SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

Employee Benefits Guide

January 1, 2025 – December 31, 2025

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This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

CONTACTS

Human Resources Department - Benefits Team
Contacts: 407-665-7952
407-665-5272

Fax: 407-665-7939

Medical and Pharmacy
Cigna One Guide – Customer Service for questions related to benefits, claims and network providers
800-244-6224
Cigna Member Portal www.mycigna.com

Cigna Pre-Enrollment Assistance – Customer Service for questions about medical and pharmacy benefits before enrollment
888-806-5042

Health Savings Account (HSA)
Customer Service: 800-244-6224
www.mycigna.com

Dental
Lincoln Financial Group
Customer Service: 800-423-2765
www.lfg.com

Vision
Eyemed Vision – "Insight" Network
Customer Service: 866-939-3633
www.eyemed.com

Life, Short-Term and Long-Term Disability
Reliance Matrix Life Insurance Co.
Customer Service: 800-351-7500
www.reliancematrix.com
customerservice@rsli.com

CONTACTS

Flexible Spending Account (FSA)
Cigna
Customer Service: 877-622-4327
www.mycigna.com

Employee Assistance Plan (EAP)
Cigna
Employer ID to access services: seminolecountyfl
Customer Service: 877-622-4327
www.mycigna.com

Cancer
Allstate Benefits
Customer Service: 800-521-3535
AB-CustomerCare@allstate.com

Critical Illness
Aetna
Customer Service: 888-772-9682
www.aetna.com/voluntary/employees

Benefit Questions, Issues/Claims, Open Enrollment
Leah Wrobleski, Account Executive
E: Leah.Wrobleski@alliant.com
D: 407-340-3700

Sarah Hill, Account Associate
E: Sarah.Hill@alliant.com
D: 407-274-2426

Nationwide
Nationwide 457B
Patty Nichols
D: 352-702-5529
Customer Service 877-677-3678
E: nichop1@nationwide.com

FRS
Florida Retirement System Pension Plan
Customer Service 866-446-9377

WHO'S ELIGIBLE FOR BENEFITS?

Employees

Seminole County Government offers a health and welfare program to all employees classified as Full Time. Your health and the health of your family are important – this is the reason we offer comprehensive health care coverage with ancillary benefit options to employees and their families. Our benefits package is designed to focus on your total well-being. Please read through all of your materials carefully. The health care coverage you elect begins with your initial eligibility date and continues through the end of the benefit plan year. The benefit plan year begins January 1 and ends December 31.

Eligible dependents

- Legally married spouse
- Natural, adopted or stepchildren up to age 26 (coverage ends at the end of the calendar year)
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

Extended Dependent Eligibility

- Medical Plan only – In the state of Florida, dependent child coverage is available up to age 30 if the dependent meets all of the following criteria:
    - Unmarried;
    - No dependents of their own;
    - A Florida resident (or student); and
    - Not otherwise insured with medical coverage
- You will be required to provide Human Resources with proof of dependent eligibility in the form of:
    - Marriage Certificate (copy)
    - Birth Certificate (copy)
    - Most recent Federal Income Tax Return, and/or
    - Court Order specifying your responsibility to provide group health care coverage to your dependent child(ren)
- For additional coverage information, please refer to the benefit booklets for each benefit.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first day of the month following 30 calendar days of service if you enroll within your initial new hire eligibility period.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

LIFE EVENTS & CHANGING YOUR BENEFITS

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change to the HR Benefits Team within 30 days after the event.

Human Resources Department - Benefits Team
407-665-7952
407-665-5272

HEALTH PLAN OPTIONS: CIGNA

You always pay the deductible and copayment ($). The coinsurance (%) shows what the employee pays after the deductible.

IN-NETWORK BENEFITS	OAP High/Buy-up	OAP Mid Plan	OAP Low Plan	HSA Plan
Network Name	Open Access Plus	Open Access Plus	Open Access Plus	Open Access Plus
Deductible Individual/Family	$250 / $500 (Embedded)	$500 / $1,500 (Embedded)	$1,000 / $3,000 (Embedded)	$1,650 / $3,300 (Non-Embedded)
Coinsurance	10%	20%	20%	10%
Maximum Out-of-Pocket	$1,500 / $3,000	$3,000 / $6,000	$3,500 / $7,000	$3,300 / $6,600
Office Visits • Primary Care • Specialist • Preventive Care	 $15 copay $25 copay $0 copay	 $25 copay $60 copay $0 copay	 $25 copay $45 copay $0 copay	 Deductible, then 10% Deductible, then 10% Covered 100%
Inpatient Hospital	Deductible, then 10%	Deductible, then 20%	Deductible, then 20%	Deductible, then 10%
Outpatient Hospital • Surgery	Deductible, then 10%	Deductible, then 20%	Deductible, then 20%	Deductible, then 10%
Emergency Room	$200 copay	$300 copay	$200 copay	Deductible, then 10%
Urgent Care	$35 copay	$35 copay	$50 copay	Deductible, then 10%
Lab (Labcorp/Quest)	$0 copay	$0 copay	$0 copay	Deductible, then 10%
X-Ray (Independent Facility)	$0 copay	$0 copay	$0 copay	Deductible, then 10%
Complex Imaging	Deductible, then 10%	Deductible, then 20%	$200 copay	Deductible, then 10%
OUT-OF-NETWORK				
Deductible Individual/Family	$500 / $1,500	$1,500 / $4,500	$3,000 / $6,000	$3,300 / $6,600
Coinsurance	50%	50%	50%	40%
Maximum Out-of-Pocket	$3,000 / $6,000	$6,000 / $12,000	$7,000 / $14,000	$6,600 / $13,200

PHARMACY BENEFITS	Retail Up to 30 Days	Mail Up to 90 Days	Retail Up to 30 Days	Mail Up to 90 Days	Retail Up to 30 Days	Mail Up to 90 Days	Retail Up to 30 Days	Mail Up to 90 Days
							*Medical deductible must be met prior to copays	
Generic	**$10**	**$25**	**$10**	**$25**	**$10**	**$25**	**$10**	**$25**
Preferred Brand	**$30**	**$75**	**$30**	**$75**	**$30**	**$75**	**$30**	**$75**
Non-Preferred Brand	**$50**	**$125**	**$50**	**$125**	**$50**	**$125**	**$50**	**$125**
Specialty	**$100**	**$250**	**$100**	**$250**	**$100**	**$250**	**$100**	**$250**

Please be aware the HSA 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 the HSA plan, the County will contribute $500 to your Health Savings Account for any coverage level (Employee only or Employee with Dependents). REMEMBER – IF YOU ENROLL IN THE HSA PLAN WITH DEPENDENTS, YOU MUST MEET THE FAMILY DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM.

HEALTH PLAN PREMIUMS – REGULAR RATES

2025 Health Insurance Premiums Regular Rates

OAP HIGH/BUY-UP PLAN	BI-MONTHLY	MONTHLY
Employee Only	$105.00	$210.00
Employee + Spouse	$385.00	$770.00
Employee + Child(ren)	$228.00	$456.00
Employee + Family	$494.00	$988.00

OAP MID PLAN	BI-MONTHLY	MONTHLY
Employee Only	$46.00	$92.00
Employee + Spouse	$310.00	$620.00
Employee + Child(ren)	$166.00	$332.00
Employee + Family	$397.00	$794.00

OAP LOW PLAN	BI-MONTHLY	MONTHLY
Employee Only	$46.00	$92.00
Employee + Spouse	$287.00	$574.00
Employee + Child(ren)	$146.00	$292.00
Employee + Family	$365.00	$730.00

HSA PLAN	BI-MONTHLY	MONTHLY
Employee Only	$46.00	$92.00
Employee + Spouse	$247.00	$494.00
Employee + Child(ren)	$113.00	$226.00
Employee + Family	$309.00	$618.00

Note: Bi-Monthly reflects 24 premium payments per year

HEALTH PLAN PREMIUMS – WELLNESS PREFERRED RATES

2025 Health Insurance Premiums Wellness Preferred Rates

OAP HIGH/BUY-UP PLAN	BI-MONTHLY	MONTHLY
Employee Only	$59.00	$118.00
Employee + Spouse (Employee AND Spouse meet the criteria)	$293.00	$586.00
Employee + Spouse (Employee OR Spouse meet the criteria)	$339.00	$678.00
Employee + Children	$182.00	$364.00
Employee + Family (Employee AND Spouse meet the criteria)	$402.00	$804.00
Employee + Family (Employee OR Spouse meet the criteria)	$448.00	$896.00

OAP MID PLAN	BI-MONTHLY	MONTHLY
Employee Only	$0.00	$0.00
Employee + Spouse (Employee AND Spouse meet the criteria)	$218.00	$436.00
Employee + Spouse (Employee OR Spouse meet the criteria)	$264.00	$528.00
Employee + Children	$120.00	$240.00
Employee + Family (Employee AND Spouse meet the criteria)	$305.00	$610.00
Employee + Family (Employee OR Spouse meet the criteria)	$351.00	$702.00

OAP LOW PLAN	BI-MONTHLY	MONTHLY
Employee Only	$0.00	$0.00
Employee + Spouse (Employee AND Spouse meet the criteria)	$195.00	$390.00
Employee + Spouse (Employee OR Spouse meet the criteria)	$241.00	$482.00
Employee + Children	$100.00	$200.00
Employee + Family (Employee AND Spouse meet the criteria)	$273.00	$546.00
Employee + Family (Employee OR Spouse meet the criteria)	$319.00	$638.00

HSA PLAN	BI-MONTHLY	MONTHLY
Employee Only	$0.00	$0.00
Employee + Spouse (Employee AND Spouse meet the criteria)	$155.00	$310.00
Employee + Spouse (Employee OR Spouse meet the criteria)	$201.00	$402.00
Employee + Children	$67.00	$134.00
Employee + Family (Employee AND Spouse meet the criteria)	$217.00	$434.00
Employee + Family (Employee OR Spouse meet the criteria)	$263.00	$526.00

Note: Bi-Monthly reflects 24 premium payments per year

PRESCRIPTIONS BREAKING YOUR BUDGET?

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

Find out if a drug is on your plan's formulary

Visit www.Cigna.com/druglist or call the customer service number on your ID card. There, you can see if your medication is covered, what tier it's covered on, and if there are any extra requirements before your plan will cover it.

Scan to learn more about prescription drugs

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Non-Preferred Brand
$$$$	Specialty Drug

Pharmacy

Customer Service for questions related to benefits, claims and network providers: 800-244-6224

Cigna Member Portal: www.mycigna.com

Customer Service for questions about pharmacy benefits before enrollment: 888-806-5042

PHARMACY BENEFITS	Retail Up to 30 Days	Mail Up to 90 Days	Retail Up to 30 Days	Mail Up to 90 Days	Retail Up to 30 Days	Mail Up to 90 Days	Retail Up to 30 Days	Mail Up to 90 Days
	OAP HIGH/BUY-UP PLAN		OAP MID PLAN		OAP LOW PLAN		HSA PLAN*	
Generic	$10	$25	$10	$25	$10	$25	$10	$25
Preferred Brand	$30	$75	$30	$75	$30	$75	$30	$75
Non-Preferred Brand	$50	$125	$50	$125	$50	$125	$50	$125
Specialty	$100	$250	$100	$250	$100	$250	$100	$250

*Medical deductible must be met prior to copays

WELCOME TO CIGNA

Simple ways to make the most of your plan

Cigna resources are designed to help you make smarter choices to improve your whole health and health plan spending.

First, register on myCigna.com®[1] to access your digital ID cards and activate all available programs

When your plan year begins, register on **myCigna.com**. That way you're ready to go whenever you need to find in-network health care providers, estimate costs or use My Health Assistant.

Register now

Access virtual care

Conveniently connect with board- certified doctors, therapists, psychiatrists and dermatologists via video or phone.[2]

Connect with Cigna One Guide®

Our friendly guides have forward-thinking technology to answer questions on your plan, offer personalized advice and connect you to the right care. They can also proactively reach out.[3]

Ensure in-network care

myCigna and Cigna One Guide can help you stay in-network, maximize savings and avoid any surprises.

Get preventive care

Preventive care, such as check-ups, biometric screenings and wellness screenings, is available at no additional cost to you.[4] It's even available virtually for maximum convenience.

Prioritize behavioral support

229K+ behavioral health and substance use providers[5] can help, either in person or virtually. We also have 24/7 therapy, including Talkspace and Ginger for Cigna, and digital tools, such as iPrevail and Happify™.[6]

Call our 24/7 Health Information Line

Talk with a clinician who can help you choose the right care, whenever you need it – late nights, holidays and more.

Simplify with mail-order medications

Express Scripts® is one of the largest pharmacies in the United States and offers convenience, savings and stress- free prescription management.

Cigna®

Offered by Cigna Health and Life Insurance Company.

FINDING A DOCTOR IN OUR DIRECTORY IS EASY

Is your doctor or hospital in your plan's Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

SEARCH YOUR PLAN'S NETWORK IN FOUR SIMPLE STEPS

Step 1

Go to **Cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

(If you're already a Cigna customer, log in to **myCigna.com** or the myCigna® app to search your current plan's network. To search other networks, use the **Cigna.com** directory.)

Step 2

Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

Step 3

Answer any clarifying questions, and then verify where you live (as that will determine the networks available).

Step 4

Optional: Select one of the plans offered by your employer during open enrollment.

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

Search first. Then choose Cigna.

There are so many things to love about Cigna. Our directory search is just the beginning.

After you enroll, you'll have access to **myCigna.com** – your one-stop source for managing your health plan, anytime, just about anyplace. On **myCigna.com**, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

Questions? Call the number on the back of your ID card.

Together, all the way.®

Cigna®

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care[1] from MDLIVE.®

Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE®

Primary Care

Preventive care, routine care, and specialist referrals

- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology[4]

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more

3 easy steps to connect to care

Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE

Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Visit myCigna.com to make an appointment for virtual care today.

Cigna®

HEALTH SAVINGS ACCOUNT (HSA)

Scan to learn more about High Deductible Health Plans

Scan to learn more about HSA's

Are you eligible?

The HSA is not for everyone. You're eligible only if you are:

- Enrolled in the High Deductible Health Plan (HSA) Medical Plan
- Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
- Not a tax dependent.
- Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How the High Deductible Health Plan with HSA works:

- Your HSA account is set up automatically after you enroll.
- To help you get started, Seminole County makes an annual contribution to your HSA of $500.
- You can contribute up to the limit set by the IRS (includes company amount).

  Individual: $4,300 per year
  Family: $8,550 per year
  Are you age 55? You can contribute an additional $1,000 per year
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

Find out more

- www.mycigna.com
- Visit www.cigna.com/expenses for a complete list of eligible/ineligible expenses.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Scan to learn more about FSA's

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. Your FSA account is integrated with your benefit information, so it's easy to manage both in one convenient place: myCigna.com®

Are you eligible?

You do not have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our HDHP Plan, you can only participate in the Dependent Care FSA for dependent care expenses.

Find out more
www.mycigna.com

Estimate carefully!

If you don't spend all the money in your account, you forfeit the leftover balance at the end of the year.

Your tax savings may vary depending on tax filing status and other variables

How the Healthcare FSA works

- Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and eligible drugstore items. Visit www.cigna.com/expenses for a complete list of eligible/ineligible expenses.
- Estimate contributions and calculate potential tax savings at Cigna.com/fsacalc.
- You can contribute up to $3,300 which is the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- You will receive a Cigna FSA card that works like a debit card and eliminates the need to pay out-of-pocket, submit a claim, or wait for reimbursement. Use your FSA card to pay for expenses that are eligible according to IRS guidelines under the plan. Be sure to save your receipts for purchases on the Cigna FSA card.
- You may use your cards until the expiration date shown on the front. You will receive new cards just before your current card expires.
- Claims are paid automatically with Autopay or you can view and pay bills online.
- You can also submit your FSA reimbursement claims with our simple-to-use online claim form.
- Monitor your account from almost anywhere with the myCigna® App.3
- You'll have immediate access to all the money in your FSA account from the first day.

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Scan to learn more about FSA's

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Cigna.

www.mycigna.com

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. You can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully!

You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Save your receipts for record keeping on utilizing the pre-tax funds.

WELLNESS PROGRAM OVERVIEW

Seminole County Government is committed to helping you achieve your best health. The County's Wellness Program, including tobacco affidavit requirements, coincides with the Benefits Open Enrollment. The Program is voluntary and is available to employees and/or spouses.

We encourage you (and your spouse) to stay on track with your health, and recommend you schedule your annual physical and complete your lab work to ensure you are prepared for the 2026 Wellness program. ***Please note, the annual physical and lab work are required. You will not see your points until these requirements have been completed and processed through claims.***

Complete five (5) of the goals/activities offered on myCigna.com – Wellness & Incentives portal.

STEPS TO THE TOBACCO* FREE REQUIREMENT FOR 2025:
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 $45 per pay period/per tobacco user tobacco surcharge.

If you and/or your spouse are a tobacco user who would like assistance to eliminate tobacco use, please refer to the list of approved Tobacco Cessation Programs provided by Human Resources, that are offered at no cost to you. You must enroll and complete a qualified program by July 31, 2025. A certificate of completion must be uploaded into PlanSource as part of open-enrollment for Plan Year 2025.

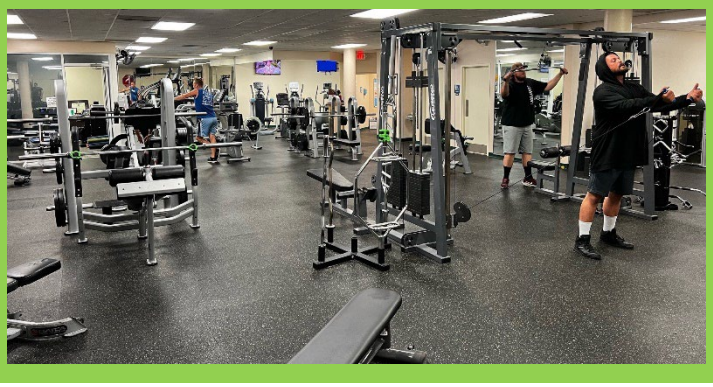
*The County follows the Affordable Care Act's definition of tobacco use. Tobacco use, as defined by the Affordable Care Act (ACA), is an average of four or more times per week within the past 6 months, including **ALL** tobacco and nicotine products, but excluding religious and ceremonial uses of tobacco.
NOTE: Tobacco products (FDA regulated tobacco products) include cigarettes, cigars, dissolvables, hookah tobacco, nicotine gels, pipe tobacco, roll-your-own tobacco, smokeless tobacco products including dip, snuff, snus, and chewing tobacco, and electronic nicotine delivery systems including vaping products, hookah pens, etc. The following nicotine products shall be deemed tobacco products unless they are used in connection with a quit program: patches, nicotine gum, lozenges, or other similar nicotine delivery methods.

HEALTHY BALANCE WELLNESS PROGRAM

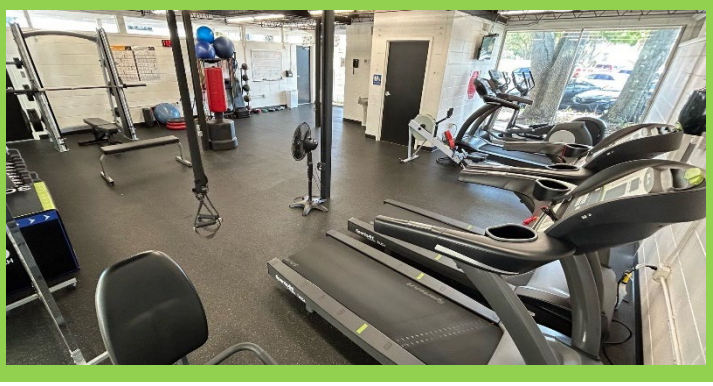
Seminole County provides ongoing resources to support our employees in improving their health and well-being through healthy lifestyle choices.

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.

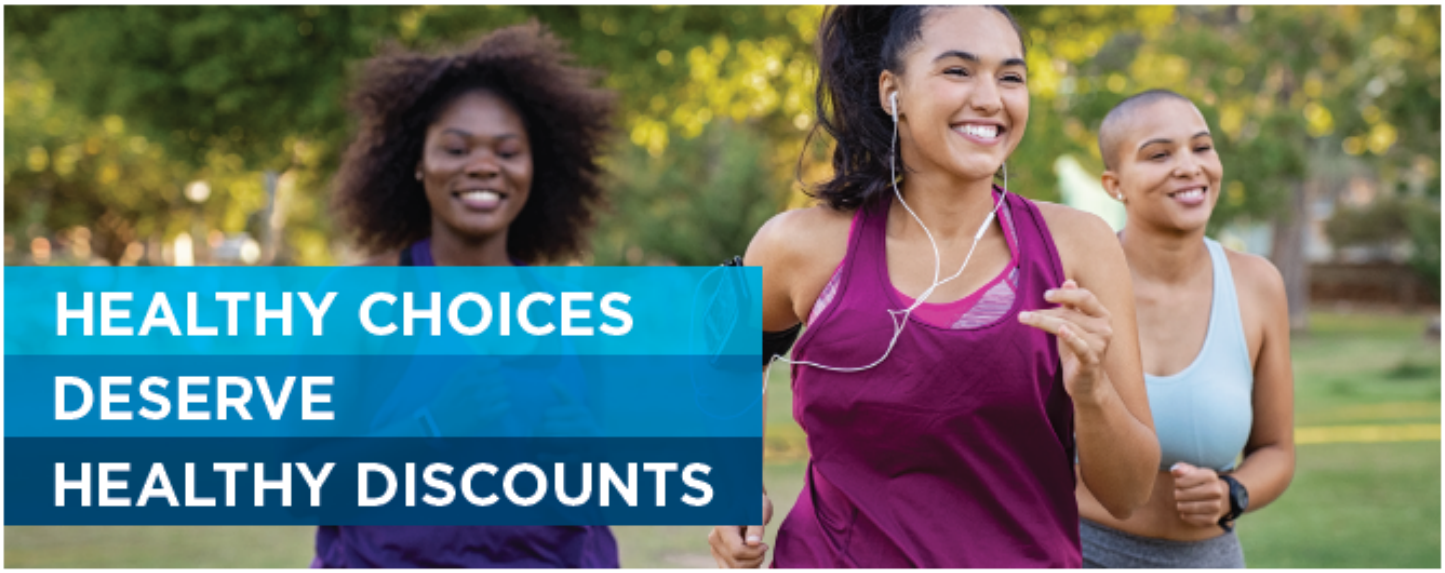
Five Points
Wellness Center
3,400 sq. foot facility
200 W. County Home Road, Sanford



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



CIGNA HEALTHY REWARDS PROGRAM



Start saving today with Cigna Healthy Rewards®*

Just use your Cigna ID wallet card when you pay and let the savings begin.

Get discounts on the health products and programs you use every day for:

- Nutritional Meal Delivery Service
- Fitness Memberships and Devices**
- Vision Care, Lasik Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts**

Real brands. Real discounts. Real easy.

Log into **myCigna.com** and navigate to Healthy Rewards Discount Program or call **800.870.3470**.

For Cigna customers who don't have access to **myCigna.com** and want an Active&Fit Direct™ gym membership:

- Call **800.870.3470**; and
- Press 3 to be transferred to a customer service agent.

* Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your health plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your your plan benefi ts. A discount program is NOT insurance, and you must pay the entire discounted charge. All goods, services and discounts offered through Healthy Rewards are provided by third parties who are solely responsible for their products, services and discounts.

** Fitness Membership and Devices along with Yoga Products and Virtual Workouts can only be accessed by login into myCigna.com and navigating to Healthy Rewards Discount Program.

Together, all the way.®

Cigna.

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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DENTAL

OUR PLANS

Lincoln Financial Group

Low PPO, Mid PPO, & High PPO Options.

You have the option to visit any dental provider but keep in mind that you will receive the highest level of benefit by choosing to receive services from a Lincoln PPO network dentist.

To find a provider near you, visit LincolnFinancial.com/FindADentist

Questions?

Contact Lincoln customer service at 1-800-423-2765

Why sign up for Dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures

MID & HIGH-LEVEL DENTAL PLANS ONLY:

- **Orthodontia** treatment to properly align teeth within the mouth (Children only)

DENTAL PLANS

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	PPO Low Plan	PPO Mid Plan	PPO High Plan
In-Network Benefits			
Calendar Year Deductible Individual/Family	$75 / $225	$50 / $150	$50 / $150
Calendar Year Maximum	$750	$1,000	$1,500
Preventive Services	Covered 100%	Covered 100%	Covered 100%
Basic Services	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 90% after deductible
Major Services	Plan pays 40% after deductible	Plan pays 50% after deductible	Plan pays 60% after deductible
Orthodontic Services (Up to 19 years)	Not Covered	50% to $1,000 (lifetime maximum)	50% to $1,000 (lifetime maximum)
Out-of-Network Benefits*			
Calendar Year Deductible Individual/Family	$100 / $300	$100 / $300	$50 / $150
Calendar Year Maximum	$500	$500	$1,500
Preventive Services	Plan pays 80% after deductible*	Plan pays 80% after deductible*	Covered 100%*
Basic Services	Plan pays 50% after deductible*	Plan pays 80% after deductible*	Plan pays 80% after deductible*
Major Services	Plan pays 25% after deductible*	Plan pays 40% after deductible*	Plan pays 50% after deductible*
Orthodontic Services (Up to 19 years)	Not Covered	50% to $1,000 (lifetime maximum)*	50% to $1,000 (lifetime maximum)*

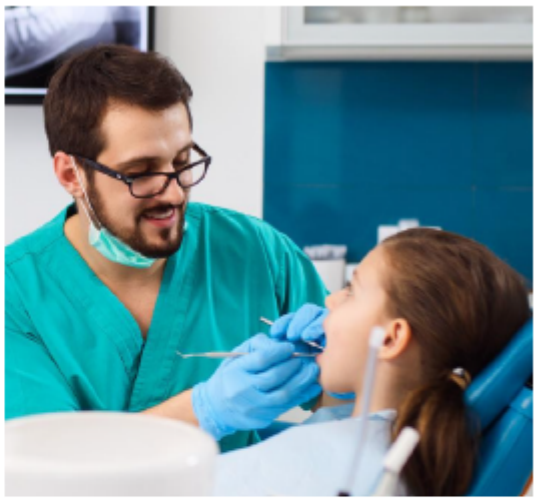
*Out of Network benefits subject to Balance Billing

DENTAL PLAN PREMIUMS

Semi-Monthly Plan Premiums	PPO Low Plan	PPO Mid Plan	PPO High Plan
Employee Only	$7.94	$10.71	$24.51
Employee + One	$13.90	$19.03	$43.12
Employee + Two or more	$20.52	$30.17	$63.24

Lincoln DentalConnect® plans

Get connected with the resources you need to keep your smile healthy



Register for online tools and information

If you're covered by a Lincoln PPO or indemnity group dental plan*, you can access a wide range of online dental health tools and information by registering for an account at **LincolnFinancial.com**. By logging into your account, you can:

- Print an ID card
- Check your claim status
- Estimate the average cost of a dental procedure
- Switch between English and Spanish in just one click
- Have your questions answered by a dentist
- Catch up with the latest dental news, trends, and developments
- Access a database of information on dental health topics, including children's dental care, senior dental care, and oral disease prevention

Find a dentist

For maximum convenience, you can look for a dentist without logging into your account by visiting **LincolnFinancial.com/FindADentist**, where you can search by:

- Location
- Dentist or office name
- Distance you're willing to travel
- Preferred specialty, language, and more

Your search will provide up to 100 dentists that most closely match your criteria. If your search does not locate the dentist you prefer, you can nominate one by clicking on the "**Nominate a Dentist**" link and completing the online form.

Check your coverage before you visit

When you call your dentist to schedule a visit, let the office know you have coverage through the *Lincoln DentalConnect*® PPO plan. To help the dental office verify your coverage, be sure to have your member ID card and/or your Social Security number on hand.

Download the Lincoln Dental Mobile App today!

Keeping track of your dental benefits is now easier than ever with the **Lincoln Dental Mobile App**.

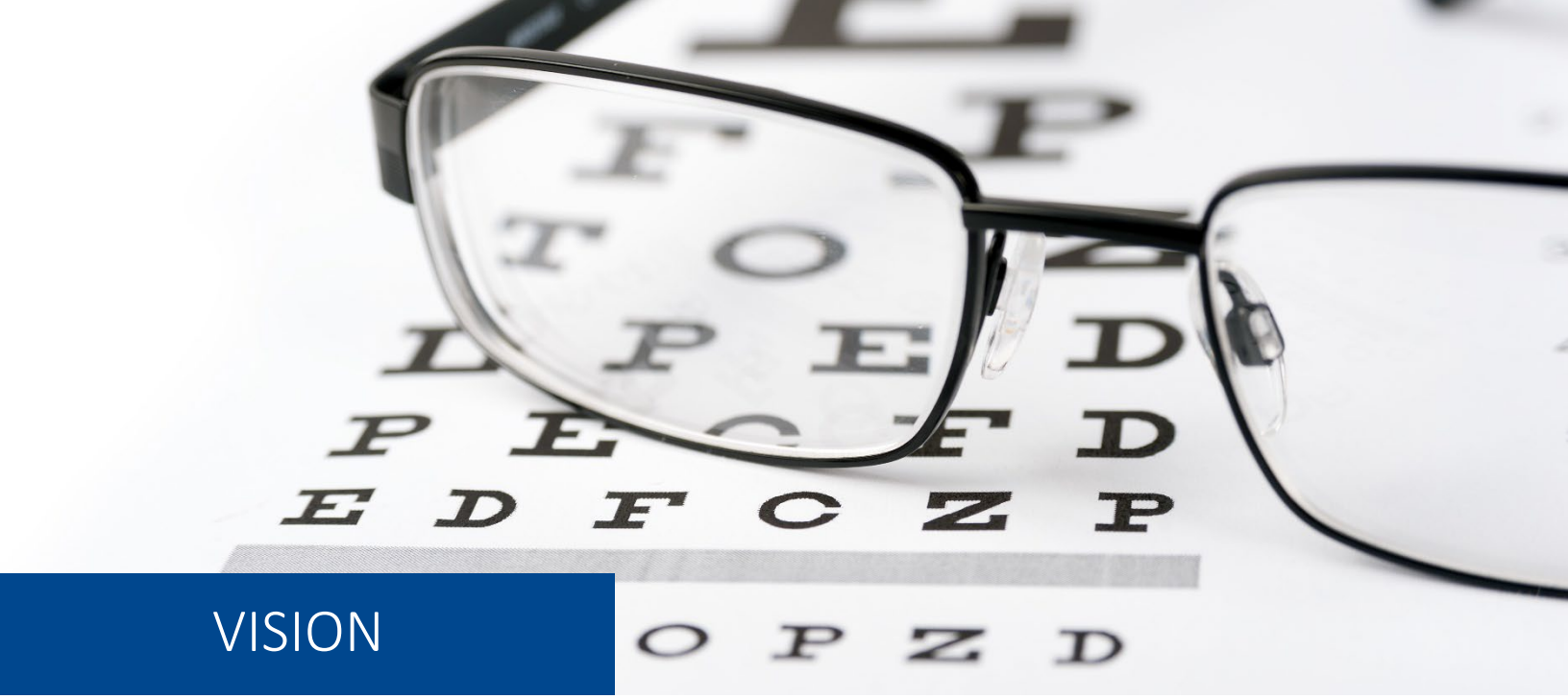
With this seamless, user-friendly tool, you can:

- Quickly access your ID card on your phone
- Find a network dentist near you
- View plan details
- Find out how much your plan covers for checkups and other services
- See what was covered and what you owe for your dentist visits
- Keep track of your claims

DENTAL

Download on the App Store

GET IT ON Google Play



VISION

OUR PLAN

EyeMed Vision Plan

Insight Network

Find an eye doctor
(Insight Network)

- **Call:** 866.804.0982
- **Visit:** eyemed.com
- **Download:** EyeMed Members App

For LASIK, call 1.800.988.4221

Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK, rebates on contact lenses, and money off on hearing aids and other related services. Visit www.eyemed.com to check out these extra savings.

Scan to learn more about Vision coverage

VISION PLAN - EYEMED

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	In-Network	Out-of-Network
Benefit Frequency • Eye Exam • Prescription Lenses • Frames	12 months	12 months
Eye Exams	$10 copay	Reimbursed up to $40
Prescription Lenses • Single Lenses • Bifocal Lenses • Trifocal Lenses • Standard Progressive	 $15 copay $15 copay $15 copay $80 copay	 Reimbursed up to $30 Reimbursed up to $50 Reimbursed up to $70 Reimbursed up to $50
Frame	$200 allowance, then 20% off	Reimbursed up to $140
Contact Lens Benefit	$200 allowance, then 15% off	Reimbursed up to $140

Semi-Monthly Plan Premiums	Vision Plan
Employee Only	$4.91
Employee + One	$9.33
Employee + Two or more	$13.70

Thinking of becoming a member? Learn more at **enroll.eyemed.com**	Looking to stay healthy with vision? Learn how at **eyesiteonwellness.com**	Already a member? Manage benefits at **eyemed.com**

Time for a little Q&A

A LOOK AT THE BENEFITS

What exactly do my EyeMed benefits cover?

If you're thinking about EyeMed, you'll want to connect with your employer to learn about the benefit options. Already a member? The easiest way to find your benefit information is to create a member account on eyemed.com or grab the EyeMed Members App (App Store or Google Play).

Does EyeMed offer any extra discounts?

We sure do. At participating in-network providers, members get 40% off an extra pair of eyeglasses or 20% off a partial pair (lenses only or frames only).* You also get 20% off non-prescription sunglasses and accessories, and discounts on LASIK laser vision correction. Call 1.800.988.4221 to find a LASIK location near you.

Can I use EyeMed benefits online?

Instantly apply your in-network benefits at checkout, with free shipping, free returns and no paperwork at these participating providers: lenscrafters.com, targetoptical.com, ray-ban.com, glasses.com and contactsdirect.com.

Can I get the same kind of care with a retail provider as I can with an independent doctor?

Many optometrists share space with a retail optical store, but operate a separate practice. All of them, wherever they practice, must meet the same state licensing and credentialing requirements. One advantage of using a vision carrier, like EyeMed, is that credentials of every in-network eye doctor are thoroughly examined and verified, so you can feel confident you're getting access to qualified eye doctors.

MEMBER HOW-TO TIPS

How do I use my benefits?

At EyeMed, we're all about easy. Just choose an in-network eye doctor from our Enhanced Provider Search, schedule your visit and go in for care or eyewear. You don't even need your ID card – just give them your name and birthday. When you stay in-network, we'll handle all the paperwork.

How do I find an eye doctor in my network?

The Enhanced Provider Search on Member Portal and the EyeMed Members App has thousands of in-network eye doctors to choose from. Filter your search to find ones near you with the brands, hours and services you most want.

LIFE & DISABILITY

reliancematrix

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

DON'T FORGET TO UPDATE YOUR BENEFICIARIES!

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss at no cost to you.

If you need additional coverage

We offer voluntary life insurance coverage that you can purchase for yourself, your spouse, and your children, as well as voluntary short-term disability. See the Voluntary Benefits section for details.

reliancematrix

Basic Life and AD&D – Reliance Matrix Insurance Company

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the County.

Basic Term Life Insurance

As an employee of Seminole County, you are provided basic life insurance equal to one time your annual base pay.

Accidental Death and Dismemberment

As an employee of Seminole County, you are provided AD&D insurance equal to one time your annual base pay.

A Note About Taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

You will see an entry on your pay stub for Life excess. This is the amount of premium you are being taxed on. This amount is not being taken out of your paycheck.

COUNTY-PAID LONG TERM DISABILITY INSURANCE (LTD)

Long Term Disability Insurance – Reliance Matrix

Seminole County provides monthly income protection benefits if you are unable to work due to a non-work-related accident or illness. Long Term Disability benefits will be paid after a minimum of 180 days of total disability, upon approval by Reliance Matrix.

The policy contains the following pre-existing condition limitation: any injury or sickness that has been diagnosed, consulted or treated, to include prescribed medications, three months prior to your effective date will NOT be covered until you have been insured twelve months by the plan.

Long Term Disability - *County Paid Benefit*

- **Elimination Period:** 180 consecutive days of total disability
- **Benefit Duration:** Benefits will not extend beyond the longer of Social Security Normal Retirement Age or Duration of Benefits listed below:

Age at Disablement	Duration of Benefits
61	To age 65
62	3 ½ Years
63	3 Years
64	2 ½ Years
65	2 Years
66	1 ¾ Years
67	1 ½ Years
68	1 ¼ Years
69+	1 Year

- **Own Occupation:** 24 months
- **Benefit Amount:** Up to 60% of Monthly Earnings up to a maximum benefit of $8,000 per month

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

- Voluntary Life Insurance
- Voluntary AD&D Insurance
- Voluntary Short-Term Disability
- Critical Illness
- Cancer Insurance

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

Seminole County offers plans to help:

- Provide income for survivors
- Replace income if you're injured or ill

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

VOLUNTARY LIFE AND AD&D INSURANCE

The Voluntary Term Life insurance plan allows you to purchase additional life insurance for you, your spouse and/or your dependent children.

Evidence of insurability is required for all employees and spouses who do not enroll during their initial eligibility period. Additionally, employees wishing to increase their voluntary life coverage, or those who choose an amount above the Guaranteed Issue amount will be asked to complete an Evidence of Insurability form. Please contact Human Resources for the form or more information.

Reliance Standard Life Insurance	
Employee	$10,000 Increments to maximum of $500,000 (not to exceed 5x annual salary)
Spouse	$5,000 Increments to maximum of $100,000 (not to exceed 50% of the employee's elected amount)
Child(ren)	Birth to 20 years (to 26 years if full-time student): $10,000
Guarantee Issue	
Employee	$500,000 (combined with basic life)
Spouse	$50,000
Child(ren)	NA

Reliance Matrix Insurance Voluntary AD&D Insurance

Additional protection is available for employees and their families from loss due to accidental death or serious injury. AD&D coverage matches the voluntary life insurance election for employees and spouse.

If you elect voluntary life insurance, you will automatically be enrolled in the AD&D coverage for the same amount as the voluntary life insurance.

VOLUNTARY SHORT TERM DISABILITY INSURANCE (STD)

Reliance Matrix

If you become disabled and cannot work for a period of time, disability insurance may provide some income protection for you and your family.

You have the opportunity to purchase Short-Term Disability insurance. You are considered "disabled" when you cannot perform the primary functions of your job due to an injury or illness. STD coverage provides weekly income protection benefits if you are temporarily unable to work due to a non-work-related accident or illness (including pregnancy).

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.

Benefits will be paid starting on the fifteenth consecutive day of an accident or illness, upon approval by Reliance Matrix.

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

Short Term Disability	
Elimination Period	14 days
Benefit	Up to 60% of weekly earnings up to $1,500 per week
Maximum Benefit Duration	180 days

PREMIUM CALCULATION

1. Multiply your average weekly salary (up to a maximum of $1,500) by .60	Example*: $750 x .60 = $450
2. Multiply the above by the corresponding rate for your age (from the table to the right)	$450 x .48 = $216
3. Divide that number by 10 for your monthly premium amount	$216 ÷10 = $21.60
4. For your per payroll deduction amount, divide this by 2.	$10.80

SHORT TERM DISABILITY RATES

Under 30	$0.62
30-34	$0.68
35-39	$0.48
40-44	$0.41
45-49	$0.48
50-54	$0.55
55-59	$0.73
60+	$0.91

ALLSTATE CANCER WITH SPECIFIED DISEASE

Cancer Insurance

Many people are concerned about the financial impact of a cancer diagnosis. Cancer insurance provides tax-free benefits for many of the costs associated with cancer treatment such as radiation, chemo, surgery, diagnostic tests, and physician charges. You can cover yourself and your family members if needed. Allstate provides coverage for this program.

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 cancer treatment (and other specified diseases). Benefits are paid in addition to other insurance and are paid directly to you, unless you choose to assign the benefits directly to a provider.

- **Guaranteed Issue**: No medical questions or tests required for coverage for new hires.
- **Flexible**: You can use the benefit money for any purpose you like, such as your deductible.
- **Payroll Deductions**: Premiums are paid through convenient payroll deductions.

New hires who waive initially will be required to provide Evidence of Insurability when applying later. Generally, employees and family members who have not been treated or diagnosed with cancer in the last five (5) years will be eligible to apply and enroll in coverage.

2025 Semi-Monthly Payroll Deductions		
	Plan 1	**Plan 2**
Employee	$7.49	$12.60
Employee and Family	$13.83	$23.51

ALLSTATE CANCER BENEFIT AMOUNTS

Hospital Confinement and Related Benefits	Plan 1	Plan 2
Continuous Hospital Confinement (daily)	$200	$300
Extended Benefits (daily)	$200	$300
Government or Charity Hospital	$200	$300
Private Duty Nursing Services	$200	$300
Extended Care Facility	$200	$300
At Home Nursing	$200	$300
Hospice Care Center (daily) or Hospice Care Team (per visit)	$200	$300
Radiation and Chemotherapy	**Plan 1**	**Plan 2**
Radiation/Chemotherapy (every 12 months)	$5,000	$10,000
Blood, Plasma, and Platelets (every 12 months)	$5,000	$10,000
Surgery and Related Benefits	**Plan 1**	**Plan 2**
Surgery Inpatient / Outpatient	$3,000 / $4,500	$4,500 / $6,750
Anesthesia (% of surgery benefit)	25%	25%
Bone Marrow or Stem Cell Transplant (once/year) Autologous / Non-Autologous (cancer or specified disease treatment) Non-Autologous (Leukemia)	$1,000 / $2,500 $5,000	$1,500 / $3,750 $7,500
Ambulatory Surgical Center (daily)	$500	$750
Second Surgical Opinion	$400	$600
Transportation and Lodging Benefits	**Plan 1**	**Plan 2**
Ambulance (per confinement)	$100	$100
Non-Local Transportation (coach fare or amount shown per mile)	$0.40/mi	$0.40/mi
Outpatient Lodging (daily; limit $2,000/12 mo. period)	$50	$50
Family Member Lodging (daily per trip; max 60 days) Transportation (coach fare or amount shown per mile)	$50 $0.40/mi	$50 $0.40/mi
Miscellaneous Benefits	**Plan 1**	**Plan 2**
Inpatient Drugs and Medicine (daily)	$25	$25
Physician's Attendance	$50	$50
Physical or Speech Therapy (daily)	$50	$50
New or Experimental Therapy (every 12 months)	$5,000	$5,000
Prothesis (per amputation)	$2,000	$2,000
Comfort/Anti-Nausea Benefit	$200	$200
Cancer Initial Diagnosis (one-time benefit)	n/a	$2,000
Cancer Screening	$50	$100
ICU	$200 Charges	$400 Charges

Critical Illness Insurance

Critical illness insurance from Aetna can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

Critical Illness Insurance pays a lump-sum benefit if you are diagnosed with a covered illness or condition. Features of this policy include:

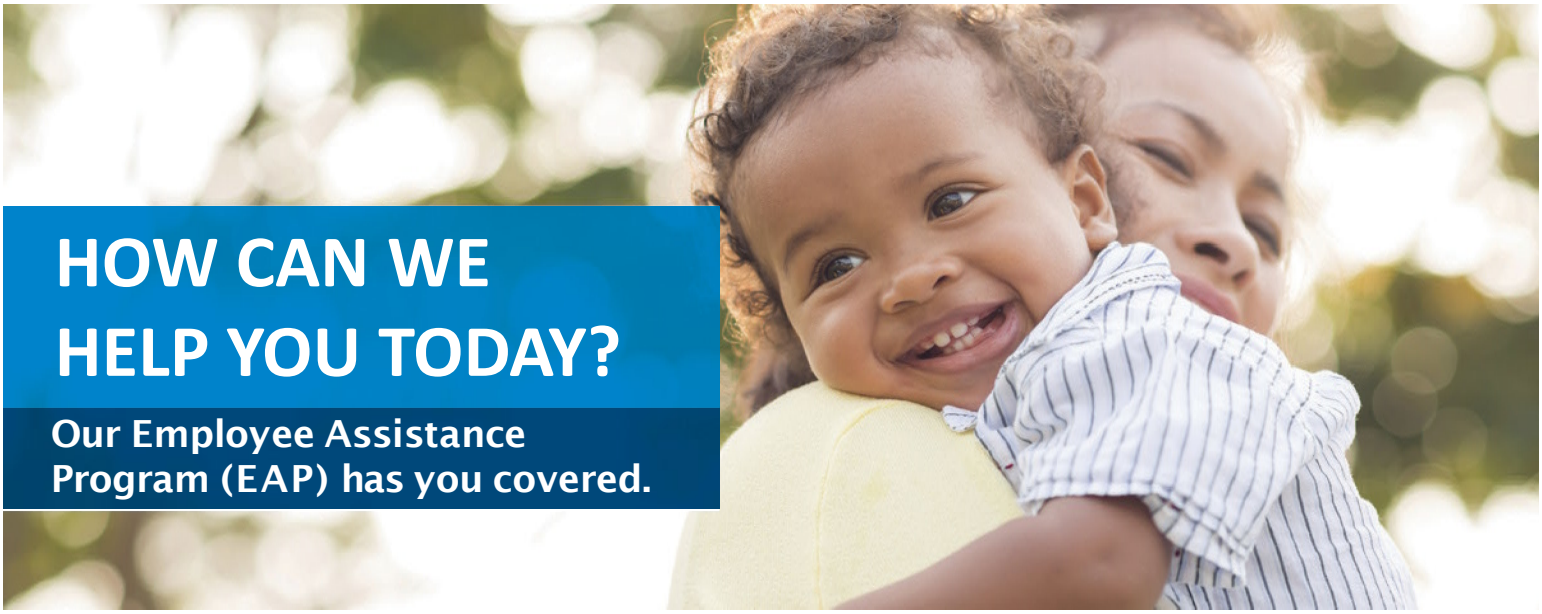
- **Flexible**: You can use the benefit money for any purpose you like, such as your deductible.
- **Payroll deductions**: Premiums are paid through convenient payroll deductions.

2025 Semi-Monthly Payroll Deductions				
	NON-TOBACCO		TOBACCO*	
	EMPLOYEE	EMPLOYEE + FAMILY	EMPLOYEE	EMPLOYEE + FAMILY
$10,000 Face Amount (Spouse and Children: 50% of face amount)	$8.04	$11.75	$13.55	$19.80
$20,000 Face Amount (Spouse and Children: 50% of face amount)	$16.08	$23.50	$27.10	$39.60

Critical Illness Benefits Covered at 100% of Face Amount
• Heart Attack (Myocardial Infarction) • Major Organ Failure • Stroke • End-Stage Renal Failure

Critical Illness Benefits Covered at 25% of Face Amount
Coronary Artery Condition Requiring Bypass Surgery (In order for benefits to be payable, bypass surgery must be done while coverage for the insured person is in force)

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



HOW CAN WE HELP YOU TODAY?

Our Employee Assistance Program (EAP) has you covered.

As an employee of Seminole County Board of County Commissioners you have access to our valuable Employee Assistance Program (EAP) at no cost to you.

EAP personal advocates will work with you and your household family members to help you resolve issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more.

Take advantage of a wide range of services ofered at no cost to you

- **10** face-to-face counseling sessions with a counselor in your area, as well as video-based sessions.
- **Legal assistance:** 30-minute consultation with an attorney, face-to-face or by phone.*
- **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.
- **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.
- **Identity theft:** 60-minute consultation with a fraud resolution specialist.

We're here to listen. Contact us any day, anytime.

Call 1.877.622.4327
Or log in to myCigna.com

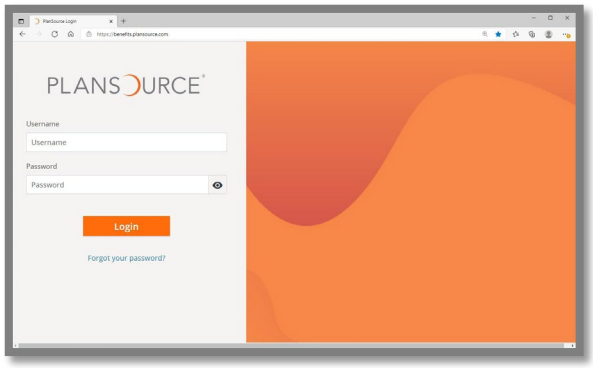
Employer ID: seminolecountyfl
(Needed for initial registration only)
If already registered on myCigna.com, simply log in and go to the EAP link under the Review My Coverage tab.

Together, all the way.®

Cigna®

PLANSOURCE: ONLINE ENROLLMENT

OPEN ENROLLMENT INSTRUCTIONS
To enroll in benefits, go to:
benefits.plansource.com

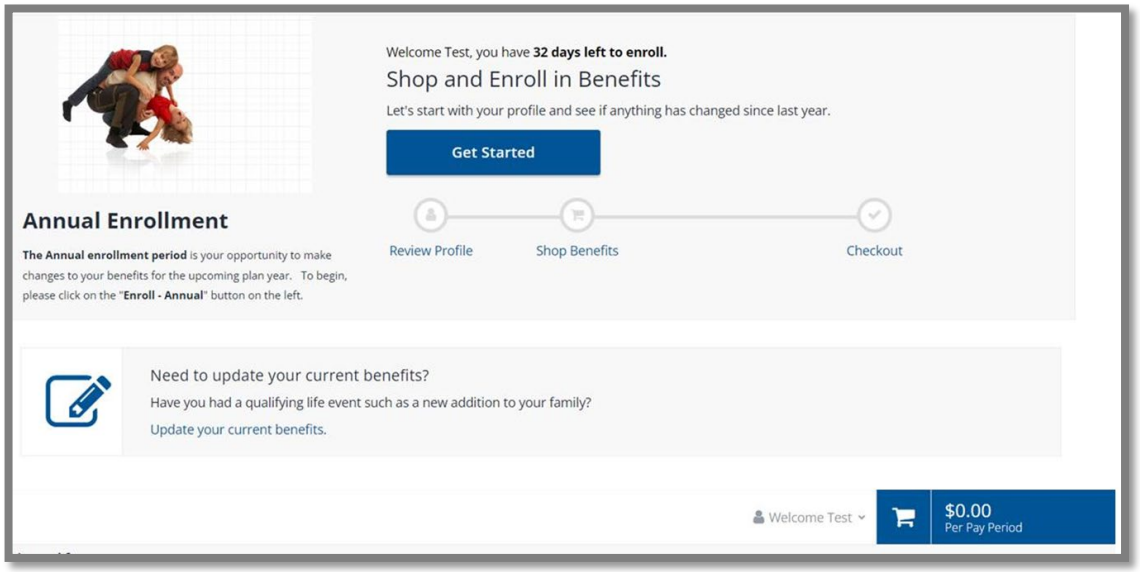


- Most USERNAMES are in the following format – initial of first name last name up to 6 letters and the last four numbers of your social security number. (ex. gwashin1234).

- All PASSWORDS have been reset to your birthdate in the YYYYMMDD format. (ex. If you're your birthdate is May 7, 2022 you would enter it as 20220507).

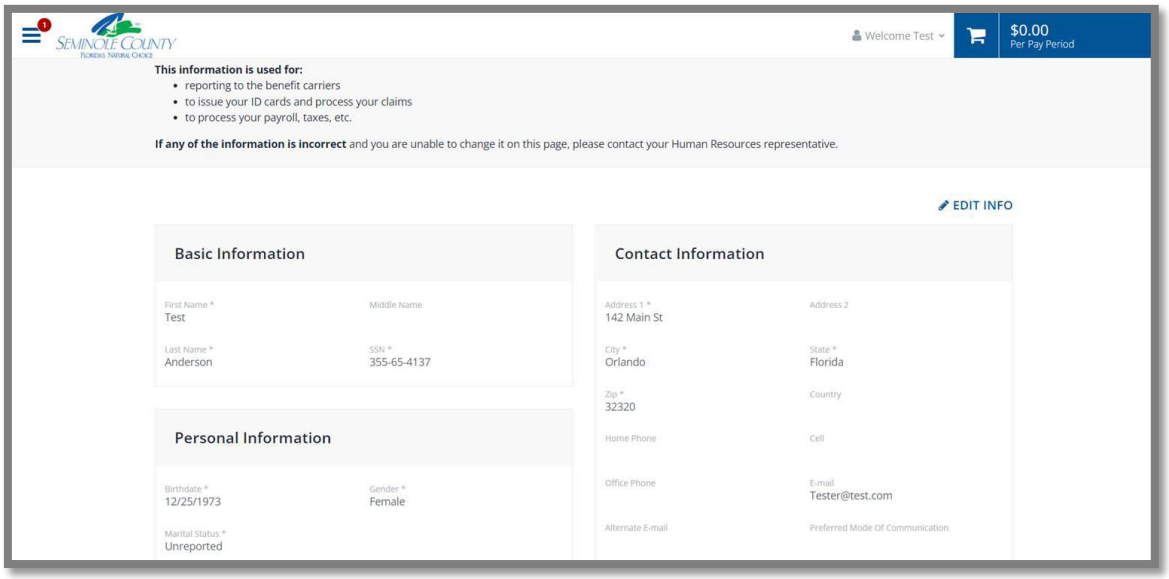
Click

"Get Started"

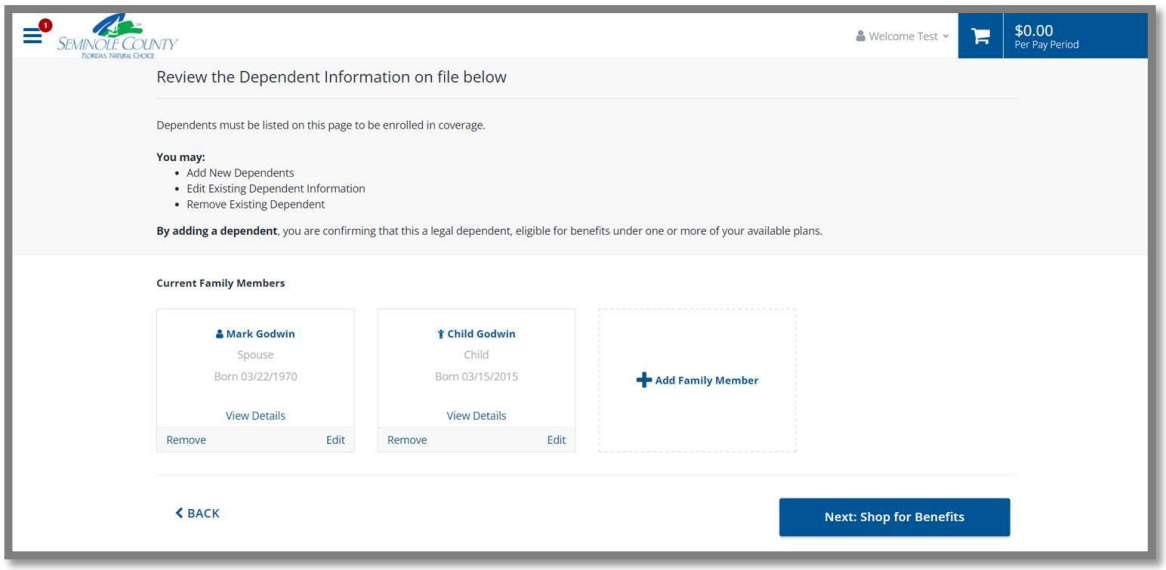


PLANSOURCE: ONLINE ENROLLMENT

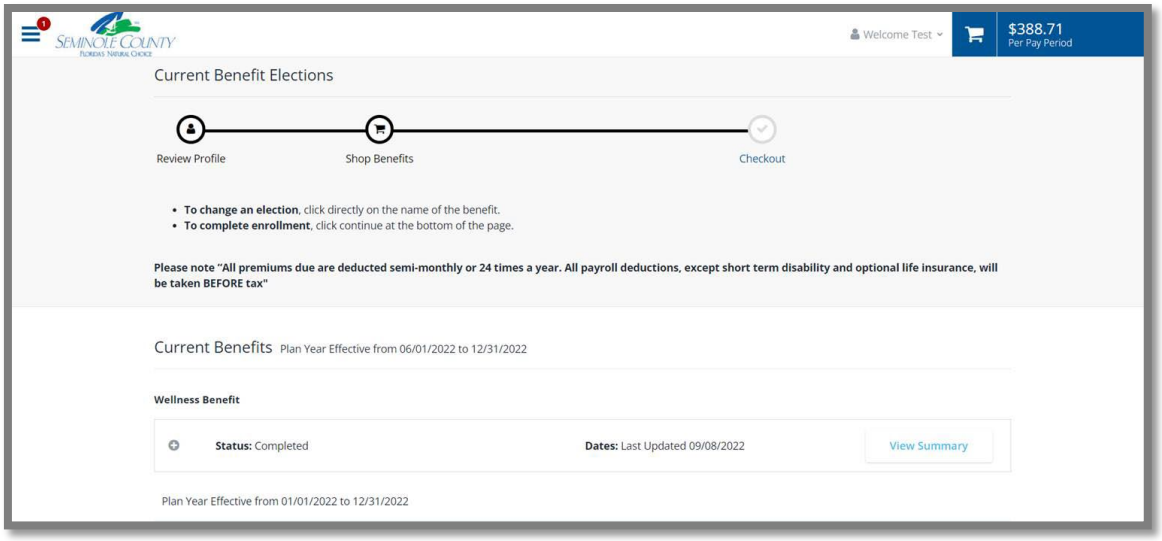
Review and Update your profile



Review and update your dependent information. Click “Next: Shop for Benefits”

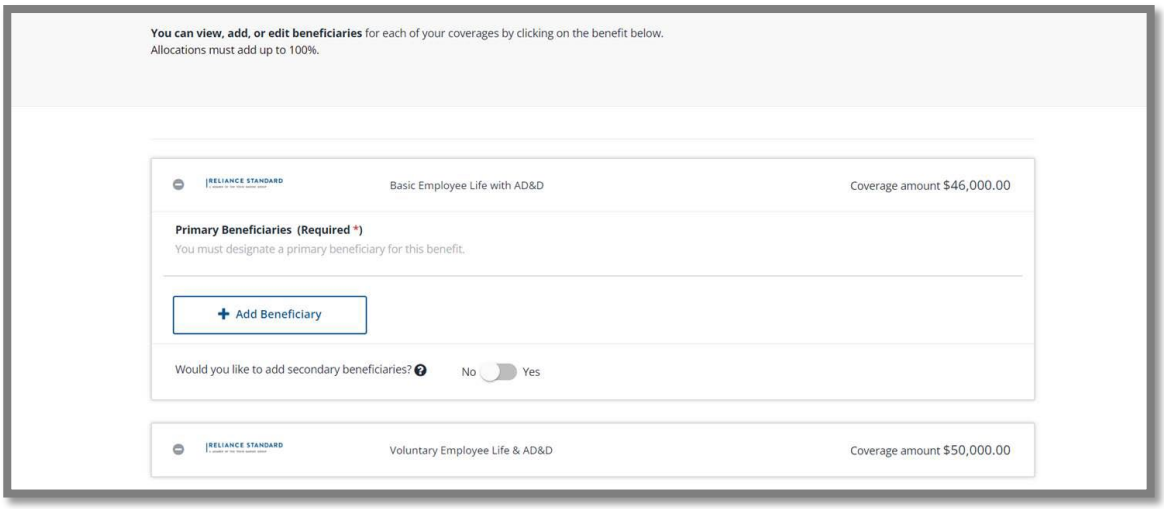


Shop for Benefits



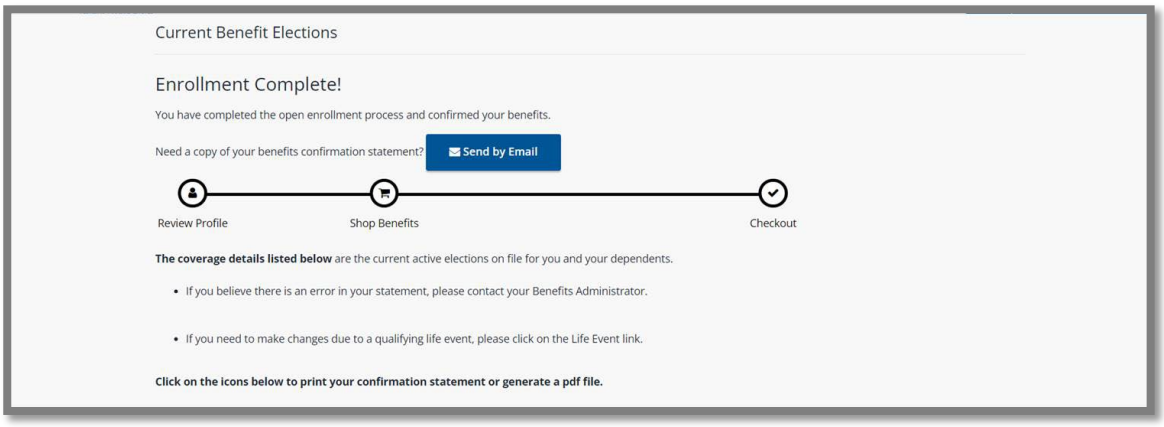
PLANSOURCE: ONLINE ENROLLMENT

Add your beneficiaries



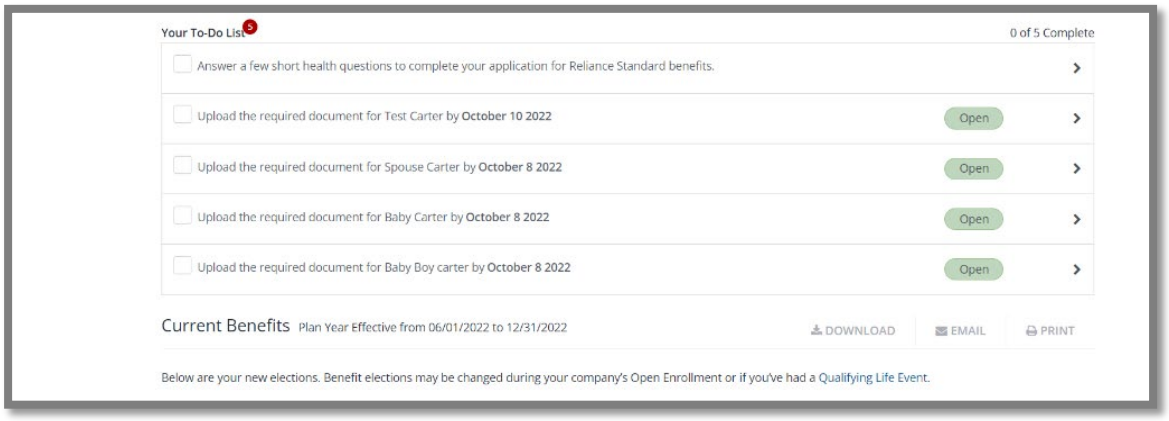
Review and Check Out

Click “Send by Email” to receive a confirmation statement



Review your “To-Do” List

Upload any required documents



PLAN NOTICES AND DISCLOSURES

IMPORTANT STATE AND FEDERAL NOTICES

These notices, along with Summary Plan Descriptions (SPD) and Summary of Benefits and Coverage (SBC's) can be obtained from the Human Resources SharePoint site.

Medicare Part D Notice

Important Notice from Seminole County Government About
Your Prescription Drug Coverage and Medicare

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:

1. 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.

2. Seminole County has determined that the prescription drug coverage offered by the CIGNA medical plans 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. Because 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 15th to December 7th.

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 Seminole County Government coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the CIGNA medical plans is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Seminole County Government prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 with Seminole County Government 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 nineteen 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 the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Seminole County Government 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 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 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 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 you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Seminole County Government
Contact-Position/Office:	Human Resources
Address:	1101 E. 1st Street, 3rd Floor, Sanford, FL 32771
Phone Number:	407-665-5272

PLAN NOTICES AND DISCLOSURES

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator 407-665-5272.

Newborns and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not more than 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 407-665-5272.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Seminole County Government's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Seminole County Government's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent because of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Seminole County Government's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Seminole County Government describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Seminole County Government, Human Resources, 1101 E. 1st Street, 3rd Floor, Sanford, FL 32771, 407-665-5272.

Michelle's Law

The Seminole County Government health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Human Resources in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Notice of Availability of Alternative Standard for Wellness Plan

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 407-665-5272 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you considering your health status.

PLAN NOTICES AND DISCLOSURES

Notice Regarding Wellness Program

Seminole County Government's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which would include a blood test for glucose, HDL, LDL, triglycerides, and total cholesterol. You are not required to complete an HRA or to participate in any blood tests or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of wellness preferred rates for completing an annual physical, lab work, and completing activities to achieve 5 points. Although you are not required to complete an HRA or participate in any biometric screenings, only employees who do so will be eligible for the wellness preferred rates.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at 407-665-5272.

The information from your HRA and/or the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Seminole County Government may use aggregate information it collects to design a program based on identified health risks in the workplace, Seminole County Government's wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual that may receive your personally identifiable health information is a health coach to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 407-665-5272.

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)**.

PLAN NOTICES AND DISCLOSURES

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – 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
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://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
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2
INDIANA – Medicaid
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: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884

PLAN NOTICES AND DISCLOSURES

KENTUCKY – 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: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102

MINNESOTA – 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

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
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, 2024, 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.


SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE


Alliant