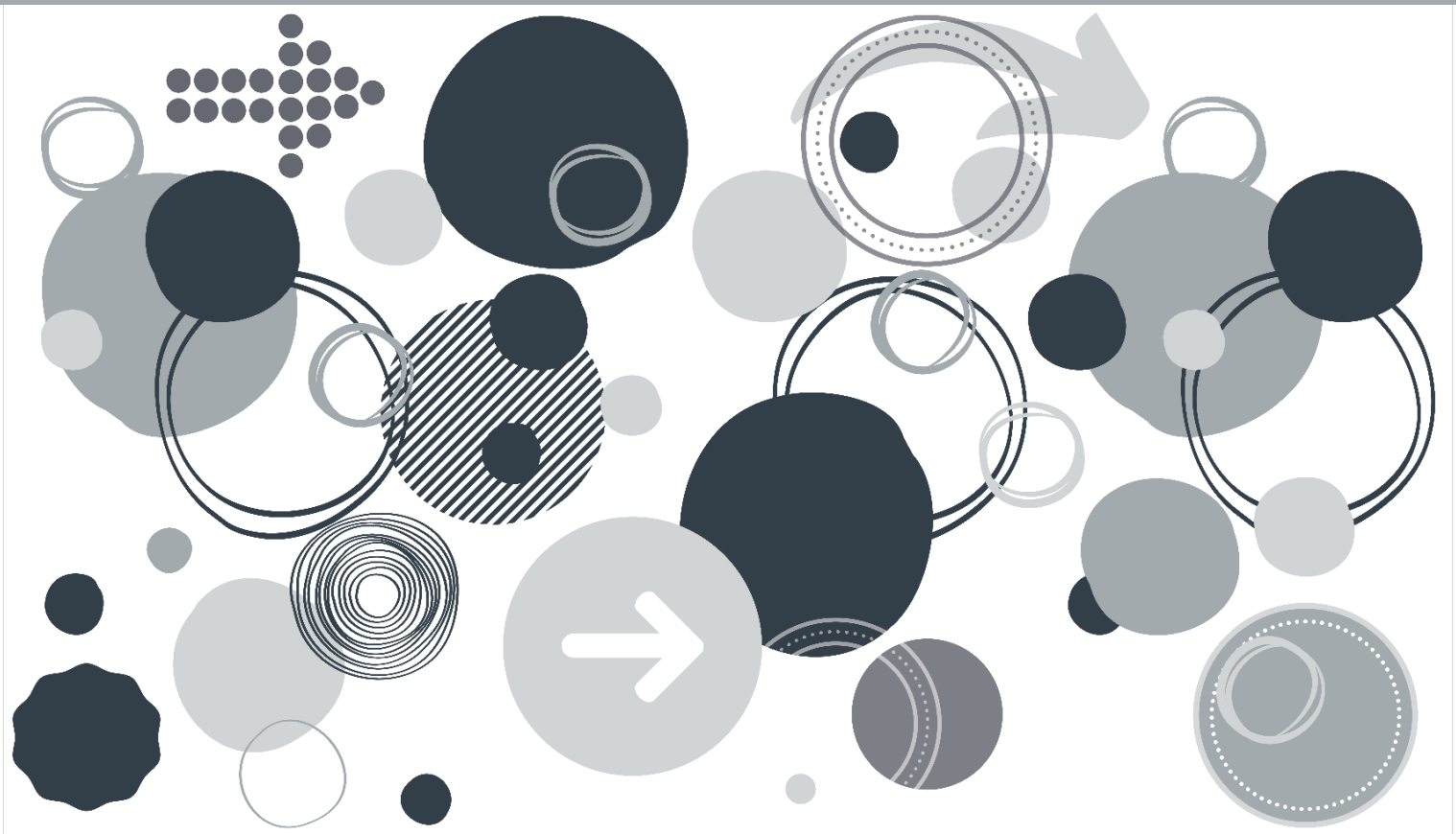
SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

Employee Benefits Guide 2021



If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 40 for more details.

Important Contacts

BENEFIT CONSULTANT

HYLANT

General Claims and Benefit Information

Customer Service Helpline: In order to help you with your benefit questions, claim issues, and general inquiries, you and your dependents may contact Hylant. Hylant is a one-source helpline for your benefit questions. Please call the toll-free number listed below, Monday-Friday during normal business hours, 8 a.m.- 4:30 p.m. ET, and speak to a customer service specialist who can assist you with your benefit questions.

Call: (407) 740-5550 **www.Hylant.com**

Be prepared: When contacting any of the companies below, it is important to have the insurance card or ID card number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

Questions About	Contact	Phone	Website
Medical	Florida Blue Member Services	800-664-5295	www.floridablue.com
	Medication Guide		http://www.floridablue.com/DocumentLibrary/Providers/Content/MedGuide.pdf
Health Savings Account (HSA)	HealthEquity	1-866-346-5800	www.healthequity.com/ed/learnhsa email: memberservices@healthequity.com
Employee Assistance Programs	ComPsych	844-669-2751	www.guidanceresources.com Company ID: SEMINOLECOUNTY
Dental	Lincoln Financial	800-423-2765	www.lfg.com
Vision	EyeMed	866-939-3633	www.eyemed.com Select “Insight” network
Life / AD&D	The Standard	877-490-9991	www.standard.com
Short Term Disability	The Standard	877-490-9991	www.standard.com
Long Term Disability	Reliance Standard	800-351-7500	www.rsli.com customer.service@rsli.com
Flexible Spending Accounts (FSA)	Chard Snyder	800-982-7715 Claims fax: 888-245-8452	www.chard-snyder.com
Professional Benefit Plans (Cancer & Specified Disease)	American Heritage/Allstate Doug Murdock	407-366-4252	doug@probenefitplans.com
Critical Illness Plan	Aetna	888-772-9682	www.aetna.com/voluntary/employees
HR Program Manager II	Bobbi Kidd	407-665-7952	bkidd@seminolecountyfl.gov
Benefits Coordinator	Tania Rivera	407-665-5272 407-665-7939 fax	trivera@seminolecountyfl.gov

This booklet is intended as a high level overview and is informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

ELIGIBILITY

Seminole County Government offers a health and welfare program to all employees classified as full time. The program offers you and your family coverage that helps reduce your medical expense, improve your health and well-being, and protect you while you are an active employee.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans described below.

Benefit	Legal Spouse	Dependent Child(ren)
Medical		Up to age 26 (End of calendar year)
Dental	√	Up to age 26 (End of calendar year)
Vision	√	Up to age 26 (End of calendar year)
Life and AD&D	√	Up to age 26 (End of calendar year)

EXTENDED DEPENDENT ELIGIBILITY

For Medical - In the state of Florida dependent coverage is available up to age 30 if the dependent is unmarried without dependents of their own, a Florida resident (or a full-time student) and uninsured. The dependent must maintain continuous service.

You may be asked to provide Human Resources with proof of dependent eligibility in the form of:

- Copy of marriage certificate
- Your most recent Federal Income Tax Return,
- Court Order specifying your responsibility to provide “group health care coverage” to your dependent children, and/or
- Copy of their birth certificate.

NEW HIRE COVERAGE

It is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event.

Waiting Period: As an eligible new hire, your plan eligibility date is the first day of the month following 30 calendar days of service. Once the necessary enrollment has been completed, benefits are effective on your plan eligibility date.

COBRA CONTINUATION OF COVERAGE

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

MAKING CHANGES DURING THE YEAR

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. You must notify Human Resources of such change(s) within 30 days from the event. Failure to notify Human Resources within the timeframe noted (and provide any necessary dependent documentation) will require you to wait until the next open enrollment period to make your change. Qualifying events will require documentation of the event such as marriage certificate, birth certificate, divorce decree, etc. to finalize the event change. For questions, please see your Human Resource representative.

A family status change includes:

- Marriage
- Divorce or legal separation
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment or
- Gain or Loss of coverage by a dependent
- Leave of absence
- Change in eligibility for Medicare or Medicaid (notice within 60 days from date of the event is required)

WELCOME BABY! Don't forget to notify Human Resources within 30 days of birth of a newborn to add dependent(s) to the plan.

TURNING AGE 65 AND BECOMING MEDICARE ELIGIBLE

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. Contact the Social Security Administration to make an appointment to discuss your options. For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

BENEFICIARY DESIGNATION

In addition to electing or making benefit changes during open enrollment, it is important to designate a beneficiary for your life insurance and Health Savings Account (HSA). Your beneficiary is the person(s) who will receive your life insurance benefits and any remaining HSA balance when you die. If you have a beneficiary in place, or if your family situation has changed, now is the time to ensure all information on record is correct.

If you do not name a beneficiary, your benefits will automatically be disbursed per the terms of the Certificate of Coverage and the bank's HSA account policies. For additional information contact Human Resources.

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan allows you to pay for many of the benefits we offer with "before-tax" dollars (e.g., medical, dental and vision coverage). By paying premiums with "before-tax" dollars, you may reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections made during the Cafeteria Plan enrollment period are effective for the entire 12-month plan year. Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Refer to the preceding page of this guide for information on what constitutes a qualifying event, and the associated timeframe you have to notify Human Resources if you intend to make a change.

HEALTH & WELL-BEING COVERAGE: MEDICAL

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), or SBC. You may access a list of participating providers through the carrier's website.

	BlueOptions Buy Up Plan 03748	BlueOptions Mid Plan 03769	BlueOptions Low Plan 05770	BlueOptions HSA Plan 05180/81
			Calendar Year	Calendar Year
Individual		$500		$1,500
Family		$1,500		$3,000
Coinsurance				
Plan Pays		80%		90%
You Pay		20%		10%
Out of Pocket Maximum	**********	Includes Deductible, Coinsurance and All Copays	**********	**********
Individual		$3,000		$3,000
Family		$6,000		$6,000
Primary Care Physician	$15 Copay	$25 Copay	$25 Copay	Ded + Coins
Specialist	$25 Copay	$60 Copay	$45 Copay	Ded + Coins
Preventive Care Services	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Urgent Care	$35 Copay	$35 Copay	$50 Copay	Ded + Coins
Emergency Room	$200 Copay	$300 Copay	$200 Copay	Ded + Coins
Provider Services	$0 Copay	$100 Copay	$100 Copay	Ded + Coins
Labs at Independent Facility	$0 Copay @ Quest	$0 Copay @ Quest	$0 Copay @ Quest	Ded + Coins
X rays at Independent Facility	$0 Copay	$0 Copay	$50 Copay	Ded + Coins
Advance Imaging (MRI, CT, PET)	Ded + Coins	Ded + Coins	$200 Copay	Ded + Coins
Ambulatory Surgical Center (ACS)	Ded + Coins	Ded + Coins	$150 Copay	Ded + Coins
Outpatient Hospital Services	Ded + Coins	Ded + Coins	Ded + Coins	Ded + Coins
Provider Services	$0 Copay	$0 Copay	$0 Copay	Ded + Coins
Inpatient Hospital Services	Ded + Coins	Ded + Coins	Ded + Coins	Ded + Coins
Provider Services	$0 Copay	$0 Copay	$0 Copay	Ded + Coins
Prescription Drugs ~ See Rx Notes Below	No Deductible	No Deductible	No Deductible	Deductible Applies, Then
Rx	$10/$30/$50/$100	$10/$30/$50/$100	$10/$30/$50/$100	$10/$30/$50/$100
Mail Order (90 day supply)	$25/$75/$125/NC	$25/$75/$125/NC	$25/$75/$125/NC	$25/$75/$125/NC
Out of Network Benefits				
Deductible				
Individual	$500	$1,500	$3,000	$3,000
Family	$1,500	$4,500	$6,000	$6,000
Coinsurance				
Plan Pays	50%	50%	50%	60%
You Pay	50%	50%	50%	40%
Out of Pocket Maximum				
Individual	$3,000	$6,000	$7,000	$6,000
Family	$6,000	$12,000	$14,000	$12,000

~RX Notes: *If you request a Brand Name Prescription Drug when a Generic is available, you will be responsible for the copayment applicable to Brand Name Prescription Drugs; and the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated on the BlueScript pharmacy Program Schedule of Benefits (unless the physician indicates "Dispense As Written" (DAW)).*

*~ Some **generic** drugs used to treat chronic conditions such as high blood pressure, diabetes, depression, high cholesterol and respiratory conditions will be covered at a $0 copay. These prescriptions are part of the Florida Blue Care Condition Program. The **generic** drugs that are covered on the list are all lower case. The drugs that are on this list in upper case letters are covered at a copayment ($10/$30/$50). This Care Condition List is subject to change throughout the year by Florida Blue. The most up to date list will be kept on SharePoint.*

~ CVS owned pharmacies will not be in the pharmacy network (see page 5 for more information).

** **Out-of-Network** services may be subject to balance billing and if admitted as an Inpatient from the ER member pays Out-of-Network Deductible and In-Network ER Copay (or Coinsurance in H.S.A. plan).*

*** Please be aware this plan has the lowest bi-monthly premium deduction. However, it is important to understand deductibles must be met for all services except preventive care. If you elect this plan, **The County will contribute $500 to your Health Savings Account. REMEMBER – IF YOU ENROLL IN THE HSA PLAN WITH DEPENDENTS, YOU MUST MEET THE FAMILY DEDUCTIBLE OUT OF POCKET MAX AND THAT THE $500 HSA CONTRIBUTION BY THE COUNTY IS A FLAT CONTRIBUTION PER FAMILY.***

TELEMEDICINE

TELADOC®

Florida Blue

Getting started **with Teladoc**

Cómo afiliarse **a Teladoc**

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors by web, phone or mobile app. It is a convenient and affordable option for quality medical care. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.

1. REGISTER

3 easy ways: download the mobile app, visit the Teladoc website or call the number below.

2. PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

3. REQUEST A VISIT

That's it! A Teladoc doctor is now just a call or click away.

Teladoc® le da acceso 24 horas, 7 días a la semana todos los días del año a una lista de médicos especialistas certificados de Estados Unidos a través de su teléfono. Configure su cuenta ahora para que cuando necesite la atención inmediata, un médico de Teladoc esté a sólo una llamada de distancia.

1. REGÍSTRESE

Llame al teléfono que figura a continuación y un representante lo ayudará a registrar su cuenta.

2. PROPORCIONE SUS ANTECEDENTES MÉDICOS

Sus antecedentes médicos proporcionan a los médicos de Teladoc la información que necesitan para realizar un diagnóstico seguro.

3. SOLICITE UNA CONSULTA

¡Eso es! Un médico de Teladoc está a sólo un llamado de distancia.

Primary Care Visits:
PCP Copay!
Dermatology Visit:
Specialist Copay

H.S.A. Plan is Deductible & Coinsurance:
Current cost is $42 for PCP & $75 for Dermatology

Talk to a doctor anytime••
¡Hable con un médico en cualquier momento!

Teladoc.com
1-800-Teladoc (835-2362)

Available on the iPhone App Store
GET IT ON Google Play

Savings are Coming Your Way!

Florida Blue
In the pursuit of health

In the new benefit year, you'll see more savings at the pharmacy counter!

Walgreens can save you money

Walgreens is a featured pharmacy in your network and that's good news! You'll pay a lower price for many prescriptions at Walgreens than anywhere else. This means you'll often pay less when you have a deductible to meet. Or if the drug costs less than your copay, you'll pay the lower price[1].

A choice of pharmacies

Your Florida Blue plan offers you a lot of pharmacy choices. In addition to Walgreens, you can choose from Publix, Winn-Dixie, Walmart, and many small, independent pharmacies throughout the state. Always use an in-network pharmacy for greatest savings on your medicines. If you use a pharmacy that is out of network, such as CVS-owned pharmacies[2], you'll pay the full price out of pocket for your prescription.

Moving your prescriptions

If you're using a CVS-owned pharmacy today, think about moving your prescriptions to another in-network pharmacy like Walgreens now. You can see a list of in-network pharmacies at floridablue.com/performancepharmacy.

Here's how to easily make the switch:

- Call or stop by your local Walgreens or other in-network pharmacy and tell the pharmacist you want to move your prescriptions from another pharmacy. They'll help you make the switch. Just have a list of your current medications handy.
- Using the free Walgreens mobile app on your smartphone, take a picture of your medicine bottle and send it to your nearest Walgreens.

If you continue to use CVS in the new benefit year, you'll experience higher out-of-pocket costs.

- You'll pay the full price of your medication out of your pocket if you don't have out-of-network pharmacy benefits.
- If you have out-of-network pharmacy benefits, you'll pay the full price of your medication and can file a claim for reimbursement. Your reimbursement will be based on out-of-network benefits.

Please refer to your summary of benefits to see if you have out-of-network pharmacy benefits. You don't need to take any action if you currently fill prescriptions at an in-network pharmacy.

1 Retail costs reflect the estimated amount you'll pay, after your health plan's cost share, such as copay and coinsurance, have been met. Actual cost will be determined at the time of purchase.
2 CVS-owned pharmacies are out of network in 2020 including Bear Creek Pharmacy, Care Pharmacy, Care Plus CVS/Pharmacy, CarePlus, CarePlus CVS Pharmacy, Longs Drug Store, Longs Pharmacy, Navarro Discount Pharmacy, Navarro Health Services, RxAmerica,Target Pharmacy and Wellness Works Pharmacy. Your specialty and mail order services will not change.

HEALTH SAVINGS ACCOUNT

WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account, commonly known as an "HSA," is an individual account you can open, add money to, and spend on eligible health care expenses. **If you elected the BlueOptions 5180/81 health plan, you are eligible for an HSA.**

SETTING UP YOUR HSA

Once you are covered by a qualified health plan you may set up your HSA. **If you are enrolling in the FSA you may not enroll in the HSA.**

Once you set up your HSA, any payroll deductions you have elected may begin. It is important to get your HSA set up as quickly as possible because you cannot turn in expenses incurred before the account was set up.

Seminole County Government will contribute $500 annually to your HSA account (amount is the same if enrolling as Individual or Family).

ADDING MONEY

The government sets the annual dollar maximum that can be contributed to an HSA depending on the level of coverage you have under your health insurance. Coverage of two or more people is considered family coverage. People who are age 55 or older can make additional catch-up contributions.

USING HSA MONEY

You decide when to spend money from your HSA. If you pay out of pocket for an eligible medical expense, you can choose to not reimburse yourself and let the money in your HSA build up, or you can reimburse yourself for the expense from your HSA.

If you use your HSA money for expenses that are not eligible, you will pay a 20% penalty plus income tax on the amount. Once you turn age 65, you may use your HSA money for any expense, medical or not, but you will pay income taxes on those non-medical expenses. To view the full list of eligible expenses, visit **www.irs.gov/publications** and refer to Publication 969.

HSA Maximum 2021 Contribution Limits	
Employee Only	**$3,600**
Employee + Dependent(s)	**$7,200**
55+ CatchUp	**$1,000**

Note: It is your responsibility to familiarize yourself with IRS regulations on HSAs and maintain records of all transactions pertaining to your HSA for audit purposes.

ELIGIBLE EXPENSES

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. In general, eligible expenses are those that qualify toward the deductibles, copays, and coinsurance with your health plan. If you use money for a dental, vision or medical expense that is not covered by the medical plan, it is important you understand your medical plan deductible still needs to be met if an expense is incurred.

PORTABILITY	FLEXIBILITY	TAX SAVINGS	PREMIUM SAVINGS
• You own 100% of the deposited funds, meaning if you change employers or retire, you do not lose the money in the accounts regardless of whether you contributed the money or if it was an employer contribution	• You can choose to spend the money on current medical expenses, or you can save your money for future use • Any unused funds will automatically roll over to the following year as there is no "use it or lose it" provision	• Contributions are tax free (pre-tax through payroll deductions or tax deductible) • Earnings are tax free • Funds withdrawn for eligible medical expenses are tax free	• By choosing the HDHP available, your payroll premium cost is lower than the traditional PPO plan

HEALTH SAVINGS ACCOUNT WITH HEALTHEQUITY

HealthEquity®
Building Health Savings™

Build funds with tax breaks

- Similar to Individual Retirement Account (IRA)
- Money contributed used to build savings for future medical costs
- Account deposits and interest earnings receive tax-favored treatment
- Funds can be invested in no-fee investment accounts
- Money contributed to HSA can be withdrawn tax-free to pay for qualified medical expenses (QME)

Move it, keep it!

- Completely portable, even if employees move
- Funds rollover from year to year

Simple start

- Establish accounts easily through integrated enrollment at HealthEquity

Peace of Mind

- Accumulated money for health expenses
- Pay insurance premiums (i.e., long-term care, COBRA, or health premiums while unemployed)

Retirement at age 65

- Pay for Medicare or employees' share of any medical insurance premiums
- Use funds penalty-free for other out-of-pocket costs after age 65 (taxes apply to non-medical use)

More Information Available at:

- Online at **healthequity.com/ed/learnhsa**
- Phone Customer Service at **1-866-346-5800**
- eMail at **memberservices@healthequity.com**

HealthEquity HSA Key Account Features...

- Best HSA value
- Debit Cards provided–no transaction fees
  - ♦ Tiered interest rates reward savings
- 24/7 telephone support from live HSA experts and online account access
- Decision support tools
  - ♦ Financial/Banking–HealthEquity
  - ♦ Care and service–Florida Blue
- Accounts funded by individual, employer or both (up to IRS max)
- Individual responsible for managing HSA, filing HSA tax form and validating IRS qualified medical expenses (QMEs)

Banking Services Feature Debit Cards For Easy Access to Funds

- Automatically mailed to member upon receipt of enrollment at HealthEquity
- Activate by calling number indicated on card's instructions
- Use to pay for qualified medical expense (QME) at point of service
- PIN provided (cannot use card at ATM)
- Debits reflected on monthly account statements
- Expenses validated by account holder

COST OF COVERAGE SUMMARY

2021 Health Insurance Funding Regular Rates		
BUY-UP PLAN		
Plan #3748	**EMPLOYEE PREMIUM**	
Coverage Type	**Bi-monthly**	**Monthly**
Employee Only	$ 91.48	$ 182.95
Employee & Spouse	$ 344.63	$ 689.25
Employee & Child(ren)	$ 200.26	$ 400.51
Employee & Family	$ 444.91	$ 889.81

MID PLAN		
Plan #3769	**EMPLOYEE PREMIUM**	
Coverage Type	**Bi-monthly**	**Monthly**
Employee Only	$ 40.00	$ 80.00
Employee & Spouse	$ 285.38	$ 570.75
Employee & Child(ren)	$ 147.95	$ 295.90
Employee & Family	$ 367.91	$ 735.82

LOW PLAN		
Plan #5770	**EMPLOYEE PREMIUM**	
Coverage Type	**Bi-monthly**	**Monthly**
Employee Only	$ 40.00	$ 80.00
Employee & Spouse	$ 263.56	$ 527.11
Employee & Child(ren)	$ 129.77	$ 259.53
Employee & Family	$ 337.54	$ 675.08

H.S.A. PLAN		
Plan #5180/81	**EMPLOYEE PREMIUM**	
Coverage Type	**Bi-monthly**	**Monthly**
Employee Only	$ 40.00	$ 80.00
Employee & Spouse	$ 225.25	$ 450.49
Employee & Child(ren)	$ 97.84	$ 195.67
Employee & Family	$ 284.16	$ 568.32

2021 Health Insurance Funding
Wellness Preferred Rates

BUY-UP PLAN

Plan #3748	EMPLOYEE PREMIUM	
Coverage Type	**Bi-monthly**	**Monthly**
Employee Only	$ 51.48	$ 102.95
Employee & Spouse (Employee AND Spouse meet the criteria)	$ 264.63	$ 529.25
Employee & Spouse (Employee OR Spouse meet the criteria)	$ 304.63	$ 609.25
Employee & Child(ren)	$ 160.26	$ 320.51
Employee & Family (Employee AND Spouse meet the criteria)	$ 364.91	$ 729.81
Employee & Family (Employee OR Spouse meet the criteria)	$ 404.91	$ 809.81

MID PLAN

Plan #3769	EMPLOYEE PREMIUM	
Coverage Type	**Bi-monthly**	**Monthly**
Employee Only	$ -	$0.00
Employee & Spouse (Employee AND Spouse meet the criteria)	$ 205.38	$ 410.75
Employee & Spouse (Employee OR Spouse meet the criteria)	$ 245.38	$ 490.75
Employee & Child(ren)	$ 107.95	$ 215.90
Employee & Family (Employee AND Spouse meet the criteria)	$ 287.91	$ 575.82
Employee & Family (Employee OR Spouse meet the criteria)	$ 327.91	$ 655.82

LOW PLAN

Plan #5770	EMPLOYEE PREMIUM	
Coverage Type	**Bi-monthly**	**Monthly**
Employee Only	$ -	$0.00
Employee & Spouse (Employee AND Spouse meet the criteria)	$ 183.56	$ 367.11
Employee & Spouse (Employee OR Spouse meet the criteria)	$ 223.56	$ 447.11
Employee & Child(ren)	$ 89.77	$ 179.53
Employee & Family (Employee AND Spouse meet the criteria)	$ 257.54	$ 515.08
Employee & Family (Employee OR Spouse meet the criteria)	$ 297.54	$ 595.08

H.S.A. PLAN

Plan #5180/81	EMPLOYEE PREMIUM	
Coverage Type	**Bi-monthly**	**Monthly**
Employee Only	$ -	$0.00
Employee & Spouse (Employee AND Spouse meet the criteria)	$ 145.25	$ 290.49
Employee & Spouse (Employee OR Spouse meet the criteria)	$ 185.25	$ 370.49
Employee & Child(ren)	$ 57.84	$ 115.67
Employee & Family (Employee AND Spouse meet the criteria)	$ 204.16	$ 408.32
Employee & Family (Employee OR Spouse meet the criteria)	$ 244.16	$ 488.32

Note: Bi-Monthly reflects 24 premium payments per year

There is NO increase to employee premiums for Plan Year 2021.

2021 WELLNESS PROGRAM OVERVIEW

In support of our employees, as a result of the delay of elective care at providers' offices due to COVID-19, the Seminole County Wellness Program will pause until 2021. At this time more than ever, we STILL encourage you to stay on track with your health and encourage you to schedule annual physicals and complete your lab work as soon as reasonably possible. Not only will this support a good pathway to meeting wellness requirements in the future, but most importantly, will keep track of your personal health.

The voluntary wellness program includes employees and covered spouses completing an annual physical exam AND meeting three (3) of four (4) biometric criteria listed (employee and covered spouse must each submit a form to qualify).

STEPS TO THE WELLNESS PROGRAM FOR 2021:

- Employees and/or Spouses currently enrolled under the county's health plan, **who currently qualify for the Wellness Preferred Rate**, will continue to qualify for Plan Year 2021.
- Because everyone who met the criteria for the wellness incentive his year will carry forward for 2021, those that did not but now wish to complete the Biometric Criteria Screening for the 2021 Wellness Initiative must have the biometric screening completed by their physician. This will include lab work. Your physician will need to initial and sign the "Annual Physical Exam Form/Wellness Confirmation" verifying 3 of the 4 biometric criteria have been met.
  - Annual physical exams and biometric criteria conducted between October 1, 2019 through September 30, 2020 will be accepted

Biometric Criteria
Must meet 3 out of the 4 Biometrics & Fasting required for all bloodwork

Biometrics	Acceptable Range
Blood Pressure	124/82 or less
Cholesterol	200 or less
Glucose (fasting)	126 or less
BMI	29 or less

If you do not meet a health outcome standard set by this program, you will have an opportunity to receive the wellness preferred rate for the insurance premiums by completing a reasonable alternative standard, which may include a physician recommendation. Please contact Bobbi Kidd (ex. 7952) or Tania Rivera (ex. 5272) to discuss the reasonable alternative

  - Then YOU ARE REQUIRED TO submit your completed Annual Physical Exam Form/Wellness Confirmation by the deadline, October 7, 2020. Please use ONE of the following options:

1. Email (strongly recommended): FORYOURHEALTH@SEMINOLECOUNTYFL.GOV
2. Fax: 407-665-7939

STEPS TO THE TOBACCO* FREE REQUIEREMENT FOR 2021:

- Employees, as well as spouses currently enrolled under the County's health plan, will be required to attest in the PlanSource system during annual enrollment, indicating they are tobacco free in order to avoid an additional $40 per pay period/per Tobacco user tobacco surcharge.

- If you and or your spouse are a tobacco user and would like to enroll in a qualified tobacco cessation program, please refer to the list of approved Tobacco Cessation Programs which are offered at no cost to you. You must enroll and complete a qualified program by September 30, 2020. A certificate of completion must be uploaded into PlanSource during Open Enrollment for Plan Year 2021

*Tobacco use, as defined by the Affordable Care Act (ACA), is an average of four or more times per week within the past 6 months, including ALL tobacco and Nicotine products, but excluding religious and ceremonial uses of tobacco.

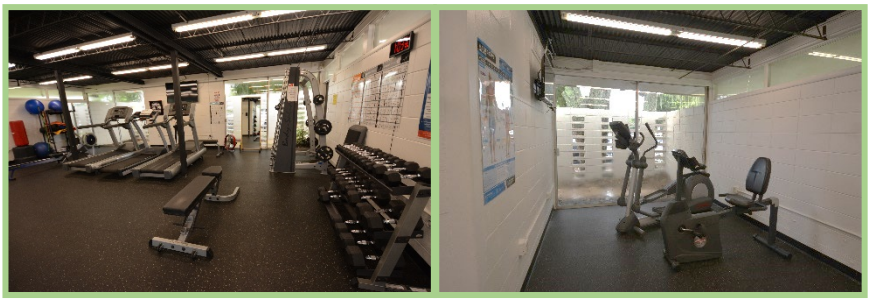
Employees who would like assistance to eliminate tobacco use* have resources through Florida Blue and ComPsych. With ComPsych employees can get a customized assistance plan which includes 5 one-on-one telephonic coaching sessions, stress management techniques, medication guidance and tips for preventing weight gain to name a few. Employees can call 844-669-2751 or log onto www.guidanceresources.com and use company id: SEMINOLECOUNTY.

HEALTHY BALANCE WELLNESS PROGRAM

Seminole County provides ongoing resources to support our employees in improving their health and well-being through healthy lifestyle choices.

The Healthy Balance Wellness Program organizes and promotes health and wellness activities including group fitness classes, challenges, seminars and webinars, participation in community fitness and team sports events, and maintains two employee wellness centers which are free for employees and spouses to use, 24 hours a day, 7 days a week.

Five Points Wellness Center | 3,400 square foot facility | 200 W. County Home Road, Sanford



County Services Building Wellness Center | 950 square foot facility | 1302 E. Second Street, Sanford

IOA 5K Run/Walk 2018

Seminole County Teams at the Lynx Funding Partners Softball Tournament 2018

DENTAL COVERAGE

Dental coverage is provided by Lincoln. With Lincoln you have access to an extensive network of dentists. Employees have the choice of three dental plans: a DHMO, Low PPO plan, and a High PPO plan.

The DHMO plan requires the use of DHMO network dentists (Lincoln Financial uses the Solstice DHMO network) and is based on a fee schedule, please see pages 15-19 for a list of the DHMO schedule.

With the PPO plans you have the option of visiting any provider, however, by choosing a network provider you'll receive the highest level of benefit and save on out of pocket costs. When utilizing **out-of-network providers** benefits will be reimbursed at a maximum allowable charge (MAC) on the Low PPO plan and the 90th percentile of usual, customary & reasonable charges (UCR) on the High PPO plan. The difference you will be responsible for is referred to as **"balance billing".** For example, if you have a procedure done that costs $80 and the reimbursement level is $60, your reimbursement will be based on $60, and you will be responsible for the difference (in this case, $20) in addition to your deductible and coinsurance.

To see a list of participating providers for any of the plans go to: www.lfg.com. See next page for instructions on how to search for DHMO and/or PPO providers that participate in the network.

Low PPO Plan		
Benefit	***In Network What you pay***	***Out Of Network What you pay****
Preventive *(routine oral exams; bitewing x-rays; routine cleanings; fluoride/sealants/space maintainers for children)*	*Covered In Full*	*20% Coinsurance Subject to Balance Billing (see above)*
Basic *(full mouth or panoramic x rays; other dental x rays; fillings; simple & surgical extractions; biopsy; prosthetic repairs; periodontal maintenance procedures; denture reline & rebase; occlusal guard & adjustments)*	*20% after deductible*	*20% after deductible* Subject to Balance Billing (see above)*
Major *(oral surgery; endodontics & root canal; non-surgical & surgical periodontics; bridges; dentures; crowns)*	*50% after deductible*	*60% after deductible* Subject to Balance Billing (see above)*
Deductible (Waived for Preventive)	*Calendar Year Deductible*	
Individual	*$50*	*$100*
Family	*$150*	*$300*
Maximum Annual Benefit	*$1,000*	*$500*
Child Orthodontia to age 19 *Deductible waived In-Network only*	*50%* *Lifetime maximum: $1,000*	

High PPO Plan		
Benefit	***In Network What you pay***	***Out Of Network What you pay***
Preventive *(routine oral exams; bitewing x-rays; routine cleanings; fluoride/sealants/space maintainers for children, full mouth or panoramic x-rays; other dental x-rays)*	*Covered In Full*	*Covered In Full Subject to Balance Billing (see above)*
Basic *(fillings; simple & surgical extractions; biopsy; prosthetic repairs; periodontal maintenance procedures, denture reline& rebase, occlusal guard & adjustments; oral surgery; endodontics & root canal; non surgical & surgical periodontics)*	*10% after deductible*	*20% after deductible* Subject to Balance Billing (see above)*
Major *(bridges; dentures; crowns)*	*40% after deductible*	*50% after deductible** Subject to Balance Billing (see above)*
Deductible (Waived for Preventive)	*Calendar Year Deductible*	
Individual	*$50*	*$50*
Family	*$150*	*$150*
Maximum Annual Benefit	*$1,500*	
Child Orthodontia to age 19 *Deductible waived*	*50%* *Lifetime maximum: $1,000*	

2021 BI-MONTHLY PAYROLL DEDUCTIONS (24 PREMIUM PAYMENTS PER YEAR)

	Employee	Employee + one	Employee + two or more
DHMO	$7.64		$19.80
Low PPO Plan	$10.27		$29.04
High PPO Plan	$23.59		$60.88

Lincoln Financial Group®

Dental PPO/DHMO

How to locate participating dentists

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1. Visit LFG.com.
2. Scroll to the bottom of the page.
3. Under Employer Benefits, click **Find a Dentist.**
4. To find dentists located in your area, a separate tab will appear to enter the zip code.
5. If a DHMO zip code is entered, a **Plan Type** box will appear to choose the network.
    - If the PPO network is selected, you can continue to search by Distance, Specialty and Last Name.
    - If the DHMO network is selected, a separate screen will appear.
        - To search for a provider click **Find a Dentist** located on the right side of the screen.
        - A new screen will appear to **Select a Network** and choose your search option.

If your search does not locate the dentist you prefer, you can nominate a dentist.

<u>To nominate a DHMO dentist:</u>

Select **Find a Form** located on the right side of the screen and click on the **Dentist Nomination Form** on the next screen.

<u>To nominate a PPO dentist:</u>

On the **Find a Network Dentist** results page, click on the **Nominate a Dentist** link located at the top right hand corner and complete the form online.

Lincoln Financial Group®

Lincoln DentalConnect℠
LDCS700
Dental Prepaid Plan

SCHEDULE OF BENEFITS

Members of the LDCS700 Dental Plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No Waiting Periods
- No Deductibles
- No Claim Forms to Submit

The member co-payments listed are offered by a participating in-network provider. The member receives:

- Most diagnostic & preventive care at No Charge
- Cosmetic & orthodontia treatment covered

Members can choose a participating provider at
http://ldc.lfg.com
Member Services Department: 1-888-877-7828

The patient/member is ultimately responsible for verifications to the accuracy and appropriateness of all fees applicable to any dental benefit provided by a network provider. We urge all of our members to verify all fees for proposed treatment via the "Schedule of Benefits" and/or with our Member Services Department prior to treatment.

The following member co-payments apply when a participating General Dentist performs services. An "*" denotes limitation on certain benefits (see "Exclusions/Limitations").

CODE	DESCRIPTION	MEMBER'S COPAY
	APPOINTMENTS	
D0120	Periodic oral evaluation - established patient	No charge
D0140	Limited oral evaluation - problem focused	No charge
D0150	Comprehensive oral evaluation - new or established patient	No charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge
D0180	Comprehensive periodontal evaluation - new or established patient	No charge
D9110	Palliative (emergency) treatment of dental pain - minor procedure	No charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	25.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No charge
D9440	Office visit - after regularly scheduled hours	35.00
	RADIOGRAPHY/DIAGNOSTIC DENTISTRY	
D0210*	X-Ray - intraoral - complete series (including bitewings)	No charge
D0220	X-Ray - intraoral - periapical first film	4.00
D0230	X-Ray - intraoral - periapical each additional film	2.00
D0240	X-Ray - intraoral - occlusal film	No charge
D0250	X-Ray - extraoral - first film	No charge
D0260	X-Ray - extraoral - each additional film	No charge
D0270*	X-Ray - bitewing - single film	No charge
D0272*	X-Ray - bitewing - two films	No charge
D0274*	X-Ray - bitewing - four films	No charge
D0277*	Vertical bitewings - 7 to 8 films	29.00
D0290	Posterior-anterior or lateral skull and facial bone survey film	150.00
D0310	Sialography	150.00
D0320	Temporomandibular Joint Arthrogram, including injection	250.00
D0321	Other Temporomandibular Joint Arthrogram films, by report	150.00
D0322	Tomographic survey	150.00
D0330	Panoramic film (not to replace FMX)	50.00
D0340	Cephalometric film, non-orthodontic	125.00
D0350	Oral/facial photographic images	20.00
D0415	Collection of microorganisms for culture and sensitivity	No charge
D0425	Caries susceptibility tests	No charge
D0431	Adjuntive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	65.00
D0460	Pulp vitality tests	No charge
D0470	Diagnostic casts	No charge
	PREVENTIVE DENTISTRY	
D1110	Routine prophylaxis-adult (once every 6 months)	No charge
D1110	Additional routine prophylaxis - adult	20.00
D1120	Routine prophylaxis - children under the age of 16 (once every 6 months)	No charge
D1120	Additional routine prophylaxis - children under the age of 16)	20.00
D1203	Topical application of fluoride (excluding prophylaxis) children under the age of 16	No charge
D1204	Topical application of fluoride (excluding prophylaxis) adult	15.00
D1310	Nutritional counseling for control of dental disease	No charge
D1320	Tobacco counseling for the control & prevention of oral disease	No charge
D1330	Oral hygiene instructions	No charge
D1351	Sealant - Per tooth - children under the age of 16	No charge
D1510	Space maintainer - fixed - unilateral - children under the age of 16	No charge
D1515	Space maintainer - fixed - bilateral - children under the age of 16	No charge

Lincoln DentalConnect LDCS700 Dental Prepaid Plan
is underwritten by Solstice Benefits, Inc.
A licensed PLHSO & TPA under Chapter 636 & 626 F.S

Solstice

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CODE	DESCRIPTION	MEMBER'S COPAY
D1520	Space maintainer - removable - unilateral children under the age of 16	No charge
D1525	Space maintainer - removable - bilateral children under the age of 16	No charge
D1550	Re-cementation of space maintainer	15.00
D8210	Removable appliance therapy	103.00
D8220	Fixed appliance therapy	103.00
	RESTORATIVE DENTISTRY	
D2140	Amalgam - 1 surface, primary or permanent	No charge
D2150	Amalgam - 2 surfaces, primary or permanent	No charge
D2160	Amalgam - 3 surfaces, primary or permanent	No charge
D2161	Amalgam - 4 surfaces, primary or permanent	No charge
D2330	Resin-based composite - 1 surface, anterior	30.00
D2331	Resin-based composite - 2 surfaces, anterior	37.00
D2332	Resin-based composite - 3 surfaces, anterior	50.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	80.00
D2390	Resin-based composite crown, anterior	115.00
D2391	Resin-based composite - 1 surface, posterior	65.00
D2392	Resin-based composite - 2 surfaces, posterior	75.00
D2393	Resin-based composite - 3 surfaces, posterior	90.00
D2394	Resin-based composite - 4 or more surfaces, posterior	115.00
D2410	Gold foil - 1 surface	75.00
D2420	Gold foil - 2 surfaces	95.00
D2430	Gold foil - 3 surfaces	125.00
D2510	Inlay - metallic - 1 surface	225.00
D2520	Inlay - metallic - 2 surfaces	235.00
D2530	Inlay - metallic - 3 or more surfaces	245.00
D2542	Onlay - metallic - 2 surfaces	325.00
D2543	Onlay - metallic - 3 surfaces	340.00
D2544	Onlay - metallic - 4 or more surfaces	350.00
D2610*	Inlay - porcelain/ceramic - 1 surface	275.00
D2620*	Inlay - porcelain/ceramic - 2 surfaces	300.00
D2630*	Inlay - porcelain/ceramic - 3 or more surfaces	325.00
D2642*	Onlay - porcelain/ceramic - 2 surfaces	360.00
D2643*	Onlay - porcelain/ceramic - 3 surfaces	390.00
D2644*	Onlay - porcelain/ceramic - 4 or more surfaces	400.00
D2650	Inlay - resin-based composite - 1 surface	200.00
D2651	Inlay - resin-based composite - 2 surfaces	220.00
D2652	Inlay - resin-based composite - 3 or more surfaces	260.00
D2662	Onlay - resin-based composite - 2 surfaces	240.00
D2663	Onlay - resin-based composite - 3 surfaces	260.00
D2664	Onlay - resin-based composite - 4 or more surfaces	283.00
D2710	Crown - resin-based composite (indirect)	195.00
D2720*	Crown - resin with high noble metal	245.00
D2721*	Crown - resin with predominantly base metal	245.00
D2722*	Crown - resin with noble metal	245.00
D2740*	Crown - porcelain/ceramic substrate	245.00
D2750*	Crown - porcelain fused to high noble metal	245.00
D2751*	Crown - porcelain fused to predominantly base metal	245.00
D2752*	Crown - porcelain fused to noble metal	245.00
D2780*	Crown - 3/4 cast high noble metal	245.00
D2781*	Crown - 3/4 cast predominantly base metal	245.00
D2782*	Crown - 3/4 cast noble metal	245.00
D2783*	Crown - 3/4 porcelain/ceramic	245.00
D2790*	Crown - full cast high noble metal	245.00
D2791*	Crown - full cast predominantly base metal	245.00
D2792*	Crown - full cast noble metal	245.00
D2799	Provisional crown	125.00
D2910	Recement inlay, onlay, or partial coverage restoration	15.00
D2920	Recement crown	15.00
D2930	Prefabricated stainless steel crown - primary tooth	45.00
D2931	Prefabricated stainless steel crown - permanent tooth	55.00
D2932	Prefabricated resin crown	95.00
D2933	Prefabricated stainless steel crown with resin window	145.00
D2940	Sedative filling	15.00
D2950	Core buildup, including any pins	70.00
D2951	Pin retention - per tooth, in addition to restoration	15.00
D2952	Post and core in addition to crown, indirectly fabricated	88.00
D2953	Each additional indirectly fabricated post - same tooth	95.00
D2954	Prefabricated post and core in addition to crown	75.00
D2955	Post removal (not in conjunction with endodontic therapy)	30.00
D2957	Each additional prefabricated post - same tooth	30.00
D2960	Labial veneer (resin laminate) - chairside	200.00
D2961*	Labial veneer (resin laminate) - laboratory	255.00
D2962*	Labial veneer (porcelain laminate) - laboratory	390.00
D2970	Temporary crown (fractured tooth)	75.00
D2980*	Crown repair, by report	95.00
	ENDODONTIC SERVICES	
D3110	Pulp cap - direct (excluding final restoration)	25.00
D3120	Pulp cap - indirect (excluding final restoration)	25.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	30.00
D3221	Pulpal debridement, primary and permanent teeth	95.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50.00
D3310	Endodontic therapy - anterior (excluding final restoration)	110.00
D3320	Endodontic therapy - bicuspid (excluding final restoration)	195.00
D3330	Endodontic therapy - molar (excluding final restoration)	245.00
D3331	Treatment of root canal obstruction; non-surgical access	85.00
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	75.00
D3333	Internal root repair of perforation defects	125.00
D3346	Retreatment of previous root canal therapy - anterior	300.00
D3347	Retreatment of previous root canal therapy - bicuspid	350.00
D3348	Retreatment of previous root canal therapy - molar	440.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	90.00
D3352	Apexification/recalcification - interim medication replacement	90.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	90.00
D3410	Apicoectomy/periradicular surgery - anterior	100.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	315.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	340.00
D3426	Apicoectomy/periradicular surgery - each additional root	95.00
D3430	Retrograde filling - per root	75.00
D3450	Root amputation - per root	110.00
D3470	Intentional reimplantation (including necessary splinting)	175.00
D3910	Surgical procedure for isolation of tooth with rubber dam	95.00
D3920	Hemisection (including root removal) , not including root canal therapy	90.00
D3950	Canal preparation and fitting of preformed dowel or post	75.00
	PERIODONTIC SERVICES	
D4210	Gingivectomy/gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	175.00
D4211	Gingivectomy/gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	81.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	195.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	185.00
D4245	Apically positioned flap	150.00
D4249	Clinical crown lengthening - hard tissue	230.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	375.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadran	325.00
D4263	Bone replacement graft - first site in quadrant	450.00
D4264	Bone replacement graft - each additional site in quadrant	325.00
D4266	Guided tissue regeneration - resorbable barrier,	

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CODE	DESCRIPTION	MEMBER'S COPAY
	per site	325.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	325.00
D4270	Pedicle soft tissue graft procedure	250.00
D4271	Free soft tissue graft procedure (including donor site surgery)	245.00
D4273	Subepithelial connective tissue graft procedures per tooth	335.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	125.00
D4341†	Periodontal scaling and root planing - 4 or more teeth per quadrant	50.00
D4342†	Periodontal scaling and root planing - 1 to 3 teeth, per quadrant	43.00
D4355†	Full mouth debridement to enable comprehensive evaluation and diagnosis	50.00
D4381†	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	60.00
D4910*	Periodontal maintenance	50.00
D4920	Unscheduled dressing change (by someone other than the treating dentist)	25.00
	PROSTHODONTICS - REMOVABLE	
D5110*	Complete denture - maxillary	325.00
D5120*	Complete denture - mandibular	325.00
D5130*	Immediate denture - maxillary (including two relines)	350.00
D5140*	Immediate denture - mandibular (including two relines)	350.00
D5211*	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	400.00
D5212*	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	400.00
D5213*	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	425.00
D5214*	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	425.00
D5281*	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	245.00
D5410	Adjustment - complete denture - maxillary	15.00
D5411	Adjustment - complete denture - mandibular	15.00
D5421	Adjustment - partial denture - maxillary	15.00
D5422	Adjustment - partial denture - mandibular	15.00
D5510*	Repair broken complete denture base	35.00
D5520*	Replace missing or broken tooth - complete denture (each tooth)	35.00
D5610*	Repair denture resin base	35.00
D5620*	Repair cast framework	35.00
D5630*	Repair or replace broken clasp	35.00
D5640*	Repair broken teeth - per tooth	35.00
D5650*	Add tooth to existing partial denture	35.00
D5660*	Add clasp to existing partial denture	35.00
D5710*	Rebase complete maxillary denture	135.00
D5711*	Rebase complete mandibular denture	135.00
D5720*	Rebase maxillary partial denture	155.00
D5721*	Rebase mandibular partial denture	155.00
D5730*	Reline complete maxillary denture (chairside)	65.00
D5731*	Reline complete mandibular denture (chairside)	65.00
D5740*	Reline partial maxillary denture (chairside)	65.00
D5741*	Reline partial mandibular denture (chairside)	65.00
D5750*	Reline complete maxillary denture (laboratory)	85.00
D5751*	Reline complete mandibular denture (laboratory)	85.00
D5760*	Reline partial maxillary denture (laboratory)	85.00
D5761*	Reline partial mandibular denture (laboratory)	85.00
D5810*	Interim complete denture - maxillary	250.00
D5811*	Interim complete denture - mandibular	250.00
D5820*	Interim partial denture - maxillary	175.00
D5821*	Interim partial denture - mandibular	175.00
D5850	Tissue conditioning - maxillary	20.00
D5851	Tissue conditioning - mandibular	20.00
D5862	Precision attachment	150.00
D5899	Denture cleaning	No charge
	PROSTHODONTICS - FIXED	
D6210*	Pontic - cast high noble metal	245.00
D6211*	Pontic - cast predominantly base metal	245.00
D6212*	Pontic - cast noble metal	245.00
D6240*	Pontic - porcelain fused to high noble metal	245.00
D6241*	Pontic - porcelain fused to predominantly base metal	245.00
D6242*	Pontic - porcelain fused to noble metal	245.00
D6245*	Pontic - porcelain/ceramic	350.00
D6250*	Pontic - resin with high noble metal	250.00
D6251*	Pontic - resin with predominantly base metal	250.00
D6252*	Pontic - resin with noble metal	250.00
D6545*	Retainer - cast metal for resin bonded fixed prosthesis	180.00
D6548*	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	225.00
D6720*	Crown - resin with high noble metal	245.00
D6721*	Crown - resin with predominantly base metal	245.00
D6722*	Crown - resin with noble metal	245.00
D6740*	Crown - porcelain/ceramic	245.00
D6750*	Crown - porcelain fused to high noble metal	245.00
D6751*	Crown - porcelain fused to predominantly base metal	245.00
D6752*	Crown - porcelain fused to noble metal	245.00
D6780*	Crown - 3/4 cast high noble metal	245.00
D6781*	Crown - 3/4 cast predominantly base metal	245.00
D6782*	Crown - 3/4 cast noble metal	245.00
D6783*	Crown - 3/4 porcelain/ceramic	245.00
D6790*	Crown - full cast high noble metal	245.00
D6791*	Crown - full cast predominantly base metal	245.00
D6792*	Crown - full cast noble metal	245.00
D6930	Recement fixed partial denture	15.00
D6940	Stress breaker	125.00
D6950	Precision attachment	195.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	105.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	75.00
D6973	Core build up for retainer, including pins	70.00
D6975	Coping - metal	95.00
D6976	Each additional indirectly fabricated post - same tooth	75.00
D6977	Each additional prefabricated post - same tooth	75.00
	ORAL SURGERY	
D7111	Extraction, coronal remnants - deciduous tooth	50.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	30.00
D7220	Removal of impacted tooth - soft tissue	50.00
D7230	Removal of impacted tooth - partially bony	65.00
D7240	Removal of impacted tooth - completely bony	80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	135.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	40.00
D7260	Oroantral fistula closure	160.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50.00
D7280	Surgical access of an unerupted tooth	125.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	125.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	125.00
D7286	Biopsy of oral tissue - soft (all others)	85.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	40.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	60.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	65.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	95.00
D7510	Incision and drainage of abscess - intraoral soft tissue	20.00
D7960	Frenulectomy - separate procedure (frenectomy or frenotomy)	105.00
D7970	Excision of hyperplastic tissue - per arch	140.00
	MISCELLANEOUS SERVICES	
D9215	Local anesthesia	No charge
D9220*	Deep sedation/general anesthesia - first 30 minutes	125.00
D9221*	Deep sedation/general anesthesia - each additional 15 minutes	15.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	20.00 per 1/2 hour
D9241*	Intravenous conscious sedation/analgesia - first 30 minutes	125.00

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CODE	DESCRIPTION	MEMBER'S COPAY
D9242*	Intravenous conscious sedation/analgesia - each additional 15 minutes	55.00
D9630	Oral irrigation/other drugs/medicament	15.00 per quadrant
D9910	Application of desensitizing medicament	20.00
D9940	Occlusal guard by report	250.00
D9950	Occlusal analysis - mounted case	75.00
D9951	Occlusal adjustment - limited	30.00
D9952	Occlusal adjustment - complete	100.00
D9972*	External bleaching - per arch	150.00
D9972*	External bleaching - both arches	275.00
	ORTHODONTIA	
D8660	Pre-orthodontic treatment visit	35.00
D8999	Orthodontic treatment plan & records	250.00
D8020	Limited orthodontic treatment of the transitional dentition (up to 24 months)	1,000.00
D8030	Limited orthodontic treatment of the adolescent dentition (up to 24 months)	1,000.00
D8040	Limited orthodontic treatment of the adult dentition (up to 24 months)	1,350.00
D8070	Comprehensive orthodontic treatment of the transitional dentition (full treatment case up to 24 months - including fixed/removable appliances)	2,200.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition (full treatment case up to 24 months - including fixed/removable appliances)	2,250.00
D8090	Comprehensive orthodontic treatment of the adult dentition (full treatment case up to 24 months - including fixed/removable appliances)	2,350.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) (includes fee for fixed/removable retainers and monthly visits)	300.00
	Orthodontic treatment is prorated over 24 months and is only payable under a current status. Solstice Benefits bears no liability towards treatment unable to be completed due to a terminated status.	

LAB FEES

Copayments marked by '*' do not include the cost of metal and laboratory fees. Additional cost to patient is as follows:

- High noble metal (precious) up to $130.00
- Noble metal (semi-precious) up to $110.00
- Predominantly base metal (non-precious) up to $55.00
- All ceramic and/or porcelain crown material fees up to $130.00
- Crown laboratory fees up to $125.00
- Laboratory fees on dentures up to $200.00
- Porcelain laboratory fees for D2610-D2644 and D2962 up to $50.00
- Denture repair laboratory fees up to $40.00

LFG211S7000110

EXCLUSIONS

1. Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
2. Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health or experimental in nature, as determined by the participating Solstice dentist.
3. Orthographic surgery or procedures and appliances for the treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
4. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions, or medications.
5. Treatment of malignancies, cysts, or neoplasms, without proof of medical necessity and prior Solstice approval.
6. Dental procedures initiated prior to the member's eligibility under this benefit plan or started after the member's termination from the plan.
7. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.
8. D9972 Excludes bleaching material for home use.

LIMITATIONS

1. Any oral evaluation (excluding problem-focused) is limited to one (1) time in any six (6) consecutive month period at no charge. All subsequent oral evaluations will be at a 25% reduction off the doctor's usual and customary fee without a frequency limitation. Problem-focused evaluations (D0140) are payable when not in conjunction with a procedure.
2. All bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
3. The dental prophylaxis or periodontal maintenance procedure is limited to one in any six (6) consecutive month period. Any additional procedures will follow D1110 and D4910 member co-payments as listed in the Schedule of Benefits.
4. Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period for children under the age of 16.
5. Sealants are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
6. Space maintainers and all adjustments are limited to children under the age of 16.
7. Harmful habit appliances are limited to one (1) time per person under the age of 16.
8. General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary and previously approved by Solstice Benefits.
9. New dentures include one (1) reline within the first six (6) months.
10. Replacement of crowns, fixed bridges or dentures is limited to once every five (5) years.
11. When crown and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
12. Copayment for endodontic procedures do not include the cost of the final restoration.
13. *Either D0210 or D0330 reimbursable once every five years.
14. Copies of X-rays can be obtained for $2 per periapical film up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
15. *D0274, D0277 or D0210 are payable only when other inclusive films have not been taken (paid) within the last six months.
16. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.
17. Emergency treatment is available for palliative treatment for the abatement of pain up to $100 per occurrence.
18. Surgical removal of impacted tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentist's or specialist's usual and customary fees. Orthodontic related surgeries except (D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
19. Co-payments marked by "†" are not eligible for reimbursement under specialty plan.
20. Member may choose Invisiline in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.
21. A broken appointment fee up to $20 may be charged by the dental office if 24 hour prior notice is not given.

SPECIALTY SERVICES

- This member Schedule of Benefits applies when listed dental services are performed by a participating general dentist, unless otherwise authorized by Solstice Benefits.
- Procedures not listed on the Schedule of Benefits that are performed by a participating general dentist will be charged at the participating general dentist's usual and customary fee less 25%.
- The participating general dentist you select may not perform all procedures listed. The co-payments shown apply to participating general dentists who do perform these services. Therefore, you are encouraged to secure availability of the scheduled services with your participating general dentist.
- Should the services of a specialist (Oral Surgeon, Endodontist, Periodontist, Prosthodontist or Pediatric Dentist) be necessary, you may receive this care In either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may obtain prior written authorization from Solstice Benefits and receive specialty treatment by an approved participating specialist at the listed co-payments. Please refer to the Specialty Care Referral Policy in you member handbook.
- Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member co-pay.

Lincoln Financial Group®

Lincoln DentalConnect LDCS700 Dental Prepaid Plan
is underwritten by Solstice Benefits, Inc.
A licensed PLHSO & TPA under Chapter 636 & 626 F.S

Solstice

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VISION COVERAGE

The following is a summary of your vision benefits. The vision care network consists of private practicing optometrists, ophthalmologists, opticians and optical retailers. For a more detailed explanation of benefits, please refer to your Certificate of Coverage or benefit summary. You may access a list of participating providers through the carrier's website. Vision coverage is provided by EyeMed. Each person covered under the plan has the freedom to visit any vision provider, however ***you receive the most benefit by seeing an In-Network provider.***

Click on *"Find an eye doctor"* at the top of the page and select the *"Insight"* network.

		Vision Plan	
Eye Exams Covered Once Every Plan Year			
Frames Covered Once Every Plan Year		$0 co-pay; $200 allowance 20% off balance over $200 allowance	Up to $140 reimbursement
Lenses (in lieu of contact lenses) Covered Once Every Plan year			
Standard Progressive Premium Progressive Tier 1 Premium Progressive Tier 2 Premium Progressive Tier 3 Premium Progressive Tier 4			
Contact Lenses (Medically Necessary) Covered Once Every Plan Year		$0 co-pay; Paid in full	Up to $210 reimbursement
Contact Lenses (Elective materials only) **Covered Once Every Plan Year**	**Conventional**		
	Disposable		

2021 BI-MONTHLY PAYROLL DEDUCTIONS (24 PREMIUM PAYMENTS PER YEAR)

	Employee	Employee + one	Employee + two or more
EyeMed Vision	$4.91	$9.33	$13.70

Additional Vision Discounts

Vision Care Services	Member Cost: In-Network
Discounted Exam Services	
Retinal Imaging Benefits	Up to $39
Contact Lens Fit and Follow-Up available once a comprehensive eye exam has been completed.)	(Contact lens fit and two follow-up visits are
Standard Contact Lens Fit & Follow-Up	$40
Premium Contact Lens Fit & Follow Up	10% off retail price
Discounted Lens Options	
Photochromic (Plastic)	$75
Standard Polycarbonate	$40
Tint (Solid & Gradient)	$15
UV Treatment	$15
Standard Plastic Scratch Coating	$15
Premium Anti-Reflective Coating	
Standard	$45
Tier 1	$57
Tier 2	$68
Tier 3	20% off Retail Price
Other Add-on Services and Materials	20% off Retail Price
40% off additional pairs of glasses	
20% off non prescription sunglasses	
Lasik: Lasik or PRK from US Laser Network 15% off retail price or 5% off promotional price; call 1.800.988.4221	
Hearing Care from Amplifon NetworkCare Discounts on hearing exam and aids; call 1.877.203.0675	

Freedom Pass: Any frame, any price, for $0 out-of-pocket*

With the Freedom Pass, employees can enjoy a special offer from Sears Optical and Target Optical. For $0 out of pocket expense, get any available frame, any brand no matter the original retail price! You're free to choose any frame in either store at no additional cost to you.

*** Offer is also available at LensCrafters, but excludes Chanel, Cartier, Tiffany, Prada, Gucci, Tom Ford and Giorgio Armani frames.**

INCOME PROTECTION BENEFITS

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at the County. Accidental Death and Dismemberment (AD&D) insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances.

BENEFITS AT-A-GLANCE

	LIFE AND AD&D COVERAGE
Life Insurance	1x Annual Salary
Accidental Death and Dismemberment	1x Annual Salary

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Employees can elect to purchase Voluntary Life Insurance that provides an additional life insurance benefit for you, your spouse and/or your dependent child(ren). If you waive voluntary life coverage when you are initially eligible you will be required to provide ***Evidence of Insurability (EOI)*** *when enrolling later. EOI is the documentation of good health in order to be approved for coverage. The carrier will review and determine approval based on EOI documentation*. Benefits may be limited and/or denied based on EOI results. Claims incurred prior to the approval of your coverage will not be covered.

BENEFITS AT-A-GLANCE

	VOLUNTARY LIFE AND AD&D COVERAGE FEATURES		
	EMPLOYEE	**SPOUSE**	
Increments	$10,000 increments	$5,000 increments Employee must have elected at least $20,000 in order to purchase	
Guarantee Issue Amounts* Applies to new hires ONLY	$500,000 (Combined with Basic Life)	$50,000	$10,000
Maximum Benefit	Not to exceed the lesser of 5x your annual salary or $500,000 (Combined with Basic Life)	$100,000 not to exceed 50% of employee combined Basic & Voluntary Life amount	$10,000
Benefit Reduction Schedule	50% at age 70	50% at employee's age of 70	N/A

** EOI not required*

	Employee	Spouse	Dependent Child(ren)
MONTHLY Rates per $1,000 of Benefit	$0.33	$0.29	$0.118 per $10k of benefit *One rate regardless of the number of children*

VOLUNTARY SHORT-TERM DISABILITY WITH THE STANDARD

Short Term Disability Insurance provides income protection in the event you become disabled and are unable to work due to sickness or non-occupational injury, including pregnancy, for a short period of time.

If you waive voluntary disability coverage when you are initially eligible, you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage are not covered. Benefits may be limited and/or denied based on the EOI results.

Rates are based on your salary and age as of January 1, 2020. To figure out what your monthly payroll deductions would be use the following table.

Your Age (as of 1/1/20)	Rate per $10 of STD Benefit
30-34	$0.68
40-44	$0.41
45-49	$0.48
50-54	$0.55
60+	$0.91

BENEFITS AT-A-GLANCE

	60% of weekly earnings
	14 days for accident 14 days for illness

Note: employees that go out on STD have the choice to use PTO, or not, to make up the difference in what they receive from The Standard up to 100% of earnings. Employees cannot receive full PTO and STD benefits that would exceed 100% of earnings.

STD Semi-Monthly Payroll Deduction Calculation	
1. Enter your average weekly earnings, not to exceed $2,500	1.
2. Multiply your weekly earnings (Line 1) by 0.60	2.
3. Enter your rate from the table above based on your age as of January 1, 2021	3.
4. Multiply Line 2 by the amount entered on Line 3	4.
5. Divide the amount on Line 4 by 10 and enter it on Line 5	5.
6. To calculate your monthly payroll deduction, multiply Line 5 by 12 and then divide by 24	6.
The amount shown on Line 6 is your estimated semi-monthly deduction for the STD Plan	

LONG TERM DISABILITY WITH THE STANDARD

Long Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time. Seminole County Government pays for the cost of this coverage.

BENEFITS AT-A-GLANCE

Benefit Amount	60% of monthly earnings
Benefit Maximum	$8,000
Definition of Disability	2-year own occupation
Benefits Begin After	180 days
Maximum Benefit Period	Social Security Normal Retirement (SSNRA)

AETNA CRITICAL ILLNESS

Recovering from a serious illness can be hard- and expensive. Most medical plans aren't designed to cover costs like childcare and transportation to doctor's appointments. Unfortunately, these expenses can come at a time when you're missing work and your paycheck.

The Aetna Critical Illness plan can help you protect your finances. The plan pays cash benefits to you when you are diagnosed with a covered condition. You can use the money to help cover your deductible or everyday expenses like utility bills, mortgage payments and groceries. It's up to you.

There are two plan options with face amounts of:

1. $10,000
2. $20,000

If you waive coverage when initially eligible, you can apply during open enrollment subject to the pre-existing condition limitation for 1 year, which apply to all applicants.

Pre-existing condition means those conditions for which medical advice, diagnosis or care was received or recommended within the 365-day period before the insured person's effective date of coverage. *We will not pay any benefits for a pre-existing condition until the insured person's coverage has been in force under this Certificate for 365 days.*

2021 EMPLOYEE CONTRIBUTIONS (PAYROLL DEDUCTIONS FOR AETNA CRITICAL ILLNESS PLAN)

Twice Monthly Deductions		***Employee + Family***
Non Tobacco		
$10,000 face amount $20,000 face amount	$8.04 $16.08	$11.75 $23.50
Tobacco*		
$10,000 face amount $20,000 face amount	$13.55 $27.10	$19.80 $39.60

You are a Tobacco User if you currently use or have used any tobacco products in the past 12 months. Tobacco products include, but are not limited to, cigarettes, cigars, snuff, dip, chew, pipe and/or any nicotine delivery system.

ALLSTATE CANCER WITH SPECIFIED DISEASE PLAN

Allstate Benefits Group Cancer and Specified Disease plan offers employees and their families benefits which can be used for the medical or non-medical expenses that can be incurred during treatment of cancer and twenty-nine other specified diseases. Benefits are paid in addition to all other insurance and are paid directly to the certificate holder (unless the certificate holder chooses to assign the benefits to a provider).

If you waive coverage when you are initially eligible you will be required to provide Evidence of Insurability when enrolling later and it may take 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.

Generally, employees & their eligible family members who have not been treated for or diagnosed with cancer in the last 5 years are eligible to apply for the coverage.

- Those with a history of Basal Cell skin cancer may be considered at any time.
- For cancers of the female generative organs, diagnosed a “Carcinoma-in-Situ,” the application may be considered after three years;
- For cancers histories involving more than one site, metastasis, leukemia, Hodgkin’s Disease and any lymph node involvement are permanently excluded from eligibility.

These conditions are waived for new employees so that the plan is offered to new employees on a Guaranteed Issue basis. The plan can be converted and made portable if the employee leaves the county.

For more details, please refer to the Allstate Cancer brochure.

2021 EMPLOYEE CONTRIBUTIONS (PAYROLL DEDUCTIONS FOR ALLSTATE CANCER PLAN)

Twice Monthly Deductions	***Employee Only***	***Employee + Family***
Plan 1	$7.49	$12.60
Plan 2	$13.83	$23.51

The Employer does not endorse this plan

FLEXIBLE SPENDING ACCOUNTS

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) allows you to set aside money from your paycheck before income taxes (Federal, Social Security, Medicare, state and local taxes, if applicable) are withheld. This money is available to pay for eligible expenses, such as your medical deductibles and copayments, prescriptions, dental expenses, eyeglasses, contact lenses and other health-related expenses that are not reimbursed by your health plan.

HOW DOES IT WORK?

You decide how much to contribute to your FSA on a plan year basis, up to the maximum allowable amount. Your annual election will be divided by the number of pay periods and deducted evenly on a pre-tax basis from each paycheck throughout the plan year.

MEDICAL FSA CLAIMS REIMBURSEMENT

Through Chard Snyder, you have a variety of ways to choose from to submit claims to get reimbursed for your claims: debit card, fax, mail or email.

DEBIT CARD AND CLAIM FILING

You will receive a debit card, which is the most convenient way to receive reimbursement. Simply swipe your debit card at your provider's office, pharmacy, hospital, etc., at time of service and your claim will be paid instantly. It is important when you are utilizing the debit card to still ask for and keep an itemized receipt on file. You may still receive a letter from Chard Snyder requesting this receipt for IRS documentation purposes. Even if you use the debit card, YOU are ultimately responsible to the IRS for documentation (i.e. a receipt). YOU are required to keep it and submit it so the plan is compliant with government regulations.

Please be advised that if you do not respond to Chard Snyder's request for an itemized receipt, your card and your account will be suspended.

EMAIL

You can submit your claims via email to askpenny@chard-snyder.com. Be sure to include a claim form and your substantiation.

FAX OR MAIL

You are also able to submit your claims via fax at 888-245-8452 or by mail at:
Chard Snyder 3510 Irwin Simpson Rd, Mason, OH 45040

Annual Health FSA Maximum Contribution 2021 Limits	
Health FSA	$2,750
Dependent Care FSA	$2,500 per person or $5,000 married couple

EXAMPLES OF ELIGIBLE EXPENSES:

Unreimbursed medical expenses (deductibles, coinsurance, copays, etc.)

Dental services (excluding cosmetic services)

Orthodontia

Glasses, contacts, and eye exams

Lasik eye surgery

Note: Cosmetic services are not eligible for reimbursement

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A HEALTH FSA

- Be sure to fund the account wisely as Health FSAs are subject to a "use it or lose it" rule. Any unused funds at the end of the year will automatically be forfeited.
- You cannot take income tax deductions for expenses you pay with your Health FSA &/or Dependent Care FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.
- You may have a Health Savings Account and a Dependent Care FSA.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

WHAT IS A DEPENDENT CARE FSA ACCOUNT?

This is a pre-tax benefit account used to pay for eligible expenses for dependents under age 13 or care for disabled spouse or dependent that allows you - or you and your spouse - to work.

DEPENDENT CARE FSA CONTRIBUTION LIMITS

Under the Dependent Care FSA, if you are married and file a joint return, or if you file a single or head of household return, the annual IRS limit is $5,000. If you are married and file separate returns, you can each elect $2,500 for the plan year. You and your spouse must be employed or your spouse must be a full-time student to be eligible to participate in the Dependent Care FSA.

CLAIMS REIMBURSEMENT

You can submit your claims via email to askpenny@chard-snyder.com. Be sure to include a claim form and your substantiation.

You are also able to submit your claims via fax at 888-245-8452 or by mail at: ChardSnyder 3510 Irwin Simpson Rd, Mason, OH 45040

Note: You can only be reimbursed for the money you put into the account. For example: if you have contributed $200 into your Dependent Care FSA, but your after-school care was $300 for the month, you can only be reimbursed for $200.

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A DEPENDENT CARE FSA

- Be sure to fund the account wisely as funds are “use it or lose it.”
- You must enroll in the dependent care FSA prior to the start of the plan year or during open enrollment (*unless you experience certain life events, called Permitted Election Change Events that allow a special mid-year enrollment.)*
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:
  - Name (who received service)
  - Provider name (provider that delivered service)
  - Date of service
  - Type of service
  - Cost of service

EXAMPLES OF ELIGIBLE EXPENSES:

In Home Babysitting Fees*

Before and After School Care

Day Care Facility Fees

Nanny Expenses

Summer Day Camp

Adult Care Facility Fees

**In order to receive reimbursement for in home babysitting fees, income must be recorded by the provider.*

For a full list of eligible expenses and requirements, visit www.irs.gov/publications and refer to Publication 503.

Introducing the Refreshed Benefit Card

A Bright New Look—Same Great Features

While it has an updated look, the Chard Snyder Benefit Card still provides the same great conveniences as the Benny® prepaid benefits card. Use it the same way as Benny. The payment comes right out of your account. When you use it at locations that confirm eligible merchandise and services at the point of sale, you won't be asked for further proof of what you purchased.

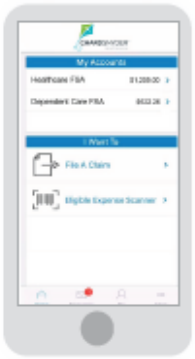
- Access to the money in your tax-free account
- Pay for merchandise and services
- No follow-up required for recognized eligible expenses

What Happens to my Benny?

- You will keep your Benny® prepaid benefit card until it expires, needs to be replaced (due to loss or damage) or you request additional cards. At that time, a set of two refreshed Chard Snyder benefit cards will be mailed to your home address in our files.
- If you are new to the plan you will automatically be mailed a set of two cards with the updated design.

The Chard Snyder Benefit Card will function exactly the same as Benny

Check Out Our Mobile App



Features

- Scan products for eligibility
- View account balances and transaction details
- Submit and review claims
- Upload paperwork

Download from the App Store or Google Play

Customer Service

Contact us through Live Chat from the Chard Snyder website, give us a call, or send us an email for quick, convenient, personal service.

800.982.7715 | askpenny@chard-snyder.com

CHARDSNYDER™
Benefit Solutions

800.982.7715 www.chard-snyder.com

New Benefit Card v8.18

Why Verify Expenses When Using The Benefit Card

The IRS requires proof that your card was used for eligible expenses.

Not all Card Swipes are the Same

Medical providers such as a doctor, dentist, hospital, or clinic do not always have systems that provide enough information to substantiate your expense. You will may receive an email or letter from Chard Snyder asking for documentation such as itemized receipts or statements, or a copy of an Explanation of Benefits (EOB) from your insurance company.

Over-the-counter healthcare merchandise barcodes can be scanned by the mobile app to check eligibility. Use your card at pharmacies and stores that confirm eligible merchandise and services and you won't be asked for further proof. Purchases at other locations will require you to pay out-of-pocket and submit a claim form and documentation of the expense.

How to Verify or Repay Your Ineligible Expense

If you receive a letter or email from Chard Snyder asking for substantiation of your purchase, you must verify your expense was eligible or repay the cost to your plan. Here's how:

Verify the expense (Substantiate)

Take a picture of your itemized bill, EOB or receipt with your mobile device. Submit it through the app, upload it through the website, or attach it to an email, or...just fax or mail a paper copy to Chard Snyder.

Repay the expense (Use ONE of the following methods)

- Log in to your account and provide banking information
- Send Chard Snyder a check with a copy of the letter or request you received
- Send in valid claims to "pay back" your account by providing paperwork to verify **other** eligible expenses

If you don't verify the expense or repay the cost, the IRS requires us to stop the use of your card.

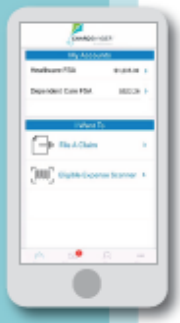
IRS Rules require all FSA claims be substantiated

SOLUTIONS

Substantiation: Provide evidence your claim was eligible

The Chard Snyder Benefit Card allows many items and services to be **AUTOMATICALLY substantiated**

Using the Chard Snyder Mobile App You can **QUICKLY** provide **PROOF** (substantiate) that your transaction is eligible according to the IRS



Don't Forget

All receipts, Explanation of Benefits (EOB) and invoices must include:

- **Date of service (during the plan year)**
- **Provider's name**
- **Name of person receiving the service**
- **Description of service or product purchased**
- **Amount you must pay**

The following may not be used to verify an expense:

- Cancelled checks
- Handwritten receipts
- Credit card receipts
- Previous balance receipts

If you don't have a receipt, contact the provider or your insurance company and request a copy of the receipt or Explanation of Benefits from their files.

CHARDSNYDER™ Benefit Solutions

800.982.7715 www.chard-snyder.com

Verify Benefit Card v8.18

EMPLOYEE ASSISTANCE PROGRAM (EAP)

We are interested in your total well-being. That is why we offer an Employee Assistance Program. This program provides a counseling service that helps you manage problems before they adversely affect your personal life, health and job performance.

EAP…TOBACCO CESSATION PROGRAM

GuidanceResources®

The HealthyGuidance® Tobacco Cessation Experience

Focused on Quitting and Staying Smoke Free

Overcoming nicotine dependence or addiction is not easy, but the ComPsych® HealthyGuidance Tobacco Cessation Program provides you with a personalized quit plan no matter where you are in the quitting process. With unlimited support, our Certified Tobacco Cessation Specialists integrate behavior-change techniques, with a mix of dependence-breaking strategies to help you quit permanently.

Personalized Assessment, Guidance and Support

The HealthyGuidance Tobacco Cessation Program is designed to help you quit and "stay quit." The program includes:

- Personal tobacco use and quit-attempt assessment
- Customized assistance plan based on your initial level of "readiness-to-quit"
- Strategies to help you deal with common fears about quitting smoking
- Guidance regarding the effectiveness and use of medications and over-the-counter nicotine dependence products
- Stress management skills instruction
- Tips for preventing weight gain
- One-on-one telephone sessions
- Ongoing relapse prevention support

Call One: Assessment and Education

The program begins with an assessment of your current and past tobacco use, which will help determine your quit plan and whether your tobacco use is more physiologically, psychologically or socially motivated. Assessing why you smoke helps determine which quitting approaches will be the most beneficial. You'll work to create a customized plan and personal goals to achieve between each call that will lead you to your quit date. The plan will help you substitute your habit of using tobacco with healthy alternatives for long-term success.

Call Two: Prepare to Quit

While there is no single "right way" to quit, there are some strategic steps that increase the chances of success. The preparation step required prior to quitting provides you with the opportunity to set a quit date, inform family and friends, anticipate challenges, remove tobacco from your personal environment and discuss nicotine replacement therapy (NRT) with your physician.

Call Three: Action Plan

According to The American Cancer Society and our years of counseling experience, quitting for good depends largely on commitment, planning and ongoing support. By understanding the factors behind your nicotine dependency, our Certified Tobacco Cessation Specialists help you choose a quitting method, develop alternative coping strategies and assume a non-smoker identity.

Call Four: Quit Day

Designating a quit day motivates you to put the preparation and planning into action at a specific time, which helps ensure success. This day requires focus and energy to cope with temptations, cravings and withdrawal symptoms and to develop new, healthier habits. Our program gives you the necessary tools and personal support to combat cravings and temptations in this early stage of quitting.

Call Five: Relapse Prevention and Follow-Up Assessment

Staying tobacco free is the final and most important stage of the process. Our Tobacco Cessation Specialists help you identify relevant relapse issues, develop skills to cope with emotional or situational "triggers" and use tactics such as exercise and better nutrition to restore overall health.Following a flexible five session model, extra sessions will be offered if additional support is needed.

Here when you need us.

Call: 844.669.2751
TDD: 800.697.0353
Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: SEMINOLECOUNTY

Contact us anytime for confidential assistance.

IMPORTANT TERMS

Balance Billing When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider typically may not balance bill you for covered services.

Brand A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs and your employer pays a higher amount when the claim is paid as well.

Coinsurance After you meet the deductible amount, you and the plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if your plan pays 70% coinsurance, you pay the remaining coinsurance share, 30% of the cost.

Copayment or Copay A form of medical cost-sharing whereby a member pays at time of service (or purchase for prescription drugs) a fixed dollar amount, regardless of whether you have met your deductible for the year.

Deductible The fixed amount of cost-sharing you are responsible for during the benefit period before the plan will pay. The deductible typically does not apply to preventive care and certain other services. Plans may have both per individual and family deductibles. Deductibles may differ if services are received in-network versus out-of-network.

Evidence of Insurability (EOI) A medical questionnaire used to determine whether an applicant will be approved or declined for coverage. This may be required for certain types of insurance coverage.

Explanation of Benefits (EOB) The statement made available to a member by their carrier after services have been received and the claim has been processed, which lists the services received, amount paid by the plan, and the amount to be paid by the member.

Flexible Spending Accounts Health or Dependent Care (HCFSA or DCFSA): An account you put money into that you use to pay for certain out-of-pocket health or childcare costs with pre-tax dollars. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. Funds deposited into a health FSA will be forfeited if you do not use them by the IRS deadline.

Formulary A list of prescription drugs covered by the plan that will be used to determine the coverage for the drug based on the tier the drug is listed.

Generic Medications that have the same active ingredients, dosage, and strength as their brand-name counterparts. Generic drugs generally have the same efficacy as their brand name counterparts at a much lower cost for you and your employer.

Guaranteed Issue When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies. Typically, no health questionnaires (EOI) or exams are required.

Health Savings Account (HSA) A tax-free, individually owned savings account used to pay for you and your eligible dependents' insurance deductibles and qualified out-of-pocket medical, dental and vision expenses. Account owners must be enrolled in a high deductible health plan and have no access to first dollar coverage such as Medicare or Direct Primary Care. Money deposited in an HSA stays with you, regardless of employer or plan, and unused balances roll over year to year. The employer and the employee can contribute to the HSA up to the annual limit for an individual or a family as stated by IRS guidelines.

High Deductible Health Plan (HDHP) Also called a "Consumer Driven Health Plan" (CDHP), has lower premiums and higher deductibles than a traditional health plan. Except for preventive care, employees must meet the annual deductible before the plan pays benefits even for office visits and prescriptions.

In-network Doctors, clinics, hospitals and other providers with whom the plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network and the member pays a lower amount for those services.

Non-Preferred Brands These medications generally have generic alternative and/or one or more preferred brand options within the same drug class which causes these drugs to cost more. You and your employers usually pay more for non-preferred brand medications. Also known as non-formulary brands.

Out-of-Network A physician, healthcare professional, facility or pharmacy that doesn't participate in the plan's network and doesn't provide services at a discounted rate. Using an out-of-network healthcare professional or facility will cost you more.

Out-of-Pocket Maximum The maximum dollar amount a member is required to pay out of pocket for allowable covered expenses under a plan during a benefit period before the plan will pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or services your plan doesn't cover.

Preferred Drug A list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary" or "formulary brand." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs not on the preferred drug list may not be covered.

Prior Authorization/Pre-Service Notification The decision by the plan that a service, treatment plan, prescription drug, medical equipment, or other services defined in the certificate of coverage and/or Summary Plan Description (SPD), is medically necessary. The plan may require preauthorization for certain services before receiving them, in order for the service to be covered.

Provider A physician (medical, dental or vision), healthcare professional or health care facility licensed, certified or accredited as required by state law recognized for payment by the plan.

Qualifying Event An occurrence defined by IRS Section 125 such as marriage/divorce, death, termination of employment, child birth/adoption, involuntary loss of coverage, etc. which triggers an employee's ability to make changes to their benefit elections at the time the qualifying event occurs outside of open enrollment.

Usual, Customary and Reasonable (UCR) The determined going rate for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount and is used typically when services are provided by an out-of-network provider.

PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator as follows:

January 1, 2021
Seminole County Government
Human Resources
1101 E. 1st Street, 3rd Floor
Sanford, FL 32771
407-665-5272

Notice Regarding Special Enrollment Rights

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within **30 days** of the loss of that coverage. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) You or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your plan administrator.

Notice Regarding Patient Protection Rights

The Seminole County Government group health plan allows members to designate a Primary Care Provider. The following paragraphs outline certain protections under the Patient Protection and Affordable Care Act (Affordable Care Act) and only apply when the Plan requires or allows the designation of a Primary Care Provider.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Plan's network. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the insurer.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

Health Insurance Marketplace Coverage Options and Your Health Coverage

There is an additional way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78 percent of your household income for 2020, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility:

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **http://flmedicaidtplrecovery.com/hipp/** Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: **http://www.in.gov/fssa/hip/** Phone: 1-877-438-4479 All other Medicaid Website: **http://www.indianamedicaid.com** Phone 1-800-457-4854
CALIFORNIA – Medicaid	**IOWA – Medicaid**
Website: **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx** Phone: 916-440-5676	Medicaid Website: **https://dhs.iowa.gov/ime/members** Medicaid Phone: 1-800-338-8366 Hawki Website: **http://dhs.iowa.gov/Hawki** Hawki Phone: 1-800-257-8563
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KANSAS – Medicaid**
Health First Colorado: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: **www.colorado.gov/pacific/hcpf/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program** HIBI Customer Service: 1-855-692-6442	Website: **http://www.kdheks.gov/hcf/default.htm** Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: **KIHIPP.PROGRAM@ky.gov** KCHIP Website: h**ttps://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**	Website: **https://www.dhhs.nh.gov/oii/hipp.htm** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740 TTY: Maine relay 711	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA - Medicaid**
Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/** Phone: 1-800-862-4840	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA - Medicaid**
Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp** Phone: 1-800-657-3739	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084	Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx** Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900	Website: **http://www.eohhs.ri.gov/** Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **https://www.coverva.org/hipp/** Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON - Medicaid**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **http://www.hca.wa.gov/** Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669	Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf** Phone: 1-800-362-3002
VERMONT - Medicaid	**WYOMING – Medicaid**
Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Medicare Notice

You must notify Seminole County Government when you or your dependents become Medicare eligible. Seminole County Government is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-855-797-2627.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice(s) that follow.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Seminole County Government and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Seminole County Government has determined that the prescription drug coverage offered by your company plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact your HR Representative. You will receive this notice each year and again, if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit U.S. Social Security Administration's at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

NOTICE OF RESCISSION OF COVERAGE

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

SUMMARY OF BENEFITS & COVERAGE (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available electronically on SharePoint. A paper copy is also available, free of charge, by calling your benefits administrator at 407-665-5272

PLAN SOURCE ENROLLMENT INSTRUCTIONS

ONLINE ENROLLMENT INSTRUCTIONS

1. Login

ENROLLMENT URL:
https://benefits.plansource.com

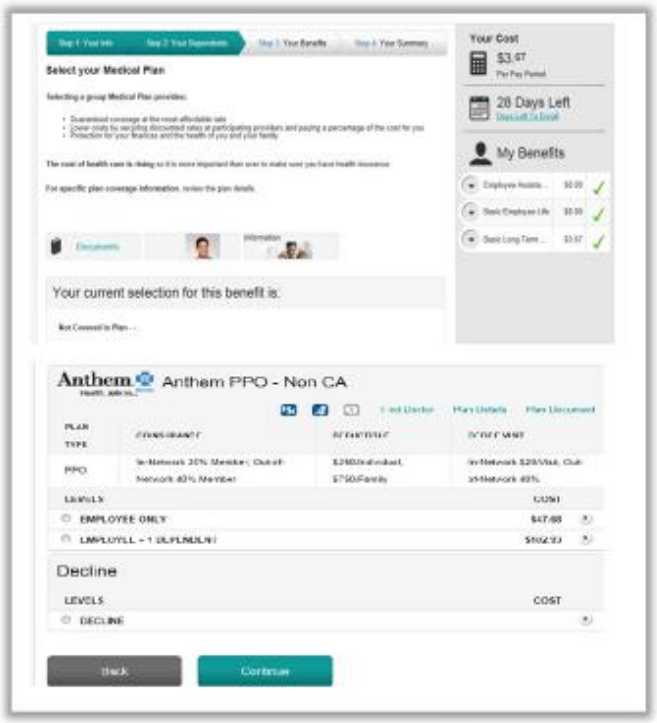
- **USERNAME**: Your user name is the following: the first initial of your first name, up to the first six characters of your last name, and the last four of your SSN. For example: If your name is Jane Anderson and the last four of your SSN is 1234, your user name would be janders1234
- **PASSWORD**: Your birthdate in YYYYMMDD format. For example: If you birthdate is August 14, 1962, your password would be 19620814. At initial login, you will be prompted to change your password

2. Launch Enrollment

- Click on "**Make a Change to My Benefits**" to begin. If you are a new hire – this link will say "**New Hire - Enroll**" and during annual enrollment "**Enroll – Annual**".

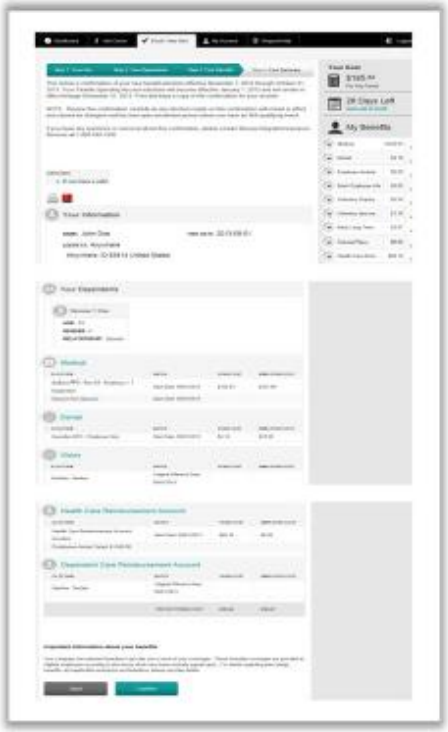
3. Enroll

- Follow the enrollment through each step of the enrollment process from top to bottom
- In making your elections, choose the plan option of choice or select the "Decline" option and then select "Continue" after each election has been made until you reach the confirm page.



4. Confirm Enrollment Selections

- Once you complete all coverage elections, you will land on the Confirmation Statement. Click the "Confirm Enrollment" button at the bottom of the page to complete your enrollment process.



This booklet is intended as a high level overview and is informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.