PASCO COUNTY FLORIDA

OPEN SPACES. VIBRANT PLACES.

2019-2020 Benefits Guide

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This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

OVERVIEW

Pasco County understands that your benefits are important to you and your family. Helping you understand the benefits available to you is essential. This Benefits Guide provides a description of our company's benefit program.

This guide is not an employee/employer contract. It is not intended to cover all provisions of all plans, but rather a quick reference to help answer most of your questions. Please see the carrier benefit summaries for more details.

Included in this guide are summary explanations of the benefits, as well as contact information for each provider. It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you.

We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable copayment and deductibles, how to file claims, preauthorization requirements, participating networks and services that may be limited or not covered (exclusions). We hope this guide will give you an overview of your benefits and help you be better prepared for the enrollment process.

Eligibility

Benefit eligible employees are provided an opportunity to participate in the Pasco County sponsored benefits program upon initial hire and annually during Open Enrollment. You are eligible for benefits on the first day of the month following 60 days if you are a full-time employee. Please refer to the following guidelines regarding eligibility and election changes.

Dependent Eligibility—Medical, Dental & Vision

A dependent is defined as a covered employee's legal spouse or a dependent child of the employee or employee's spouse. Dependent children may be covered until the end of the calendar year in which they turn age 26. A dependent child is defined as:

- A natural child
- A step-child
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the covered employee or the employee's spouse
- Unmarried children of any age who become mentally or physically disabled before reaching the age limit

FL Statute 627.6562 Dependent Coverage: Health insurance coverage may be available for dependents ages 26 to 30. Please contact your Human Resources Department for more information.

Qualifying Event

Coverage elections made at Open Enrollment cannot be changed until the next annual Open Enrollment period. The only exception to this IRS Section 125 Rule is if you experience a "Qualifying Event." A Qualifying Event allows you to make a change to level of coverage within 30 days of the event.

Examples of Qualifying Events include, but are not limited to:

- Marriage
- Divorce
- Birth, adoption, or legal custody of a dependent child
- Involuntary loss of other group insurance coverage
- Death
- Spouse's open enrollment

If you experience a Qualifying Event, contact Human Resources and submit all required documents within 30 days of the event.

Your Responsibility

Before you enroll, make sure you understand the plans and ask questions if you do not. After you enroll, you should always check your first paycheck stub to make sure that the correct amount is being deducted and all of the benefits you elected are included.

Any corrections must be made within the first 30 days of enrollment. You should also verify that all beneficiary information is up to date.

MEDICAL & PHARMACY

Administered by Florida Blue

Pasco County is providing five plan options through **Florida Blue**. The plans offered are the Blue Options 3900 (PPO), BlueCare 52 (HMO), Blue Options 5781 (PPO), BlueCare 56 (HMO), Blue Care 122/123 (HMO HSA) plan.

The BlueCare HMO plans consist of a broad network of physicians and hospitals. Benefits are provided for services rendered only by participating physicians and facilities. Services rendered by non-participating physicians and facilities are not covered unless it is an emergency. If you elect one of the BlueCare options you will need to elect a primary care physician, however, you do not need referrals to see specialists.

One of the HMO plans is a Health Savings Account (HSA) eligible plan. Learn more about HSAs on page 8.

The BlueOptions PPO plans also provide you access to a broad physician and hospital network. Under these plans you are not required to elect a primary care physician and out-of-network benefits are available. However, you will always save on out-of-pocket costs by seeking out services within the BlueOptions network.

Please note: If you do not actively enroll or actively waive coverage, you will automatically be enrolled in the Blue Options 3900 plan.

You can locate a physician by contacting Florida Blue Member Services at **800.352.2583** or on **www.floridablue.com**.

Explanation of Calendar Year Deductible and Calendar Year Out-of-Pocket Maximum

Calendar Year Deductible

The Calendar Year Deductible is a specified dollar amount that you must pay for certain covered services per calendar year. There are individual and family deductibles. Once an individual or a family deductible has been satisfied, then coinsurance applies, if applicable. Coinsurance is your share of the costs of a health care service. It is the amount a member pays after the deductible has been met.

Calendar Year Out-of-Pocket Maximum

The Calendar Year Out-of-Pocket Maximum is the amount of covered expenses, (including deductible, coinsurance, and copayments) that must be paid by you, either individually or combined as a covered family.

After the individual/family out-of-pocket maximum has been satisfied in a calendar year, payment for in-network covered services requiring copayment and coinsurance for that covered individual/family will be payable by Florida Blue at the rate of 100% for the remainder of the calendar year, subject to any other terms, limitation, and exclusions.

EMPLOYEE CONTRIBUTIONS MONTHLY

***Employee may receive a $10 per pay ($20 per month) discount with a valid Tobacco Free Survey response.**

Medical Coverage	Blue Options 3900 (PPO)	BlueCare 52 (HMO)	Blue Options 5781 (PPO)	BlueCare 56 (HMO)	BlueCare 122/123 HMO with HSA
Employee Only	$20.00	$50.00	$50.00	$60.00	$20.00
Employee + Spouse	$80.00	$290.00	$200.00	$400.00	$80.00
Employee + Child(ren)	$30.00	$120.00	$40.00	$180.00	$30.00
Employee + Family	$220.00	$490.00	$490.00	$670.00	$220.00

Dental Coverage	Florida Combined BlueDental P210 DHMO	Florida Combined BlueDental Choice PPO Copayment	Florida Combined Choice PPO	Humana DHMO CS 250	Humana PPO 14
Employee Only	$7.50	$16.34	$29.38	$11.36	$15.46
Employee + One	$13.56	$33.62	$60.50	$21.60	$29.74
Employee + 2 or more	$22.36	$55.32	$99.52	$29.42	$51.04

Vision Coverage	Option A – Low	Option B – High
Employee Only	$3.94	$4.98
Employee + Spouse	$8.36	$10.72
Employee + Child(ren)	$8.00	$10.26
Employee + Family	$13.34	$17.12

MEDICAL & PHARMACY

Medical Plan Comparison

Carrier Name	Florida Blue		
Type of Plan	Blue Options 3900 (PPO)		BlueCare 52 (HMO)
Network Access	In-Network (Blue Options)	Out-of-Network	In-Network
Plan Year Deductibles (CYD)			
Individual	$1,500	$4,500	$1,500
Family	N/A, Each Person Meets CYD	N/A, Each Person Meets CYD	N/A, Each Person Meets CYD
Your Benefit Plan			
Coinsurance (when applicable)	50%	50%	30%
Individual Out-of-Pocket Maximum	$6,350	$20,000	$6,350
Family Out-of-Pocket Maximum	$12,700	$20,000	$12,700
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Professional Services			
Primary Care Physician (PCP) Office Visits	$35 Copay	50% After CYD	$40 Copay
Specialist Office Visits	$50 Copay	50% After CYD	$65 Copay
Preventive Care Visits	No charge	50%	No charge
Hospital Services			
Inpatient Hospitalization	Option 1 – $1,500 Option 2 – $2,500	50% After CYD	30% After CYD
Outpatient Hospitalization	Option 1 – $300 Option 2 – $400	50% After CYD	30% After CYD
Urgent Care Center	50% After CYD	50% After CYD	$85 Copay
Emergency Room	50% After CYD	50% After In-Network CYD	$300 Copay
Independent Lab / X-Ray	No charge Lab / 50% After CYD X-Ray	50% After CYD	No charge Lab / $65 Copay X-Ray
MRI, MRA, CT and PET – Facility	$200 Copay	50% After CYD	$200 Copay
Pharmacy			
Tier 1	$10 Copay (Generic Only)	50% (Generic Only)	$10 Copay
Tier 2	Not covered	Not covered	$30 Copay
Tier 3	Not covered	Not covered	$50 Copay
Mail Order Pharmacy (90-days)	$25 Copay (Generic Only)	Not covered	2.5x Copay

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

MEDICAL & PHARMACY

Medical Plan Comparison

Carrier Name	Florida Blue		
Type of Plan	Blue Options 5781 (PPO)		BlueCare 56 (HMO)
Network Access	In-Network	Out-of-Network	In-Network
Plan Year Deductibles (CYD)			
Individual	$1,500	$4,500	$0
Family	$4,500	$13,500	$0
Your Benefit Plan			
Coinsurance (when applicable)	30%	50%	0%
Individual Out-of-Pocket Maximum	$5,500	$11,000	$2,000
Family Out-of-Pocket Maximum	$11,000	$22,000	$4,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Professional Services			
Primary Care Physician (PCP) Office Visits	$30 Copay	50% After CYD	$25 Copay
Specialist Office Visits	$55 Copay	50% After CYD	$35 Copay
Preventive Care Visits	No charge	50%	No charge
Hospital Services			
Inpatient Hospitalization	30% After CYD	$500 + 50% After CYD	$300 per day, up to $1,500
Outpatient Hospitalization	30% After CYD	50% After CYD	$100 per visit
Urgent Care Center	$60 Copay	$60 After CYD	$35 Copay
Emergency Room	$250 Copay	$250 Copay	$250 Copay
Independent Lab / X-Ray	No charge Lab / $50 Copay X-Ray	50% After CYD	No charge
MRI, MRA, CT and PET – Facility	$250 Copay	50% After CYD	$200 Copay
Pharmacy			
Tier 1	$10 Copay	50%	$10 Copay
Tier 2	$60 Copay	50%	$25 Copay
Tier 3	$100 Copay	50%	$40 Copay
Mail Order Pharmacy (90-days)	2.5x Copay	Not covered	2x Copay

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

MEDICAL & PHARMACY

Health Savings Account
One of our 2019 plan options is a Health Savings Account (HSA) Compatible Plan–BlueCare 122/123 illustrated to the left.

A Health Savings Account is a tax-advantaged savings account that belongs to you. It is an account paired with a qualifying high-deductible health plan.

Traditional plans have high premiums. At the end of the year, all of the money you have spent on premiums is gone. On the other hand, with a health savings account, the premium is lower, and some of the money you have spent on premiums can go into your savings account instead.

The account belongs to you! You will not lose your money and you take the money with you if you leave your job, retire, or drop out of the health plan. You can use the money in your savings account to pay for qualified out of pocket healthcare expenses, such as deductibles, eyeglasses, dental work, Medicare premiums, and much more.

For all individuals who join the HSA plan 122/123, Pasco County will contribute $100 a month into your account! If you are enrolled in the plan 12 months, this is $1,200 in a savings account that belongs to you! You may contribute an additional pre-tax amount of up to $2,300 as an individual and $5,800 if enrolled in a family plan. If you are over age 55 you can add a catch up contribution of an additional $1,000.

The funds in your account must be used for qualified healthcare expenses. Using the funds for items other than those approved by the IRS will result in a 20% penalty to you.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

Carrier Name	Florida Blue	
Type of Plan	**BlueCare 122 – Individual (HMO/HSA Compatible Plan)**	**BlueCare 123 – Family (HMO/HSA Compatible Plan)**
Network Access	In-Network	
Plan Year Deductibles (CYD)		
Individual	$5,000	$5,000
Family	N/A	$10,000
Your Benefit Plan		
Coinsurance (when applicable)	10%	10%
Individual Out-of-Pocket Maximum	$6,550	$6,850
Family Out-of-Pocket Maximum	N/A	$10,000
Lifetime Maximum Benefit	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP) Office Visits	10% After CYD	10% After CYD
Specialist Office Visits	10% After CYD	10% After CYD
Preventive Care Visits	No charge	No charge
Hospital Services		
Inpatient Hospitalization	10% After CYD	10% After CYD
Outpatient Hospitalization	10% After CYD	10% After CYD
Urgent Care Center	10% After CYD	10% After CYD
Emergency Room	10% After CYD	10% After CYD
Independent Lab / X-Ray	10% After CYD	10% After CYD
MRI, MRA, CT and PET– Facility	10% After CYD	10% After CYD
Pharmacy		
Tier 1	$10 After CYD	$10 After CYD
Tier 2	$50 After CYD	$50 After CYD
Tier 3	$80 After CYD	$80 After CYD
Mail Order Pharmacy (90-days)	2.5x Copay After CYD	2.5x Copay After CYD

PROVIDER DIRECTORY

Finding Quality Care While Saving Money – Log in to your Florida Blue member account today!
When you receive your Florida Blue member ID card go to **www.floridablue.com** and click on login/register in the upper right corner of the page. You will be able to:

Research hospitals and facilities – Your cost may vary depending on where you go for care. With the Medical Services Cost Estimator tool, you can research and compare facilities based on their quality, expertise and price.

Compare drug costs and save – Use the interactive Drug Shopper that will show you your cost for brand and generic drugs at pharmacies you select. With mail-order benefits, you will see how much you can save by ordering a 90-day supply.

Save money by using your benefits wisely – When you're faced with major health care decisions, such as surgery, diagnostic tests or ongoing treatment, you have access to a team of Care Consultants.

Care Consultants understand your benefits and treatment choices that can save you time and money.

Take advantage of member discounts – With discounts up to 60% on health-related services such as gym membership, weight loss programs, vision care and travel, you will have more affordable choices to help you stay healthy.

Make lab appointments online with Quest Diagnostics – Our members save the most money by using Quest Diagnostics for lab services in Florida. And when you make your appointment online, you will also save valuable time!

How to locate an In-Network doctor

Find a Plan   Find a Doctor   Find a Florida Blue Center   Log in

1. Go to **www.FloridaBlue.com**
2. Click on Find a Doctor
3. On the drop down under "Just Browsing? Select a Plan", click on either:
4. "BlueCare (HMO)" or "BlueOptions"
5. From there you can search by provider name, location, type, etc.

Just Browsing? Select a Plan

Find a provider that accepts your plan by selecting from the dropdown list below, or login your Member Account, and we will access your plan for you.

BlueCare (HMO)

Continue

EMPLOYEE WELLNESS CENTERS

Administered by Healthstat

The most important thing you can do for you and your family is to stay healthy. Pasco County has partnered with Healthstat to provide a Wellness Center just for you! Our onsite Wellness Center offers Acute Care, Preventive Care and Disease Management and will help you meet your goals and is open to all Pasco County employees, spouses, dependents and retirees **enrolled** in the health insurance plan.

Eligibility

Member may use the Wellness Center when they become benefit eligible and are enrolled in one of the Medical Health Plans.

Visit our Wellness Centers and receive:

Acute Care – Do you have a cold, flu, headache or sore throat?

Preventive Care – Stay Healthy! Get your annual physical as well as vaccinations.

Disease Management – Get help developing a treatment plan for chronic conditions such as asthma, diabetes and weight management

You can depend on Quality of Care at our Wellness Center: On staff:

Physician – Board-certified with a minimum of five years in primary care specialty.

Nurse Practitioner – performs physicals, interprets tests and provides treatment. The nurse practitioner has a Masters or Doctor's of Nursing Degree.

Locations and Hours

Port Richey

7421 Ridge Rd., Unit 110 Port Richey, FL 34668

Monday- Friday:
7:00 a.m.- 6:00 p.m.
Saturday: 7:00 a.m. - 12:00 p.m.

Dade City

36739 State Road 52, Suite 104
Dade City, FL 33525

Tuesday and Thursday:
7:00 a.m.- 6:00 p.m.

NEW!

Land O' Lakes

4111 Land O' Lakes Blvd., Suite 301
Land O'Lakes, FL 34639

Monday, Wednesday, Friday:
7:00 a.m.- 6:00 p.m.

Saturday: 7:00 a.m.- 12:00 p.m.

Schedule an appointment: 866.959.9355
Scheduling Line open
Monday- 7am- 5pm, Tuesday to Friday 7am- 8pm and Saturday 9am- 1pm
Online scheduling available after the first visit!

The wellness center is dedicated to help our employees with acute and preventive care as well as development of a healthy living plan and disease management. The centers should not be used to treat emergency situations such as head injuries, open wounds or chest pains. The wellness centers are not equipped with x-ray or imaging equipment.

URGENT CARE VS. EMERGENCY CARE

Choosing the Right Health Care Setting - Emergency Room and Urgent Care
When an emergency strikes, you know you need medical care fast. But what if you're not sure if it's a true emergency?

While the answer is not always simple, knowing the difference between urgent care and emergency care and where to seek treatment could save you time and money.

Symptoms

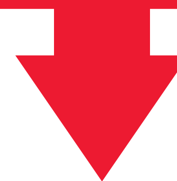
- Fever, colds and flu
- Sprains, strains and broken bones (without obvious deformity)
- Minor allergic reactions and asthma attacks
- Ear or sinus pain
- Nausea, vomiting and diarrhea
- Rashes
- Sore throat
- Stitches
- Cuts and scrapes
- Frequent and painful urination
- Minor head injuries without loss of consciousness
- Heat stroke and dehydration

Urgent Care

When you need treatment right away for minor illnesses and injuries

Symptoms

- Chest pain, numbness n face, arm or leg, or difficulty speaking
- Heart attack
- Life-threatening or disabling conditions
- Severe shortness of breath
- Coughing up or vomiting blood
- Symptoms of stroke
- Sudden or unexplained loss of consciousness
- High fever with stiff neck, mental confusion or difficulty breathing
- Wound that will not be stop bleeding
- Inability to urinate
- Head injury with loss of consciousness
- Infants under eight weeks with fever



Emergency Care

When you need immediate treatment for serious illnesses and injuries CALL 911.

Be prepared for medical care
Whether you're going to urgent care or the ER, take with you a list of all current prescription medications including dosages and any over-the-counter medications and vitamins. Many medications and even vitamins, can interact with the treatment options your physician recommends.

Also, take with you a list of any known allergies especially to medications. The list should include any previous invasive medical procedures and surgeries, the dates they were done and the names of the physicians or surgeons who treated you.

DENTAL BENEFITS

Administered by Florida Combined Life / Florida Blue Dental

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with Pasco County's dental benefit plans. You have a total of five dental plan options available to you; three options with Florida Combined and two options with Humana.

Florida Combined Life provides you a choice between (1) a Dental DHMO, (2) a Dental PPO with copayments, and (3) a Dental PPO.

DHMO

When you select the DHMO (BlueDental Care), you will need to select a contracted dentist for each family member. When seeking dental care, you must go to your DHMO-selected dentist in order to receive plan benefits. Plan benefits are not available when you seek care from a non-contracted dentist.

The DHMO offers you comprehensive dental benefits at an affordable payroll deduction. All benefits are subject to a schedule that outlines copays and charges for services. For a complete summary of copays by procedure, please refer to the Florida Combined Life BlueDental Care benefit summary.

In order to change your DHMO dentist, you should contact Florida Combined Life and make a primary dentist selection change.

PPO

BlueDental Choice Copayment
This PPO is a lower cost, easy-to-use program that stresses preventive care. You have the freedom to go in or outside of the Blue network, but you will always save on out-of-pocket costs by seeking out care from a participating dentist. When you use a participating dentist, you will pay a specified copayment for each procedure, and you will always know up front what your cost will be.

BlueDental Choice
This PPO allows you the freedom to go in or outside of the network and includes an annual deductible and plan maximum. Your coinsurance will be based on the service rendered.

Please note: there is a 12 month waiting period for major services under the PPO plan. Unless you had prior creditable coverage with the County under another dental plan, you will not be eligible for benefits for services listed under the major services category (Type III) for 12 months.

Dental Insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. DBA Florida Blue. These companies are independent licenses of the Blue Cross and Blue Shield Association.

DENTAL BENEFITS

Dental Plan Comparison

Carrier Name	Florida Combined Life (Florida BlueDental)				
Type of Plan	BlueDental Care P210 DHMO	BlueDental Choice PPO Copayment		BlueDental Choice PPO	
Network Access	In-Network	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Maximum	$0	$1,000		$2,000	
Your Responsibility					
Calendar Year Deductible (CYD)					
Individual / Family	$0	$50 / $150		$100 / $300	
Preventive-Class I					
Routine Office Visits	$10 copay	$0	30%	$0	20%
Teeth Cleaning	$0	$10 copay	30%	$0	20%
Full Mouth / Panoramic X-rays	$0	$17 copay	50% after CYD	20% after CYD	50% after CYD
Basic-Class II					
Fillings	See Benefit Summary	See Benefit Summary	50% after CYD	20% after CYD	50% after CYD
Simple Extractions	$35 copay	$17 copay	50% after CYD	20% after CYD	50% after CYD
Periodontal scaling	$65 copay per quadrant	$61 copay per quadrant	65% after CYD	20% after CYD	50% after CYD
Endodontics	See Benefit Summary	See Benefit Summary	65% after CYD	20% after CYD	50% after CYD
Major-Class III					
Dentures	$375 + Lab	See Benefit Summary	65% After CYD	50% after CYD	70% after CYD
Crowns*	$370 per tooth	See Benefit Summary	65% After CYD	50% after CYD	70% after CYD
Child and Adult Orthodontia					
Benefit	25% discount **	20% discount**	Not Covered	20% discount**	Not Covered

*Out of Network Benefits subject to Balance Billing for charges over the reimbursement schedule
**Not all Providers participate in discount

DENTAL BENEFITS

Administered by Humana

Humana provides you with additional dental plan options by offering: (1) a Dental DHMO and (2) a Dental PPO.

DHMO (CS 250)

When you select the DHMO you will have the opportunity to visit any of the general dentists within the Humana network as well as the alternative of seeing a network Specialist Dentist to complete more intricate procedures. When you consult the schedule of benefits, you will know up front how much your out-of-pocket will be. Any procedure not listed in the schedule of benefits is eligible for a 25% discount.

When you enroll in the Humana DHMO, you will want to elect your primary care dentist. This election can be changed at any time by calling Humana or by logging into: **www.mycompbenefits.com**.

PPO 14

This PPO emphasizes preventive care routine exams, cleanings, and x-rays the simplest way to keep those nasty toothaches away. You can obtain benefits in or outside of the Humana network. You will always save on out-of-pocket costs by seeking services from a provider within the network.

Please note: There is a 12 month waiting period for major services under the PPO plan. Unless you had prior creditable coverage with the County under another dental plan, you will not be eligible for benefits for services listed under the major services category (Type III) for 12 months.

Predetermination Review- Humana can assist you and your dentist by determining which benefits would be payable for services and procedures. Have your dentist fax your treatment plan to Humana, note that it is a predetermination review and Humana will let your dentist know which benefits would be payable.

Carrier Name	Humana/CompBenefits		
Type of Plan	DHMO CS 250	PPO 14	
Network Access	In-Network	In-Network	Out-of-Network
Calendar Year Maximum	$0	$1,000	
Your Responsibility			
Calendar Year Deductible			
Individual / Family	$0	$50 / $150	
Preventive -Class I			
Routine Office Visits	$5 copay	$0	20%
Teeth Cleaning	$0	$0	20%
Full Mouth / Panoramic X-rays	$0	20% after CYD	50% after CYD
Basic-Class II			
Fillings	See Schedule of Benefits	20% after CYD	50% after CYD
Simple Extractions	$25 copay	20% after CYD	50% after CYD
Periodontal Scaling	$55 copay per quadrant	50% after CYD	50% after CYD
Endodontics	See Schedule of Benefits	50% after CYD	50% after CYD
Major-Class III			
Dentures	$325 + lab	50% After CYD	50% After CYD
Crowns	$310 per tooth + lab	50% After CYD	50% After CYD
Child and Adult Orthodontia			
Benefit	See Schedule of Benefits	Not covered	

VISION BENEFITS

Administered by Humana Vision

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

The Humana vision program is being offered as a part of Pasco County's commitment to your well-being. You have the option of choosing one of the two plans being offered: Plan A or Plan B.

Pasco County's vision program provides affordable, quality vision care, nationwide. Through the Humana provider network, you can obtain a comprehensive vision examination, as well as eyeglasses (lenses and frames), or contact lenses in lieu of eyeglasses.

Carefully review the vision care program summary provided and take advantage of this very important benefit coverage.

Carrier Name	Humana			
Type of Plan	**Option A – Low**		**Option B – High**	
Network Access	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Care Wellness Copay	$10		$10	
Eye Exam	No charge after copay	Reimbursed up to $30	No charge after copay	Reimbursed up to $30
Frequency	12 Months		12 Months	
Materials Copay	$25		$25	
Lenses				
Single Vision	No charge after copay	Reimbursed up to $25	No charge after copay	Reimbursed up to $25
Bifocals	No charge after copay	Reimbursed up to $40	No charge after copay	Reimbursed up to $40
Trifocals	No charge after copay	Reimbursed up to $60	No charge after copay	Reimbursed up to $60
Frequency	12 months		12 months	
Frames				
Selected Frames	$130 allowance + 20% discount on any overage	Reimbursed up to $65	$150 allowance + 20% discount on any overage	Reimbursed up to $65
Frequency	24 Months		12 Months	
Contacts Copay	**(In Lieu of Any Other Eyewear Benefits)**			
Elective	$130 allowance after copay	Reimbursed up to $104	$150 allowance after copay	Reimbursed up to $104
Medically Necessary	Covered in full	Reimbursed up to $200	Covered in full	Reimbursed up to $200
Frequency	12 Months		12 Months	
Value Added Discounts				
Eyewear	Discounts available		Discounts available	
Lasik	Discounts available		Discounts available	

MyHumana

Register now at **Humana.com**

Find your personalized benefits information in one place – MyHumana

As a Humana member, you have a secure website on **Humana.com** called MyHumana. With MyHumana, you have fast, easy access to your personalized benefits information, planning tools and wellness resources.

Some of what you can do on MyHumana:

- Claims – Check if a claim has been paid along with your estimated cost, if any
- ID cards – View, print and email up-to-date medical and dental Humana member ID cards
- Coverage details – Review deductibles, coverage levels and limits
- Provider search – Use "Find a doctor" to find in-network providers near you
- Update your communications preferences – Select which communications you want to receive from Humana and how you want to receive them – via paper or email

Registering is easy

- Have your Humana member ID or Social Security number available
- Go to **Humana.com,** Select **"Sign In"** at the top of the page
- Select "**Register Now**" at the right of the page, and then "Get Started"
- Choose "**All other members"**
- Fill in some basic information – like your Humana member ID number (first 9 digits) or Social Security number, date of birth, ZIP code, and email and click "next"
- Create a username, password and security prompt and click "next" to finish

Now, how easy was that? You're all set – jump in and start exploring!

You don't have to wait for health and benefits guidance – you can get it right away with MyHumana.

Please note, all features may not be available to all members.

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FLEXIBLE SPENDING ACCOUNTS (FSA)

Administered by Maestro

Health Care FSA

As an eligible employee, you may enroll in a Health Care Flexible Spending Account if you meet the definition of eligibility described on page two (2).

Flexible Spending Accounts (FSA) help you save money by providing a way to pay for certain types of health care on a pre-tax basis.

How an FSA works

During Open Enrollment, you decide how much money you want to contribute. The minimum contribution is $5 per paycheck and the maximum is $2,700 per year.

A way to save taxes

Enrolling in an FSA can save you money by reducing your taxable income. Your total savings will depend upon your family income, tax status and expected amount of health care costs.

The contributions you make to a Flexible Spending Account are deducted from your wages before your Federal, State or Social Security taxes are calculated and are not reported to the IRS.

Once enrolled in a health care FSA you will receive a benefit debit card for use when paying for approved medical expenses at the point of service. There is no need to file a claim! Your entire election is available to you at the beginning of the plan year, which is October 1st.

Estimate expenses carefully

To receive the greatest savings, you must carefully estimate the amount of eligible out-of-pocket expenses you will have for the plan year. Once you have estimated the total amount, divide it by number of pay periods (24). That amount is what you may want to have deducted from your gross pay (before taxes) each pay period to be used to fund your Flexible Spending Account.

If you terminate employment before the end of the plan year and have an account balance, you may be eligible to elect COBRA for this benefit. If you do not elect COBRA, any unclaimed contributions will be forfeited. You have 60 days from date of termination to file claims for expenses incurred prior to termination.

Rollover Up to $500

Although we still want you to be conservative in your calculations, you are able to rollover up to $500 of unused funds into each plan year. Any unused amount remaining in the account over $500 will be forfeited according to IRS regulations.

For Health Savings Account Participants

If you elect to participate in the BlueCare 122/123 plan and elect an HSA deduction you are not eligible to participate in the Flexible Spending Account plan.

To estimate your health care expenses for the coming plan year, be sure to review your monthly health expenses from last year. Using these figures as a guideline, you can better estimate the amount of expenses you will most likely incur in the twelve month period.

Eligible expenses

According to IRS regulations, the following are eligible expenses under a Health Care FSA. These expenses must be incurred during the short plan year and must not be eligible for reimbursement from insurance policies or any other source. Also, expenses can only be incurred by you, your spouse or any dependent (if you furnished more than over one half of the dependent's support during the plan year).

Examples of eligible expense include:

- artificial limbs, eyes, etc.
- chiropractic care, licensed services/practitioner
- deductibles/coinsurance (if not reimbursed from another source)
- dental fees, including braces, treatments, etc.
- prescription drugs
- durable medical equipment, wheelchairs, etc.
- prescription eyeglasses and contact lenses, solutions, enzymes
- hearing aids and batteries
- nursing home (for medical reasons)
- ophthalmologist, optometrist services
- orthodontic expenses
- physical examinations
- radial keratotomy (PRK, LASIK)
- smoking cessation programs and prescription medication
- transportation, tolls or parking expense for medical care vaccinations, immunizations

FLEXIBLE SPENDING ACCOUNTS (FSA) (CONT'D)

Qualified Expenses

In addition to medical, dental and vision expenses, keep in mind that your savings account can be used to pay premiums for the following specified plans and situations:

- COBRA
- Qualified Long-Term Care Plans (up to specific limits)
- Premiums for health coverage during a period of unemployment
- Retiree health plan contributions (age 65 or older only under an employer's retiree health plan)
- Medicare Part B, Part D and Medicare Advantage (age 65 and over only)

Dependent Care FSA

NEW!

This account allows participant to set aside up to an annual maximum of $5,000 if the participating employee is single or married and files a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and adults. Please note, if a family's income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by ComPsych

From time to time, many of us face problems at work or at home that we are not sure how to handle. These can range from employer problems to marital problems or even substance abuse. Pasco County is pleased to offer its employees a confidential Employee Assistance Program administered by ComPsych.

This program offers you professional assistance in dealing with almost any life issue. From stress or depression to legal or financial issues, Pasco County **EAP can help!**

These services are available to you and your dependents by calling a toll-free phone line open 24 hours a day/7 days a week. All conversations are confidential and private. In addition to support over the telephone, each employee and family member can receive up to 6 sessions with a counselor per issue each calendar year.

Types of issues for which you can obtain support:

- **Confidential Counseling** for stress, depression, family issues, substance abuse, child care, work life services, educational resources, marriage counseling, and elder care resources.
- **Financial Information & Resources** such as investment plans, estate planning, debt reduction, retirement planning, bankruptcy, tax support, college funding, and budget management.
- **Legal Support & Resources** including telephonic counseling, referrals and discounts for services, such as creating or modifying a will, consumer issues, criminal matters, living wills, power of attorney, separation and divorce, and traffic matters. The first 30 minutes is free, then a 25% reduced rate will be charged thereafter.
- **GuidanceResources Online** information on work, school, children, wellness, legal and financial issues, and more. Contains timely articles and "ask the expert" for personal responses to your questions.

Confidential and Here to Help!

Web Address: **www.guidanceresources.com**

Company Web ID COM589

Employee Services: **800.272.7255**

LIFE INSURANCE

Administered by Sun Life

Basic Life Insurance

Pasco County provides all full-time eligible employees with a Basic Life insurance benefit in the amount of the greater of $50,000 or 1x annual salary at no cost to you. Basic Life of $50,000 is reduced by 50% at age 70, therefore anyone over the age of 70 would be paid $25,000.

The Plan will also match your Basic Life Insurance benefit for Accidental Death or Dismemberment (AD&D). The AD&D benefit will provide your beneficiary with an additional amount equal to the life insurance in force if death is due to an accident. If the employee is dismembered (such as loss of an eye or limb), benefits will be paid to the employee as a percentage of the AD&D amount.

Beneficiary Information

Please make sure that your beneficiary information is up to date and correct. Please contact the Human Resources department for a beneficiary form if you need to make changes. If you do not specify a beneficiary, benefits will be distributed in accordance with the insurance contract, and/or by law.

Supplemental Life Insurance

You can purchase supplemental life insurance for yourself and your dependents through Sun Life. In order to elect coverage for your dependent spouse and/or child(ren), you must elect additional coverage for yourself. Employee & Spouse rates vary depending on age and benefit amount.

- **Employee Coverage:** As an employee, you can apply for additional life insurance in increments of $10,000 not to exceed $500,000 or 7 times your annual earnings, whichever is less. The guaranteed issue amount for newly eligible employees is $100,000. Amounts over $100,000 will require medical underwriting.
- **Spouse Coverage:** As an employee, you can apply for additional life insurance for your spouse in increments of $5,000 not to exceed 50% of your elected voluntary insurance amount. You may purchase additional life insurance for your spouse in amounts between $5,000 to a maximum of $50,000.
- **Child(ren) Coverage**: As an employee, you can purchase life insurance for your child(ren) up to a maximum of $25,000. Children from birth to 14 days are not eligible for a benefit. Unmarried children age 14 days to 26 years are eligible for coverage in increments of $5,000 up to the maximum of $25,000. One premium amount covers all children; not just one child.

VOLUNTARY ACCIDENT INSURANCE AND VOLUNTARY RATES

Voluntary Accidental Death & Dismemberment Insurance

You can also elect voluntary Accidental Death & Dismemberment coverage for yourself and your dependents. Benefits are payable if death is due to a covered accident. Benefits are also payable for accidental loss of limb, sight or speech.

Employee—Increments of $10,000 to a maximum of $100,000

Spouse— You can elect 40% of the amount you elected for yourself if you also choose to cover your child(ren). You may elect 50% of your benefit amount if you have no children on the plan.

Child(ren)- If you have elected coverage for your spouse you can elect 10% of your benefit amount for your children. If you have no spouse on the plan, you many elect 15% of your benefit amount.

Note: At age 70, Supplemental and Basic Life Insurance coverage is reduced by 50%. Reduction in AD&D for employee at ages 75 and age 80. Spouses Age 70 and over are not eligible for AD&D coverage.

Employee Supplemental Life Monthly Premium (Post-Tax)

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
Under 25	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
25-29	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$4.90	$5.60	$7.30	$7.00
30-34	$0.80	$1.60	$2.40	$3.20	$4.00	$4.80	$5.60	$6.40	$7.20	$8.00
35-39	$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$7.00	$8.00	$9.00	$10.00
40-44	$1.30	$2.60	$3.90	$5.20	$6.50	$7.80	$9.10	$10.40	$11.70	$13.00
45-49	$2.20	$4.40	$6.60	$8.80	$11.00	$13.20	$15.40	$17.60	$19.80	$22.00
50-54	$3.60	$7.20	$10.80	$14.40	$18.00	$21.60	$25.20	$28.80	$32.40	$36.00
55-59	$6.20	$12.40	$18.60	$24.80	$31.00	$37.20	$43.40	$49.60	$55.80	$62.00
60-64	$9.70	$19.40	$29.10	$38.80	$48.50	$58.20	$67.90	$77.60	$87.30	$97.00
65-69	$10.50	$21.00	$31.50	$42.00	$52.50	$63.00	$73.50	$84.00	$94.50	$105.00
70+	$14.30	$28.60	$42.90	$57.20	$71.50	$85.80	$100.10	$114.40	$128.70	$143.00

Voluntary Accidental Death & Dismemberment (Post-Tax)

Age	Employee Monthly Rates per $10,000 of Coverage*	Family Monthly Rates per $10,000 of Coverage*
All Ages	$0.30	$0.50

Coverage		Increment	=	Units	X	Rate	=	Monthly Premium
$	÷	$10,000	=		X	$	=	

DISABILITY INSURANCE

Administered by Sun Life

Long-Term Disability (LTD)

You are automatically enrolled in the Pasco County Long-Term Disability (LTD) insurance plan provided by Sun Life Insurance. There is a 90-day elimination period before LTD will start paying you for lost income. If you are approved for benefits, the plan will provide for lost wages in the event that you are unable to work due to sickness or an off the job injury. LTD will provide 40% of your monthly earnings up to a maximum of $5,000 per month. You can elect to increase your benefit to 60% at an additional cost to you. If you elect the buy up option after your initial eligibility date, you will be subject to medical underwriting.

Pre-Existing Conditions: A pre-existing condition is an illness or any related condition for which a member received services, supplies or medication during the 3 months before the enrollment date. Benefits are not payable for a pre-existing condition until you have been enrolled for 12 months.

Short-Term Disability (STD)

This important benefit provides a source of income should you become disabled from a non-work related injury or illness. Short-Term Disability provides 66.67% of your weekly earnings to a maximum weekly benefit of $500. The benefit starts after 14 calendar days due to sickness or injury, the weekly benefit is paid as long as you are to be determined to be disabled, up to a maximum of 13 weeks.

Pre-Existing Conditions: A pre-existing condition is an illness or any related condition for which a member received services, supplies or medication during the 3 months before the enrollment date. Benefits are not payable for a pre-existing condition until you have been enrolled for 12 months.

Short-Term Disability (Post-Tax)

To calculate your Short-Term Disability bimonthly premium divide your annual salary by 52. Multiply that result by 66.67%. Divide that result by 10 and multiply by the applicable rate to the right. Multiply that result by 12 and divide by 26.

Example: 50 years old salary

$50,000/52 = $961.54.

$961.54 x .6667 = $641.06

$641.06/10 = $64.11

$64.11*.289 = $18.53 per month or $8.55 per paycheck.

Coverage Amount	Rate per $10 of Weekly Benefit
18-49	$0.214
50-54	$0.289
55-59	$0.416
60-64	$0.497
65+	$0.612
70+	$0.612

How to Calculate the Long-Term Disability Buy-UP Premium (Post-Tax)

Divide your annual income by 12 to determine your Covered Monthly Earnings (CME). Use the lesser of your CME or $8,333, and multiply by the rate below. Divide this amount by 100. The amount equals your monthly rate.

Age	Rate
All Ages	$0.404

1. Your annual earnings
2. Divide by 12 ÷ 12
3. Equals monthly earnings
4. Lesser of monthly earnings or $8,333
5. Rate from chart
6. Rate x amount on line 4
7. Divide by 100 ÷ 100
8. Equals monthly cost

Retirement Benefits

Florida Retirement System (FRS)
The Florida Retirement System offers you the option of participating in two FRS retirement plans: the FRS Investment Plan and the FRS Pension Plan.

The FRS Investment Plan is a defined contribution plan in which employer and employee contributions are defined by law, but your ultimate benefit depends in part on the performance of your investment funds. The FRS Investment Plan is funded by employer and employee contributions that are based on your salary and FRS membership class. The Investment Plan directs contributions to individual member accounts, and you allocate your contributions and account balance among various investment funds.

The FRS Pension Plan is a defined benefit plan, in which you are promised a benefit at retirement if you meet certain criteria. The amount of your future benefit is determined by a formula, based on your earnings, length of service, and membership class. Your benefit is pre-funded by contributions paid by your employer.

You can get more information at **www.myfrs.com**. Make sure to register for an account, take advantage of the videos, workshop and other information available to you.

Deferred Compensation
In addition to the FRS, employees have the option to participate in Deferred Compensation (457) retirement plans. These tax-deferred, employee-funded plans allow you to have a set amount deducted each paycheck and invested in select funds. Our Deferred Compensation participating companies are listed below.

Nationwide Retirement Solutions Plan #37604001 (Stephen Duganieri **631.767.2308**/**877.677.3678**, **www.nrsforu.com**)

ICMA Plan #300371 (Meghan Doherty **866.620.6070** ext. 4938, **www.icmarc.org**)

Mass Mutual (Hartford) Plan #109158 (Jason Cintron **352.428.8902**, **www.massmutual.com**)

VALIC Plan #56190 (Randy Ramos **813.269.3357**, **www.valic.com**)

Administered by AFLAC*

Accident Indemnity Advantage 3

The Accident Indemnity plan will pay you in the event you are injured in an accident. The plan will provide added financial resources to help you pay for expenses incurred as a result. Flat dollar amounts are payable for wellness visits, x-rays, emergency treatment, hospitalization and more. You can choose to cover yourself and your eligible family members. Contributions are taken on a pre-tax basis. Class A amounts are for employees who spend at least 80% of their working hours in an office environment. Class B is for all others.

Monthly Payroll Deductions (Pre-Tax)

Accident Indemnity	Class A	Class B
Employee Only	$18.59	$21.19
Employee + Spouse	$30.42	$33.28
Employee + Child(ren)	$33.15	$37.57
Employee + Family	$46.80	$51.35

Cancer Protection Assurance Plan 1

This plan pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of benefits payable throughout the cancer treatment. You can use these cash benefit to pay for out-of-pocket medical expenses, the rent or mortgage, groceries or bills. Your choice. A wellness benefit is also payable under the plan. Contributions are taken on a pre-tax basis and coverage is available for your and your eligible dependents.
In addition to the base plan you can also choose to add additional riders to your plan. Contact the Aflac representative for details.

Monthly Payroll Deductions (Pre-Tax)

Cancer Care Preferred	Base Premium	Initial Diagnosis Rider (per unit)	Specified Disease Rider	Dependent Child Rider
Employee Only	$18.10	$1.19	$.91	N/A
Employee + Spouse	$29.03	$2.81	$.91	N/A
Employee + Child(ren)	$18.10	$1.19	$.91	$.91
Employee + Family	$29.03	$2.81	$.91	$.91

*You must enroll through AFLAC to begin payroll deductions.

Critical Care and Recovery

The Critical Care Recovery Plan pays you cash in the event you experience a catastrophic event such as a heart attack or stroke. Benefits payable include a $7,500 First-Occurrence Benefit, a $3,500 Reoccurrence Benefit and a $300 per day Hospital Confinement Benefit. The plan has no lifetime maximum and is completely portable. Contributions are based on your age and you can also cover your spouse.

Monthly Payroll Deductions (Pre-Tax)

Critical Care and Recovery	18-35	36-45	46-55	56-70
Employee Only	$8.84	$13.78	$19.24	$26.00
Employee + Spouse	$12.74	$21.19	$31.85	$46.67

Personal Short-Term Disability

If you become disabled and cannot work, this benefit will provide you with a source of income to help you continue to pay your bills. You can choose your monthly benefit and your maximum benefit period. Contributions are based on your age and income. Class A amounts are for employees who spend at least 80% of their working hours in an office environment. Class B is for all others.

Class A Monthly Payroll Deductions (Post-Tax)

Annual Income Required	Monthly Disability Income	Ages 18-49	Ages 50-64
		3 Month	3 Month
$12,000	$800	$17.98	$18.72
$19,000	$1,000	$22.10	$23.40
$38,000	$1,900	$41.99	$44.46
$50,000	$2,600	$57.46	$60.84

Class B Monthly Payroll Deductions (Post-Tax)

Annual Income Required	Monthly Disability Income	Ages 18-49	Ages 50-64
		3 Month	3 Month
$12,000	$800	$18.72	$21.84
$19,000	$1,000	$23.40	$27.30
$38,000	$1,900	$44.46	$51.87
$50,000	$2,600	$60.84	$70.98

CONTACT INFORMATION

Resource / Service Provider	Contact Source	Details
Florida Blue (Medical Insurance)	Member Services Website	800.352.2583 www.floridablue.com
Pasco County Health/Wellness Center	Dade City, Land O'Lakes and New Port Richey	866.959.9355
Florida Combined Life (Dental Insurance)	Member Services Website	877.325.3979 (DHMO) 888.223.4892 (PPO) www.floridabluedental.com
Dental: Humana/CompBenefits	Member Services Website	800.342.5209 www.mycompbenefits.com
Vision: Humana	Member Services Website	800.979.4760 www.humana.com
Flexible Spending Account: Maestro	Claims Services Card Services Employee Portal	704.845.5608 888.488.5054 https://msave.maestrohealth.com/ Page/Home
Employee Assistance Program: ComPsych	Member Services Website	800.272.7255 www.guidanceresources.com Company Web ID: COM589
Life & Disability: Sun Life	Member Services Website	800.247.6875 www.mysunlifebenefits.com
Florida Retirement Services	Member Services Website	866.446.9377 www.myfrs.com
Voluntary Products: AFLAC	Member Services Website	727.422.2602 www.aflac.com

LEGAL NOTICES

HIPAA Special Enrollment Rights – If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the health coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

Michelle's Law – The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. This law applies to medically necessary leaves of absence that begin on or after January 1, 2010.

If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other pot-secondary institutions).

Your employer will require a written certification from the child's physician that states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

Section 111 – Effective January 1, 2009 Group Health Plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help establish who pays first. The mandate requires Group Health Plans to collect additional information, more specifically Social Security Numbers for all enrollees, including dependents six months of age or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

Women's Health and Cancer Rights Act of 1998 – 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
- 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.

The Newborn's and Mother's 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 insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

Patient Protection: If the Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care 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.

For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage.

The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

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 **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 **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 January 31, 2019. Contact your state for more information on eligibility.

State	Phone / Email	Website
ALABAMA – Medicaid	855.692.5447	http://myalhipp.com
ALASKA – Medicaid	866.251.4861 CustomerService@MyAKHIPP.com	The AK Health Insurance Premium Payment Program: http://myakhipp.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	855.MyARHIPP (855.692.7447)	http://myarhipp.com
FLORIDA – Medicaid	877.357.3268	http://flmedicaidtplrecovery.com/hipp
GEORGIA – Medicaid	404.656.4507	www.medicaid.georgia.gov | Click on Health Insurance Premium Payment (HIPP)
INDIANA – Medicaid	877.438.4479 800.403.0864	Healthy Indiana Plan for low-income adults 19-64 | http://www.in.gov/fssa/hip/ All other Medicaid | http://www.indianamedicaid.com
IOWA – Medicaid	800.257.8563	http://dhs.iowa.gov/hawk-i
KANSAS – Medicaid	785.296.3512	http://www.kdheks.gov/hcf
KENTUCKY – Medicaid	800.635.2570	http://chfs.ky.gov
LOUISIANA – Medicaid	888.695.2447	http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
MAINE – Medicaid	800.442.6003 TTY: Maine relay 711	http://www.maine.gov/dhhs/ofi/public-assistance/index.html
MASSACHUSETTS – Medicaid and CHIP	800.862.4840	http://www.mass.gov/eohhs/gov/departments/masshealth
MINNESOTA – Medicaid	800.657.3739 or 651.431.2670	http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
MISSOURI – Medicaid	573.751.2005	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
MONTANA – Medicaid	800.694.3084	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
NEBRASKA – Medicaid	Phone: 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178	http://www.ACCESSNebraska.ne.gov
NEVADA – Medicaid	800.992.0900	http://dhcfp.nv.gov
NEW HAMPSHIRE – Medicaid	603.271.5218 Toll-Free:800.852.3345, ext 5218	https://www.dhhs.nh.gov/oii/hipp.htm
NEW JERSEY – Medicaid and CHIP	609.631.2392 800.701.0710	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid CHIP: http://www.njfamilycare.org/index.html
NEW YORK – Medicaid	800.541.2831	https://www.health.ny.gov/health_care/medicaid/
NORTH CAROLINA – Medicaid	919.855.4100	https://dma.ncdhhs.gov
NORTH DAKOTA – Medicaid	844.854.4825	http://www.nd.gov/dhs/services/medicalserv/medicaid
OKLAHOMA – Medicaid and CHIP	888.365.3742	http://www.insureoklahoma.org
OREGON – Medicaid	800.699.9075	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
PENNSYLVANIA – Medicaid	800.692.7462	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
RHODE ISLAND – Medicaid	855.697.4347	http://www.eohhs.ri.gov
SOUTH CAROLINA – Medicaid	888.549.0820	http://www.scdhhs.gov
SOUTH DAKOTA – Medicaid	888.828.0059	http://dss.sd.gov
TEXAS – Medicaid	800.440.0493	http://gethipptexas.com
UTAH – Medicaid and CHIP	877.543.7669	Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip
VERMONT – Medicaid	800.250.8427	http://www.greenmountaincare.org
VIRGINIA – Medicaid and CHIP	Medicaid: 800.432.5924 CHIP: 855.242.8282	http://www.coverva.org/programs_premium_assistance.cfm
WASHINGTON – Medicaid	800.562.3022, ext. 15473	http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
WEST VIRGINIA – Medicaid	855.MyWVHIPP (855.699.8447)	http://mywvhipp.com/
WISCONSIN – Medicaid and CHIP	800.362.3002	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
WYOMING – Medicaid	307.777.7531	https://health.wyo.gov/healthcarefin/medicaid/

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/19)

MEDICARE PART D

Important Notice from Pasco County 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 Pasco County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not 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. Pasco County has determined that the prescription drug coverage offered by the Florida Blue Plan, 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 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 Pasco County coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Your current coverage pays for other health expenses in addition to prescription drugs. 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.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back during the annual 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 with Pasco County 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 November 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 Capital Mechanical 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.

MEDICARE PART D (CONT'D)

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 **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 **www.socialsecurity.gov**, or call them at **800.772.1213** (TTY **800.325.0778**).

Date:	October 1, 2019
Name of Entity:	Pasco County
Contact:	Human Resources
Address:	7536 State Street, Suite 111 New Port Richey, FL 34654
Phone Number:	727.847.8030

Remember: Keep this Non-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 non-creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

MEDICARE D NOTICE
(NON-CREDITABLE COVERAGE PLAN 3900)

Important Notice from Pasco County 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 Pasco County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Pasco County has determined that the prescription drug coverage offered by the Florida Blue Plan 3900 is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Florida Blue Plan 3900. This also is Important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. You can keep your current coverage with Florida Blue. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully- it explains your options.

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 through December 7th.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under Plan 3900 is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, Please see pages 9- 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage**), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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 Pasco County 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 about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1.800.772.1213** (TTY **1.800.325.0778**).

Remember: Keep this Non-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 non-creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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The information in this guide is a summary of the benefits available to you and should not be intended to take the place of the official carriers' Member Certificates or our plan's Summary Plan Descriptions (SPD). This guide contains a general description of the benefits to which you and your eligible dependents may be entitled as a full-time employee. This guide does not change or otherwise interpret the terms of the official plan documents. To the extent that any of the information contained in this guide is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases and the plan documents and carrier certificates will prevail. This Guide highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept with your most recent Summary Plan Description.

Pasco County reserves the right, in its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the benefit plans.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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