance
Non-Preferred Brand Name	$50 Copay	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	2x Retail Copay	50% Coinsurance

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridablue.com. When completing the necessary search criteria, select BlueOptions network.

Plan References

***Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.*

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

Dental Insurance

Florida Combined Life BlueDental Choice Plus PPO Plan

The County offers dental insurance through Florida Combined Life, a subsidiary of Florida Blue, 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 Florida Combined Life's customer service.

Dental Plan Premium

The County offers all benefit-eligible employees, medical and dental coverage as a "bundled" package. However, employees can elect to opt-out of the dental plan and remain on the medical plan only. In order to opt-out of the dental plan, employee will be required to waive this election in Bentek.

Please Note: if a participant elects to opt-out of the MCBOCC's sponsored dental plan payroll deduction will remain the same. There will not be a decrease in premium.

In-Network Benefits

The BlueDental Choice Plus 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 Florida Combined Life BlueDental Choice Plus network. These participating dental providers have contractually agreed to accept Florida Combined Life's contracted fee or "allowed amount." This fee is the maximum amount a Florida Combined Life dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Florida Combined Life BlueDental Choice Plus PPO provider. Florida Combined Life reimburses out-of-network services based on what it determines as the Usual, Customary and Reasonable (UCR). The UCR 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 Florida Combined Life's UCR and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The BlueDental Choice Plus PPO plan requires a $50 individual or a $100 Family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the BlueDental Choice Plus PPO plan will pay for each covered member is $1,000 for in-network and out-of-network services combined. All services, including preventive services, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

Florida Combined Life
Customer Service: (888) 223-4892 | www.floridabluedental.com
Group Number: 247L66

Florida Combined Life BlueDental Choice PPO Plus Plan At-A-Glance

Network	BlueDental Choice Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$100	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Calendar Year)*		
Bitewing X-rays *(1 Per Calendar Year)*		
Class II Services: Basic Restorative Care		
Complete X-rays	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Fillings		
Simple Extractions		
Deep Cleaning		
Endodontics *(Root Canal Therapy)*		
Periodontics		
Oral Surgery		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Implants		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Dependent Children Up to Age 26)*	Plan Pays: 100% After CYD	Plan Pays: 100% After CYD *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact Florida Combined Life's customer service or visit www.floridabluedental.com. When completing the necessary search criteria, select BlueDental Choice Plus 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 calendar year covered under the preventive benefit.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Treatment Review" 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

Humana Vision 100 Plan

The County offers vision insurance through Humana to benefit-eligible employees. The monthly costs for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the carrier's summary plan document or contact Humana's customer service.

Vision Insurance – Humana Vision 100 Plan

Monthly Premiums

Tier of Coverage	Employee Cost
Employee Only	$7.24
Employee + Family	$20.52

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employee and covered dependent(s) may select any network provider who participates in the Humana 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 Humana Insight network. When going out of network, the provider will require payment at the time of appointment. Humana will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

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

Humana | Customer Service: (877) 398-2980 | www.humana.com
Group Number: VS3145

Humana Vision 100 Plan At-A-Glance

Network	Insight	
Services	**In-Network**	**Out-of-Network**
Eye Exam	$10 Copay	Up to $30 Reimbursement
Contact Lens	Standard - Up to $55 Copay Premium - 10% Off Retail	Not Covered
Frequency of Services		
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses		
Single	$25 Copay	Up to $25 Reimbursement
Bifocal		Up to $40 Reimbursement
Trifocal		Up to $60 Reimbursement
Frames		
Retail	Up to $100 Retail Allowance then 20% Discount Over $100	Up to $50 Reimbursement
Contact Lenses*		
Non-Elective *(Medically Necessary)*	No Charge Requires Prior Authorization	Up to $200 Reimbursement
Elective *(Fitting, Follow-up & Lenses)*	Up to $100 Retail Allowance; then 15% Discount Over $100	Up to $80 Reimbursement
LASIK		
Discount Programs	Contact Humana's Customer Service for Program Details	Discount Programs Not Available Out-of-Network

Locate a Provider

To search for a participating provider, contact Humana's customer service or visit www.humana.com. Login or select "Find a doctor or pharmacy" at the bottom of the page. Choose "vision" and then choose "Humana Vision (Humana Insight Network)". Complete the additional search criteria and click "Get Results".

Plan References

**Contact lenses are in lieu of spectacle lenses and a frame.*

Important Notes

- *Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.*
- *After copay, standard polycarbonate available at no charge for dependents under age 19.*

Health Reimbursement Account

Questions and answers regarding a Health Reimbursement Account (HRA) have been provided below and on the following page to help employees understand how an HRA works in conjunction with their Insurance plans.

Employees who enroll in the medical plan automatically will receive a Health Reimbursement Account (HRA) funded by the County. HRA funds can be used for qualified medical, dental, and vision expenses. The HRA provides tax-free funds to cover expenses not paid by the employee's medical, dental, and vision insurance plans.

Employee Only: $470 **Employee + Family:** $940

How are the funds accessed?

There are two convenient ways to access the HRA funds:

- ✓ BenefitsWorkshop Debit MasterCard; and
- ✓ Manually submit receipts for reimbursements. If this option is selected, employee must pay for their expenses out-of-pocket and then submit a reimbursement request form along with the appropriate documentation to BenefitsWorkshop. The reimbursement request form can be found on Bentek's EBC or on BenefitsWorkshop's website www.benefitsworkshop.com/martincounty.

What is a BenefitsWorkshop Debit Card?

For those enrolling in the medical plan for the first time, employees will be mailed a debit card along with materials explaining how to use the card. The BenefitsWorkshop debit card allows immediate access to account funds for eligible expenses at approved providers that accept MasterCard. When employee has an eligible expense, simply swipe the card and the funds are automatically deducted from their account (up to the available balance). If purchasing other items or services, employee should use a different payment method for those expenses. For example, if paying for a prescription and buying a gallon of milk at the pharmacy, employee should only use the debit card for the prescription portion of expense. There will be a $5.00 charge to replace lost, stolen or damaged cards.

If I use the BenefitsWorkshop debit card, do I still submit my receipts?

Certain expenses, including copayments paid at provider offices or pharmacies, may be processed without further action on the employee's part. All other expenses must be documented with a receipt, bill or insurance statement (Explanation of Benefits) that includes the name of the service provider, name of patient, date of service, the nature of the service, items purchased, and the amount of the expense. Debit card receipt are not acceptable. The documentation should be mailed or faxed to BenefitsWorkshop within ten days of the transaction, along with an HRA Expense Documentation form available on Bentek or on BenefitsWorkshop's website www.benefitsworkshop.com/martincounty. Failure to provide adequate documentation in a timely manner could result in the suspension of their account, the deduction of the ineligible amount from their account, and other actions as BenefitsWorkshop and the employer deem appropriate.

How do I check the balance on my card?

If employee is currently enrolled in the BlueOptions Plan, employee may obtain their HRA balance or check on the status of charges by contacting BenefitsWorkshop's Customer Service at (888) 537-3539 or by logging on to www.benefitsworkshop.com/martincounty.

What are the BenefitsWorkshop debit card advantages?

- ✓ Eliminates the need to pre-pay an expense
- ✓ Eliminates waiting for reimbursement
- ✓ Eliminates paperwork on most copays
- ✓ Allows online access to account information

I am enrolled in the BlueOptions Plan. What happens to my unused HRA funds at the end of the Plan Year?

If employee continues coverage in the BlueOptions Plan, any remaining HRA balance will be added to their new Plan Year HRA funding.

What happens to my unused HRA funds if I discontinue participation in the medical plan, separate employment or retire from the County?

Employees benefits under the HRA will generally cease, meaning that expenses incurred after they are no longer a participant will not be reimbursed. The HRA debit card will be deactivated effective the last day of employment, but an employee will have access to their HRA Funds through the end of the month in which they terminate employment. If employee retires and elects to continue coverage under the retiree medical/dental plan, they will have access to the HRA funds through the end of the plan year in which they retire. However, if employee has been insured under the BlueOptions medical plan for six (6) full plan years (January 1 to December 31), the HRA balance (if any) is vested. In this case, any unused funds will roll into a Retirement Health Savings (RHS) account administered by ICMA. If employee meets the vesting criteria and are separating employment, please contact the Benefits Specialist to discuss the HRA / RHS transition process.

Health Reimbursement Account *(Continued)*

Health Care Reimbursement Account (HRA)	Flexible Spending Accounts (FSA)
✓ **Employer** Funded Account	✓ **Employee** Funded Accounts
✓ Enrollment is automatic if enrolled in medical plan	✓ Employees must enroll annually
✓ Funds used for eligible medical, dental, and vision expenses for employees and dependent(s) enrolled in medical plan	✓ Funds used for eligible medical, dental, vision & dependent care for employee and qualified dependent(s)
✓ Unused funds accumulate and roll over year to year	✓ Unused funds will be forfeited at the end of the plan year (once the filing deadlines have expired)

For employees who have the HRA and also elect an FSA, FSA monies will be used first since it is employee funded.

What are some examples of qualified expenses that would be eligible for reimbursement?

- ✓ Acupuncture
- ✓ Ambulance Service
- ✓ Birth Control Pills
- ✓ Chiropractic Care
- ✓ Corrective Contact Lenses
- ✓ Dental Fees
- ✓ Diagnostic Tests and Health Screenings
- ✓ Doctor Fees
- ✓ Drug Addiction and Alcoholism Treatment
- ✓ Prescription Drugs
- ✓ Experimental Medical Treatment
- ✓ Eyeglasses
- ✓ Hearing Aids and Exams
- ✓ Injections And Vaccinations
- ✓ In Vitro Fertilization
- ✓ Nursing Services
- ✓ Orthodontic Fees
- ✓ Surgery
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs
- ✓ X-rays

Claims Processing Address
PO Box 56828, Jacksonville, FL 32241
Fax: (904) 880-2830 | Email: info@benefitsworkshop.com

BenefitsWorkshop | Customer Service: (888) 537-3539 | www.benefitsworkshop.com/martincounty

Flexible Spending Accounts

The County offers Flexible Spending Accounts (FSA) administered through BenefitsWorkshop. The FSA plan year is from January 1 to December 31.

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 (2) types of FSAs:

Health Care FSA

This account allows participant to set aside up to an annual maximum of $2,750. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

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

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

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 day care centers, preschool, and before/after school care for eligible children and dependent adults.

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

- A child under the age of 13, or
- A child, spouse or other dependent 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, reimbursement is only up to the amount that has been deducted from the participant s paycheck for the Dependent Care FSA.

A sample list of qualified expenses eligible for reimbursement include, but are 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 $550 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed (only if the employee re-enrolls the next year). Dependent Care funds cannot be carried over.
- When a plan year ends and all claims have been filed, all unused funds with the exception of the $550 rollover for the Health Care FSA will be forfeited and not returned.
- Employee can enroll in an FSA only during the Open Enrollment period, a Qualifying Event, or 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 they have 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.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by 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 will automatically receive a debit card for payment of eligible expenses. If member has a BenefitsWorkshop Health Reimbursement Account debit card, the Health Care FSA and Dependent Care FSA available balances will be added to the debit card. Health care expenses will be deducted first from the Health Care FSA balance and then will be deducted from the HRA. This way forfeitable money is used first. 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 health care providers and facilities, and most pharmacy retail outlets. BenefitsWorkshop 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 County. This card will not expire at the end of the benefit year. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $83.33 based on a monthly pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

	With a Health Care FSA	Without a Health Care FSA
Salary	$30,000	$30,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$29,000	$30,000
Estimated Tax 22.65% = 15% + 7.65% FICA	- $6,568	- $6,795
After Tax Expenses	- $0	- $1,000
Spendable Income	$22,432	$22,205
Tax Savings	**$227**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds which remain in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the $550 carry over that may be allowed for the Health Care FSA.* ***This rule is known as "use-it or lose-it."***

BenefitsWorkshop | Customer Service: (888) 537-3539
www.benefitsworkshop.com | Email: info@benefitsworkshop.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 New Directions. 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?

An Employee Assistance Program (EAP) 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 can negatively affect employee or family member's well-being. Coverage includes six (6) 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 the services confidential?

Yes. Receipt of EAP services are completely confidential. The content of conversations with EAP professionals are confidential within the confines of the law and cannot be shared with employer without consent. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), New Directions 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 only receive reports on whether the referred employee is complying with the prescribed treatment plan.

New Directions | Customer Service: (800) 624-5544 | eap.ndbh.com
Company Code: martinbocc

Basic Life and AD&D Insurance

The County offers Basic Term Life and Accidental Death & Dismemberment (AD&D) insurance to all eligible employees through The Standard. The County will contribute a portion of the premium for this coverage and the available benefit amount will be determined by employee classification and pay grade as provided in the table below.

Basic Life and AD&D Insurance Benefit & Premium Schedule

Employee Classification	Basic Life Benefit	AD&D Benefit	Employee Cost Per Month
Elected Officials	$250,000	$250,000	$42.48
Officers	$100,000	$100,000	$17.00
Department Directors	$75,000	$75,000	$12.76
Division Manager/ Administrators	$50,000	$50,000	$8.50
Active Employees	$25,000	$25,000	$4.26

The Basic Term Life insurance benefit will be paid in the event of the insured's natural death. The AD&D insurance rider pays a benefit 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, partial benefits may also be payable.

If employee did not enroll in the Life Insurance plan when first eligible and wants to purchase this coverage, employee will be required to complete The Standard's Medical History Statement form, which can be obtained on the Employee Benefits Center.

Employee's life insurance beneficiary designation(s) may be made online during the Open Enrollment period and any time during the plan year. To complete life insurance designation(s) online, log on to www.mybentek.com/martincounty. A beneficiary designation confirmation statement may also be printed and retained for records.

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

The Standard | Customer Service: (800) 247-6888 | www.standard.com
Policy Number: 642407

Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible employee may elect to purchase additional Life insurance on a voluntary basis through The Standard. This coverage may be purchased in addition to the Basic Term Life and AD&D coverage. Voluntary Life insurance offers coverage for employee, spouse and/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 $50,000.**

- Employee may elect coverage in the following amounts:
  Option 1: $25,000 **Option 2:** $50,000 **Option 3:** $75,000
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of benefit amount at age 70
  - Reduces to 50% of benefit amount at age 75
- Premium Calculation:
  Elected Coverage ÷ $1,000 x Employee Rate (see table) = Monthly Premium

Voluntary Life Insurance Rate Table

Monthly Premium

Age Bracket *(Based On Employee Age)*	Employee/Spouse Cost *(Rate Per $1,000 of Benefit)*
< 30	$0.094
30-34	$0.096
35-39	$0.127
40-44	$0.178
45-49	$0.269
50-54	$0.410
55-59	$0.663
60-64	$0.880
65-69	$1.495
70-74	$2.656
75+	$10.072

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 $25,000.**

- Employee **must** participate in the Voluntary Employee Life plan for spouse to participate.
- Employee may elect Spouse Dependent Life coverage in the following amounts, not to exceed 100% of employee's Voluntary Life coverage amount:
  Option 1: $25,000 **Option 2:** $50,000 **Option 3:** $75,000
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of benefit amount at age 70
  - Reduces to 50% of benefit amount at age 75
- Premium Calculation:
  Elected Coverage ÷ $1,000 x Employee Rate (see table) = Monthly Premium

Voluntary Dependent Child(ren) Life Insurance

- Employee **must** participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- Coverage is $10,000 for eligible children, not to exceed 100% of the employee's Voluntary Life coverage amount. Late applications are subject to medical underwriting approval.
- Employee may cover unmarried dependent children from living birth through the end of the calendar year in which the child turns age 26.
- Cost for coverage is $2.00 a month regardless of the number of eligible children covered.
- If employee did not enroll in the voluntary life plans for dependents when first eligible and now want to purchase this coverage or increase coverage, employee and/or dependent child will be required to complete The Standard's Medical History Statement form. The Medical History Statement form can be found on at www.mybentek.com/martincounty.

The Standard | Customer Service: (800) 247-6888 | www.standard.com
Group Number: 642407

Voluntary Long Term Disability

The County offers Long Term Disability (LTD) insurance to all eligible employees through The Standard. The LTD benefit pays a percentage of monthly earnings if employee becomes disabled due to an illness or non-work related injury.

Voluntary Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of $5,000 per month.
- Employee must be disabled for 90 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 91st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- Benefits are payable up to age 65 if disability occurs before age 62. Please see The Standard's Group Certificate for schedule of age benefits if employee becomes disabled at age 62 or older.
- The employee will receive benefits for the first 24 months if unable to return to employee's own occupation.
- After 24 months, if employee can return to any occupation in which they are suitably trained, educated, and capable of performing, employee must return to that occupation (if the salary of that occupation does not meet the salary of the employee's own occupation, the plan will pay the difference).
- Benefits may be reduced by other income.

Long Term Disability Rate Table

Monthly Rates

Age Bracket *(Based On Employee Age)*	Employee Cost *(Rate Per $100 of Benefit)*
< 35	$0.196
35-44	$0.402
45-54	$0.883
55-99	$1.430

LTD Premium Calculation

The LTD premium will be based on age and salary per $100 of monthly benefit. To determine the monthly premium, use the following rate calculation formula:

Monthly Salary (not to exceed $8,333) x Premium Rate for Age (listed above) ÷ $100 = Monthly LTD Premium

The Standard | Customer Service: (800) 247-6888 | www.standard.com
Policy Number: 642407

Supplemental Insurance

Aflac

County employees may purchase supplemental insurance on a voluntary basis through Aflac. Descriptions of the variety of coverage options available are provided below. To learn more about these options or to schedule a personal meeting, contact the County's Aflac representatives using the contact information provided below.

All Aflac programs help employees:

- ✓ Protect their income
- ✓ Supplement their medical plan
- ✓ Provide a financial safety net for unexpected health issues

Short-Term Disability – Provides employee with a source of income if they are unable to work due to an off-the-job injury or illness. Employee can select a monthly benefit amount, elimination period and benefit period tailored to their needs and budget.

Accident Advantage – Provides employee with cash benefits if they or a covered dependent receives treatment for injuries sustained in a covered accident, 24/7. This program includes, but is not limited to, hospital benefits, wellness benefits, injury and surgical benefits, accidental death and dismemberment benefits, physician visit benefits, transportation and lodging benefits.

Cancer Protection Assurance – Provides employee with cash benefits if they or a covered dependent are diagnosed with internal cancer or skin cancer. This policy includes, but is not limited to, a lump sum initial diagnosis benefit that grows each year, a wellness benefit, hospital benefits, radiation and chemotherapy benefits, surgical/anesthesia benefits, transportation and lodging benefits.

Hospital Choice – Provides employee with cash benefits if they or a covered dependent are hospitalized due to a covered accident or illness. This program includes, but is not limited to, hospital benefits, surgical benefits, physician visits and major diagnostic benefits.

Critical Care Protection – Provides employee with cash benefits if they or a covered dependent are diagnosed as having had a named specified health event. This program includes a first occurrence benefit that grows every year as well as re-occurrence benefits, hospital confinement benefits, continuing care benefits, ambulance benefits, transportation, and lodging benefits.

Dental Insurance – Add to the Florida Blue Dental coverage or choose Aflac's dental coverage alone. Employee may add orthodontic and cosmetic riders to help budget expenses. With Aflac, employee can choose their own dentist since there is no network. There is no annual deductible or pre-certification, and wellness benefits begin on the first day of coverage (other waiting periods may apply).

Life Solutions Term & Whole Life Insurance – Face amounts are available up to $500,000 for employee and are offered as 10, 20 and 30 Year Term or Whole Life Insurance. These policies include an accelerated death benefit and other riders, including Term riders to cover employee's spouse and/or dependent child(ren). In addition, Juvenile Life Insurance is available as Term or Whole Life for dependent children and grandchildren, in coverage amounts of $10,000, $20,000 and $30,000.

Agent: Karen Zabaglo
Phone: (772) 284-3210 | Email: karen_zabaglo@us.aflac.com
Agent: Loire Lucas
Phone: (772) 708-5931 | Email: loire_lucas@us.aflac.com

Additional County Benefits

The County also offers a variety of non-insurance related benefits such as paid leave and holidays, tuition reimbursement, deferred compensation, and other ancillary products. Please make sure to contact the Constitutional Office to learn more about all the benefit offerings available.

MetLife	(561) 704-4378	Agent: Janet Froyen jfroyen@madisonplanning.com
Credit Union - Gold Coast FCU	(772) 335-2083	www.gcfcu.org
Florida Retirement System (FRS)	(844) 377-1888	www.dms.myflorida.com/retirement
MY FRS Financial Guidance	(866) 446-9377	www.myfrs.com

Deferred Compensation

Deferred Compensation is a second retirement source for employees. It is strictly an employee contributory plan. The County does not match the amount employee deposits or make any deposits into the account on employee's behalf. It is tax deferred money deposited into an account. Employee pays taxes on the money once they withdraw it. The County offers three (3) Deferred Compensation companies:

ICMA Retirement Corporation	(866) 731-1055	Agent: Steve Feigelis SFeigelis@icmarc.org
VALIC	(772) 418-5031	Agent: Jim McCudden jim.mccudden@valic.com
Nationwide Retirement	(772) 284-9660	Agent: Mark Schilling schillm@nationwide.com

Legal & Identity Theft Plan

LegalShield

The County offers employees the opportunity to participate in a voluntary pre-paid legal program offered through LegalShield. By enrolling in the legal plan, a participant and their family will have direct access to a nationwide network of law firms who will provide direct access for a variety of situations. The plan provides assistance, but is not limited to the following benefits:

- ✓ Divorce
- ✓ Child Custody & Support
- ✓ Civil Litigation
- ✓ Bankruptcy
- ✓ Name Changes
- ✓ Criminal Defense
- ✓ Traffic Tickets
- ✓ Wills & Living Trusts
- ✓ Real Estate
- ✓ Credit Report Issues
- ✓ Contract Review
- ✓ Adoption

IDShield

The County also offers employees the opportunity to participate in an identity theft plan called IDShield through LegalShield which protects employee, spouse and/or dependent child(ren). IDShield coverage includes consultation with licensed fraud investigators, credit report with analysis, privacy & security monitoring, credit monitoring and full restoration benefits with a $5 million service guarantee, should employee or covered family member become a victim of identity theft. The IDShield coverage also includes access to licensed investigators available 24/7, lost wallet assistance and fraud alerts.

There are several levels of coverage options that may be purchased. The cost per month, for each option, are as follows:

	Employee Cost *(Monthly Rates)*
LegalShield Legal Plan	
IDShield Individual Plan	
IDShield Family Plan	
LegalShield & IDShield Individual Plan Combo	
LegalShield & IDShield Family Plan Combo	

Plan benefits include unlimited phone consultations. For additional information please contact the County's dedicated Agent Steve Baker.

Agent: Steve Baker | Phone: (321) 613-0037
Email: sb@legalshieldassociate.com

LegalShield | Customer Service: (800) 654-7757 | www.legalshield.com

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.

GEHRING®
GROUP
EMPLOYEE BENEFITS | RISK MANAGEMENT

4200 Northcorp Parkway, Suite 185
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970
www.gehringgroup.com

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