Employee Benefit Highlights

HERNANDO COUNTY FLORIDA

2026

Hernando County Splash Park located at the Anderson Snow Sports Complex – photo taken by David Kraut, BOCC Multimedia Communication Specialist.

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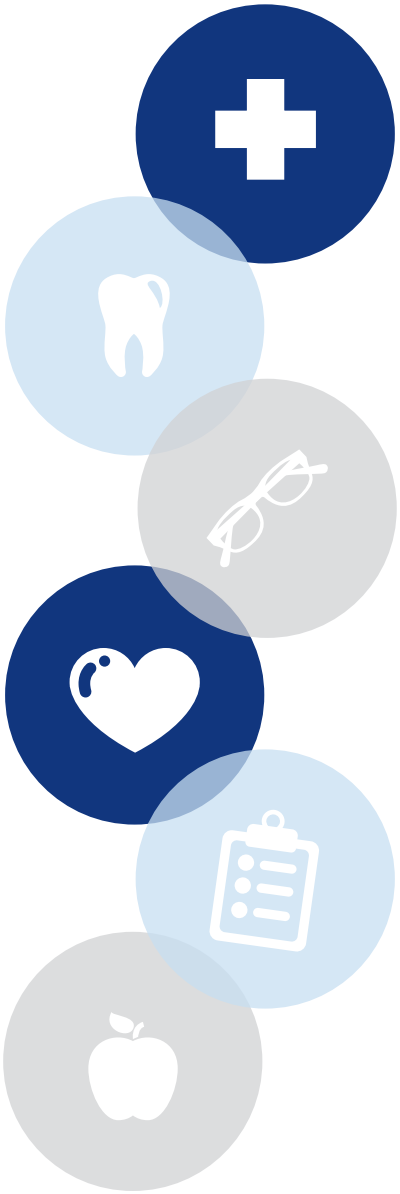


This booklet is merely a summary of benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The County reserves the right to amend, modify or terminate the plan at any time. This booklet should not be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

Contact Information

	Human Resources Department	Mary Spencer	Direct Line: (352) 540-6643 Office: (352) 754- 4013 Email: mspencer@hernandocounty.us
		Shevella Carridice, Cigna On-Site Representative	Phone: (727) 247-4939 Email: HernandoCountyBOCC@cignahealthcare.com
		Taylor Witkowski, Well-being Coordinator	Phone: (813) 295-1995 Email: Taylor.Witkowski@cignahealthcare.com
	Online Benefit Enrollment	Bentek Support	Phone: (888) 5-Bentek (523-6835) Email: support@mybentek.com app.mybentek.com/hernandocounty
	FMLA	The Hartford	Phone: (888) 301-5615 www.thehartford.com
	Medical Insurance	Cigna Healthcare	Phone: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Express Scripts Pharmacy through Cigna Healthcare	Phone: (800) 835-3784 www.mycigna.com
	Telehealth	MDLIVE through Cigna Healthcare	Phone: (888) 726-3171 www.mycigna.com
HSA	**Health Savings Account**	Cigna Healthcare	Phone: (800) 244-6224 www.mycigna.com
	Dental Insurance	Cigna Healthcare	Phone: ((800) 244-6224 www.mycigna.com
	Vision Insurance	EyeMed	Phone: (866) 939-3633 www.eyemed.com
		Vision Service Plan (VSP)	Phone: (800) 877-7195 www.vsp.com
FSA	**Flexible Spending Accounts**	Cigna	Phone: (800) 244-6224 www.mycigna.com
	Basic, AD&D & Voluntary Life Insurance	The Hartford	Phone: (888) 563-1124 www.thehartford.com
	Voluntary Short Term Disability & Long Term Disability	The Hartford	Phone: (888) 277-4767 www.thehartford.com
	Employee Assistance Program	Cigna	Phone: (877) 622-4327 www.mycigna.com
	Supplemental Benefits	BeneCom	Phone: (813) 996-2525 Email: info@mybenecom.com www.benecom.com
	Legal Plan	BeneCom	Phone: (813) 996-2525 Email: info@mybenecom.com www.benecom.com

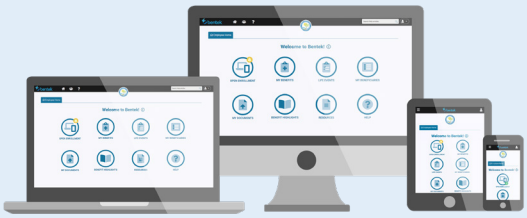
Introduction

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

Online Benefit Enrollment

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

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



To Access the Employee Benefits Center:

- ✓ Log on to **app.mybentek.com/hernandocounty**
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

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

To access Bentek using a mobile device, scan code.

Medical Plan Opt-Out Benefit

In an effort to ensure equitable contribution to the health care of every employee, the County offers an "opt-out" option to eligible employees who have waived participation in the County's medical plan and who can show evidence of medical insurance under another medical plan. If an employee chooses to receive the "opt-out" benefit, they will receive the following benefits paid by the employer:

- Low Dental Plan (optional)
- Long Term Disability Insurance
- $10,000 Basic Life Insurance
- EAP (Employee Assistance Program)

Wellness Center Opt-In Benefit

Employees who elect to opt out of the medical plans offered by the County may choose to elect the Wellness Center Opt-In Benefit. This benefit allows employees to use the services offered by the Employee Wellness Center including primary healthcare visits, lab work, generic prescriptions, and all other programs offered to employees through the Wellness Center. The cost to the employee is $40 per pay period ($80 per month for Property Appraiser employees). This benefit is offered to the employee only. Dependent family members of employees are not eligible for this benefit.

Medical Plan Premium Incentive Benefit

Two4You is an employee wellness incentive program that rewards participants with a $25 per pay period discount on health insurance premiums. To qualify, employees must complete a standard bloodwork panel and an annual wellness checkup between October 1, 2024, through November 30, 2025, and submit proof of completion to Human Resources. Unless using the Care ATC Clinic, where documentation is not required. All employees enrolled in the company's health plan are eligible. Completed documentation should be submitted to two4you@co.hernando.fl.us by November 30, 2025. New hires in 2025–2026 are exempt for the first year but must complete requirements by 11/30/2026 to qualify for future discounts.

Benefits While Not Actively At Work

If an employee is out of work due to an approved leave of absence or Workers' Compensation, the employee may continue to have benefit coverage based on the type of leave they take.

Employees on an Approved FMLA Leave

Employee missing work due to a serious health condition or to care for a family member's serious condition, please contact The Hartford by calling (888) 301-5615 or log on to www.thehartford.com.

Employees information will be verified by a Benefits Specialist who will initiate the FMLA leave process and answer any questions. Employee will be notified of the status of FMLA leave once it is processed. Employee must notify their department and Human Resources if requiring FMLA leave.

If the employee is approved for FMLA leave, Hernando County will continue to provide employer contributions towards the employee's benefits. The employee is required to continue to pay the employee share of benefit elections while on leave. For further information regarding payments, please contact the Human Resources Department.

Active Duty Leave

If the employee has not returned to active duty when FMLA leave ends, benefits may terminate at the end of that month. Employees may continue coverage for eligible insurance benefits by paying the total premium amount under COBRA. Upon expiration of benefits, a COBRA notice will be mailed to the home address on record to provide an opportunity to elect coverage. The Human Resources Department determines eligibility for FMLA.

The Hartford | Phone: (888) 301-5615 | www.thehartford.com

Workers' Compensation

If an employee is placed out of work and receives Workers' Compensation benefits, Hernando County will continue to provide employer contributions for the employee's core benefits which include medical, dental, vision, EAP and life insurance. Employees are required to continue to pay the employee share for these core benefits and any supplemental benefits the employee may have while out on workers' compensation. For information on how to make payment arrangements, please contact the Human Resources Department.

At the expiration of benefits, the employee may continue insurance coverages by paying the total premium amount under COBRA. Upon the expiration of benefits, a COBRA notice will be mailed to the home address on record to provide an opportunity to elect coverage.

Group Insurance Eligibility

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

Employee Eligibility

Employees are eligible to participate in the County's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first of the month following 60 days of employment. For example, if an employee is hired on April 11, then the effective date of coverage will be July 1.

Separation of Employment

If employee separates employment from the County, insurance will continue through the end of the month in which the separation occurred (Short Term Disability terminates coverage on the date in which separation occurs). COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

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

- A natural child
- A legally adopted child
- A stepchild
- A newborn (up to age 18 months) of a covered dependent (Florida State Statute)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse.

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent (taxable dependents) may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

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

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

Dependent Age Requirements *(continued)*

Dental Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 30.

Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 30.

Disabled Dependents

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

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

Proof of disability will be required upon request. Please contact the Human Resources Department if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under the employee's medical, dental and vision insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, imputed income must be reported on the employees W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare taxes. Imputed income is the dollar value of insurance coverage attributable to covering each adult dependent child. Contact the Human Resources Department for further details if covering an adult dependent child who will turn age 27 any time during the upcoming calendar year or for more information.

Please note: *There is no imputed income if the adult dependent child is eligible to be claimed as a dependent for Federal income tax purposes on the employee's tax return.*

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Flexible Spending Accounts (FSA), Health Savings Accounts (HSA) and/or certain supplemental insurance polices are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the Open Enrollment Period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

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

IMPORTANT NOTES

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

Summary of Benefits and Coverage

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

From:	Human Resources Department
Address:	15470 Flight Path Drive, Brooksville, FL, 34604
Phone:	(352) 754-4013
Email:	mspencer@hernandocounty.us
Website URL:	app.mybentek.com/hernandocounty

SBC's are also posted on Bentek and EICE. The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Human Resources Department at the following web address: app.mybentek.com/hernandocounty.

If there are any questions about the plan offerings or coverage options, please contact the Human Resources Department at (352) 754-4013.

Medical Plan Resources

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

Healthy Rewards

Cigna's Healthy Rewards is provided automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to www.mycigna.com and select Healthy Rewards to learn more about these programs or contact Cigna's Healthy Rewards at (800) 870-3470.

- Vision Care
- Lasik Vision Correction Services
- Fitness Club Discounts
- Nutrition Discounts
- Hearing Care

Cigna Healthcare Wellness Experience

The Cigna Wellness Experience is designed to support members in improving overall health and well-being. The program includes:

- Digital Coaching
- Well-being Challenges
- Health Assessment
- Rewards Program
- Integration with Devices

For more information regarding the Cigna Healthcare Wellness experience, please contact Cigna's customer service or visit www.mycigna.com.

Mobile App

Mobile app provides on-the-go access to the medical benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Telehealth

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

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

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

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

MDLIVE
Phone: (888) 726-3171 | www.mycigna.com

Medical Insurance

The County offers medical insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below. For more detailed information about the medical plans, please refer to Cigna's Summary of Benefits and Coverage (SBC) document or contact Cigna's customer service. Employees enrolled in the HDHP plan receive a monthly County contribution of $125 to a Health Savings Account (HSA), regardless of coverage tier.

Medical Insurance – Cigna Open Access Plus Plan with Wellness Incentive

24 Payroll Deductions - Per Pay Period Cost (12 Payroll Deductions for Property Appraiser)

Tier of Coverage	Total Premium Per Month	Employer Contribution Per Month	Employee Contribution Monthly	Employee Contribution Semi-Monthly
Employee Only	$1,464.00	$906.00	$558.00	$279.00
Employee + Spouse	$2,842.00	$1,402.00	$1,440.00	$720.00
Employee + Child(ren)	$2,542.00	$1,287.00	$1,255.00	$627.50
Employee + Family	$3,684.00	$2,085.00	$1,599.00	$799.50

Medical Insurance – Cigna Open Access Plus Plan without Wellness Incentive

24 Payroll Deductions - Per Pay Period Cost (12 Payroll Deductions for Property Appraiser)

Tier of Coverage	Total Premium Per Month	Employer Contribution Per Month	Employee Contribution Monthly	Employee Contribution Semi-Monthly
Employee Only	$1,464.00	$856.00	$608.00	$304.00
Employee + Spouse	$2,842.00	$1,352.00	$1,490.00	$745.00
Employee + Child(ren)	$2,542.00	$1,237.00	$1,305.00	$652.50
Employee + Family	$3,684.00	$2,035.00	$1,649.00	$824.50

Medical Insurance – Cigna HDHP Open Access Plus Plan with Wellness Incentive

24 Payroll Deductions - Per Pay Period Cost (12 Payroll Deductions for Property Appraiser)

Tier of Coverage	Total Premium Per Month	Employer Contribution Per Month	Employee Contribution Monthly	Employee Contribution Semi-Monthly
Employee Only	$781.00	$781.00	$0.00	$0.00
Employee + Spouse	$1,347.00	$1,277.00	$70.00	$35.00
Employee + Child(ren)	$1,222.00	$1,162.00	$60.00	$30.00
Employee + Family	$2,060.00	$1,960.00	$100.00	$50.00

Medical Insurance – Cigna HDHP Open Access Plus Plan without Wellness Incentive

24 Payroll Deductions - Per Pay Period Cost (12 Payroll Deductions for Property Appraiser)

Tier of Coverage	Total Premium Per Month	Employer Contribution Per Month	Employee Contribution Monthly	Employee Contribution Semi-Monthly
Employee Only	$781.00	$731.00	$50.00	$25.00
Employee + Spouse	$1,347.00	$1,227.00	$120.00	$60.00
Employee + Child(ren)	$1,222.00	$1,112.00	$110.00	$55.00
Employee + Family	$2,060.00	$1,910.00	$150.00	$75.00

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

Cigna Open Access Plus Plan At-A-Glance

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In Network**	**Out of Network***
Single	$1,000**	$2,000**
Family	$2,000**	$4,000**
Coinsurance		
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Limit		
Single	$2,500	$5,000
Family	$5,000	$10,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays (*Includes Rx*)	
Physician Services		
Primary Care Physician *(PCP)* Office Visit(†)	$0 Copay(†)/$15 Copay	40% After CYD
Specialist Office Visit(†)	$20 Copay(†)/$30 Copay	40% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Blood Work)****	No Charge	40% After CYD
X-rays	No Charge	40% After CYD
Advanced Imaging *(MRI, PET, CT)*	$100 Copay	40% After CYD
Outpatient Surgery at Surgical Center	$100 Copay	40% After CYD
Physician Services at Surgical Center	No Charge	40% After CYD
Urgent Care *(Per Visit)*	$30 Copay	$30 Copay
Hospital Services		
Inpatient Hospital *(Per Admission)*	$750 Copay	40% After CYD +$750 Copay
Outpatient Hospital *(Per Visit)*	$300 Copay	40% After CYD +$300 Copay
Physician Services at Hospital	No Charge	40% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$250 Copay	$250 Copay
Mental Health / Alcohol & Substance Abuse		
Inpatient Hospitalization *(Per Admission)*	No Charge	40% After CYD + $750 Copay
Outpatient Services *(Per Visit)*	No Charge	40% After CYD
Outpatient Office Visit	No Charge	40% After CYD
Prescription Drugs *(Rx)*		
Calendar Year Rx Deductible *(Per Member)*	$150	Not Covered
Generic	$15 Copay	Not Covered
Preferred Brand Name	$30 Copay After Rx CYD	Not Covered
Non-Preferred Brand Name	$50 Copay After Rx CYD	Not Covered
Mail Order Drug *(90-Day Supply)*	2x Retail Copay After Rx CYD	Not Covered

Locate a Provider

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

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage*

***The deductible applies to limited services only.*

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

Important Notes

(†)Copay when utilizing a Tier 1 Provider.

Cigna HDHP Open Access Plus Plan At-A-Glance

Locate a Provider

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

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage.*

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

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out of Network***
Single	$2,075	$3,200
Family	$4,150	$6,400
Coinsurance		
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Limit		
Single	$5,000	$10,000
Family	$5,000	$10,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays (*Includes Rx*)	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	20% After CYD	40% After CYD
Specialist Office Visit	20% After CYD	40% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Blood Work)***	20% After CYD	40% After CYD
X-rays	20% After CYD	40% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD	40% After CYD
Outpatient Surgery at Surgical Center	20% After CYD	40% After CYD
Physician Services at Surgical Center	20% After CYD	40% After CYD
Urgent Care *(Per Visit)*	20% After CYD	40% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After CYD	40% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD	40% After CYD
Physician Services at Hospital	20% After CYD	40% After CYD
Emergency Room *(Per Visit)*	20% After CYD	20% After In-Network CYD
Mental Health / Alcohol & Substance Abuse		
Inpatient Hospitalization *(Per Admission)*	20% After CYD	40% After CYD
Outpatient Services *(Per Visit)*	20% After CYD	40% After CYD
Outpatient Office Visit	20% After CYD	40% After CYD
Prescription Drugs *(Rx)*		
Generic	$15 Copay After CYD	Not Covered
Preferred Brand Name	$30 Copay After CYD	Not Covered
Non-Preferred Brand Name	$50 Copay After CYD	Not Covered
Mail Order Drug *(90-Day Supply)*	2x Retail Copay After CYD	Not Covered

Health Savings Account

The Cigna High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollee to open a Health Savings Account (HSA). An HSA is an interest-bearing account where funds may be used to help pay employee and dependent(s) current and future deductible, coinsurance and qualified medical expenses not covered by the plan.

2026 Plan Year Funding:

- The HSA portion of employee's premium will fund the employee's HSA on a per pay period contribution basis, with an annual contribution amount as follows:
  - Employee Only: $1,500
  - Employee + Spouse: $1,500
  - Employee + Children: $1,500
  - Employee + Family: $1,500

Employee may opt to additionally fund an HSA to the IRS contributions listed below. This is done via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction; this decision must be made during Open Enrollment. However, changes to employee HSA contributions can be made during the plan year.

- **2025 IRS Contribution Limitations:** $4,300 (individual coverage) $8,550 (family coverage)
- **2026 IRS Contribution Limitations:** $4,400 (individual coverage) $8,750 (family coverage)
- Individuals age 55 and older can also make additional "catch-up" contributions up to $1,000 annually

This maximum HSA amount would include any employer and employee contributions (pre-tax or post-tax). If employee is receiving an employer contribution, employee will want to account for this towards the annual IRS total maximum so employee does not over-contribute for the tax year. Guidelines regarding the HSAs are established by the IRS.

What to know about an HSA

- Employee owns the HSA funds from day one and decides how and when to spend the money.
- No use-it or lose-it rules; funds are in the account when needed, now or in the future. Participant cannot fund a traditional Health Care FSA, however, participant may fund a Limited Purpose FSA for dental and vision expenses only.
- HSA funds earn interest.
- The HSA will be funded with employer contributions. If the employee desires to fund the remaining deductible balance they may do so with pre-tax payroll deductions.
- HSA dollars may be used tax-free for all eligible medical expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employee plan for retirement.
- An account holder may write a check or withdraw funds with a Health Savings Account Debit Card.
- A monthly per account service fee determined by the bank may be deducted automatically from the HSA.
- Account holder can access HSA statements at any time to track account balance and activity online at www.mycigna.com.
- To be eligible to open an HSA, employee must be covered by a qualified high deductible health plan. Employee may not be covered under another medical plan that is not a qualified high deductible health plan including a plan the employee's spouse may have selected where he/she has family coverage. Please Note: Eligibility status to qualify for an HSA is specifically driven by the County employee and NOT dependents.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Over-age dependent is not able to use HSA funds for qualified expenses, even if the dependent is covered under the medical plan as Federal law does not recognize them as a qualified dependent.
- If the employee is enrolled in Medicare, TRICARE or TRICARE for Life, the employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits the County from contributing HSA funds into the account. If the employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then the employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts.
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare will receive the full family HSA funding. These funds can be utilized for the active employee and spouse expenses.
- Active employee ON Medicare and with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse will not receive any HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

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

Dental Insurance

Cigna Total DPPO Low Plan

The County offers two (2) dental insurance plans through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage for the Cigna Total DPPO Low Plan is provided below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to Cigna's summary plan document or contact Cigna's customer service.

Dental Insurance – Cigna Total DPPO Low Plan

24 Payroll Deductions - Per Pay Period Cost
(12 Payroll Deductions for Property Appraiser)

Tier of Coverage	Total Premium Per Month	Employer Contribution Per Month	Employee Contribution Monthly	Employee Contribution Semi-Monthly
Employee Only	$35.00	$35.00	$0.00	$0.00
Employee + 1 Dependent	$57.70	$57.70	$0.00	$0.00
Employee + Family	$87.40	$87.40	$0.00	$0.00

In-Network Benefits

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

Out-of-Network Benefits

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

Calendar Year Deductible

The Total DPPO Low Plan requires a $75 individual and $225 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

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

WellnessPlus Progressive Maximum Benefit

Cigna allows employees to earn an additional $175 towards their calendar year benefit maximum for the following year. To qualify for the benefit, employees must receive at least one (1) Class I service during the calendar year.

- **Year 1:** $1,500 Benefit Maximum
- **Year 2:** $1,675 Benefit Maximum
- **Year 3:** $1,850 Benefit Maximum
- **Year 4:** $2,025 Benefit Maximum

Mobile App

Mobile app provides on-the-go access to the dental benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

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

Cigna Total DPPO Low Plan At-A-Glance

Network	Total Network	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$75	$75
Per Family	$225	$225
Waived for Class I Services?	Yes	Yes
Calendar Year Benefit Maximum		
Per Member	$1,500	$1,500
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Year)*	Plan Pays: 100% Deductible Waived**	Plan Pays: 80% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(4 Per Year)*		
Bitewing X-rays *(2 Per Year)*		
Complete X-rays *(1 Every 3 Years)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam or Composite)*	Plan Pays: 70% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Periodontics		
Oral Surgery		
General Anesthesia		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 30% After CYD *(Subject to Balance Billing)*
Dentures		
Bridges		
Implants		

Locate a Provider

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

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Out-of-Network Benefits section on the previous page.*

***Included in Calendar Year Benefit Maximum.*

Important Notes

- *Each covered family member may receive up to four (4) routine cleanings per calendar year covered under the preventive benefit.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

Dental Insurance

Cigna Total DPPO High Plan

The County offers two (2) dental insurance plans through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage for the Cigna Total DPPO High Plan is provided below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to Cigna's summary plan document or contact Cigna's customer service.

Dental Insurance – Cigna Total DPPO High Plan

24 Payroll Deductions - Per Pay Period Cost
(12 Payroll Deductions for Property Appraiser)

Tier of Coverage	Total Premium Per Month	Employer Contribution Per Month	Employee Contribution Monthly	Employee Contribution Semi-Monthly
Employee Only	$48.38	$35.00	$13.38	$6.69
Employee + 1 Dependent	$79.88	$57.70	$22.18	$11.09
Employee + Family	$120.98	$87.40	$33.58	$16.79

In-Network Benefits

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

Out-of-Network Benefits

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

Calendar Year Deductible

The Total DPPO requires a $75 individual and $225 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the The Total DPPO will pay for each covered member is $2,500 for in-network and out-of-network services combined. All services, including preventive services, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

WellnessPlus Progressive Maximum Benefit

Cigna allows employees to earn an additional $250 towards their calendar year benefit maximum for the following year. To qualify for the benefit, employees must receive at least one (1) Class I service during the calendar year.

- **Year 1:** $2,500 Benefit Maximum
- **Year 2:** $2,750 Benefit Maximum
- **Year 3:** $3,000 Benefit Maximum
- **Year 4:** $3,250 Benefit Maximum

Mobile App

Mobile app provides on-the-go access to the dental benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

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

Cigna Total DPPO High Plan At-A-Glance

Network	Total Network	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$75	$75
Per Family	$225	$225
Waived for Class I Services?	Yes	Yes
Calendar Year Benefit Maximum		
Per Member	$2,500	$2,500
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Year)*	Plan Pays: 100% Deductible Waived**	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(4 Per Year)*		
Bitewing X-rays *(2 Per Year)*		
Complete X-rays *(1 Every 3 Years)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam or Composite)*	Plan Pays: 70% After CYD	Plan Pays: 70% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Periodontics		
Oral Surgery		
General Anesthesia		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Dentures		
Bridges		
Implants		

Locate a Provider

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

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Out-of-Network Benefits section on the previous page.*

***Included in Calendar Year Benefit Maximum.*

Important Notes

- *Each covered family member may receive up to four (4) routine cleanings per calendar year covered under the preventive benefit.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

Vision Insurance

EyeMed Vision Care Plan

The County offers two (2) vision insurance plans to benefit-eligible employees. The costs per pay period for coverage for the EyeMed Vision Care Plan are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to EyeMed's summary plan document or contact EyeMed's customer service.

Vision Insurance – EyeMed Vision Care Plan

24 Payroll Deductions - Per Pay Period Cost
(12 Payroll Deductions for Property Appraiser)

Tier of Coverage	Employee Contribution Monthly	Employee Contribution Semi-Monthly
Employee Only	$5.66	$2.83
Employee + Family	$14.42	$7.21

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employees and covered dependent(s) may select any network provider who participates in the EyeMed Select network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may choose to receive services from vision providers who do not participate in the EyeMed Select network. When going out of network, the provider will require payment at the time of appointment. EyeMed will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

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

Mobile App

Mobile app provides on-the-go access to the vision benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

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

EyeMed Vision Care Plan At-A-Glance

Network		Select	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 Copay	Up to $35 Reimbursement
Contact Lens Fit & Follow-Up:	Standard Lens	Up to $40 Allowance	Not Covered
	Premium Lens	10% Off Retail Price	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		$25 Copay	Up to $25 Reimbursement
Bifocal		$25 Copay	Up to $40 Reimbursement
Trifocal		$25 Copay	Up to $60 Reimbursement
Frames			
Allowance		$120 Retail Allowance; Then 20% Discount Above $120	Up to $48 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		Covered at 100%	Up to $200 Reimbursement
Elective *(Lenses)*	Conventional	$135 Allowance; Then 15% Off Balance Over $135	Up to $95 Reimbursement
	Disposable	$135 Allowance	Up to $95 Reimbursement

Locate a Provider

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

Plan References

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

Important Notes

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

Vision Insurance

VSP Vision Service Plan

The County offers two (2) vision insurance plans to benefit-eligible employees. The costs per pay period for coverage for the VSP Vision Plan are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to VSP's summary plan document or contact VSP's customer service.

Vision Insurance – VSP Vision Service Plan

24 Payroll Deductions - Per Pay Period Cost
(12 Payroll Deductions for Property Appraiser)

Tier of Coverage	Employee Contribution Monthly	Employee Contribution Semi-Monthly
Employee Only	$10.10	$5.05
Employee + Family	$21.72	$10.86

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employees and covered dependent(s) may select any network provider who participates in the VSP Choice network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may also choose to receive services from vision providers who do not participate in the VSP Choice network. When going out of network, the provider will require payment at the time of appointment. VSP will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

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

Mobile App

Mobile app provides on-the-go access to the vision benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Vision Service Plan (VSP)
Phone: (800) 877-7195 | www.vsp.com

VSP Vision Service Plan At-A-Glance

Network	VSP Choice	
Services	**In-Network**	**Out-of-Network**
Eye Exam	$10 Copay	Up to $45 Reimbursement
Frequency of Services		
Examination	Every Plan Year	
Lenses	Every Plan Year	
Frames	Every Plan Year	
Contact Lenses	Every Plan Year	
Lenses		
Single	$25 Copay	Up to $30 Reimbursement
Bifocal	$25 Copay	Up to $50 Reimbursement
Trifocal	$25 Copay	Up to $65 Reimbursement
Standard Progressive Lenses	Covered at 100%	Up to $50 Reimbursement
Frames*		
Allowance	$200 Retail Allowance; Then 20% Discount Above $200	Up to $70 Reimbursement
Contact Lenses**		
Non-Elective *(Medically Necessary)*	Covered at 100%	Up to $210 Reimbursement
Elective *(Fitting, Follow-up & Lenses)*	Up to $150 Allowance	Up to $105 Reimbursement
LASIK		
Conventional, Custom and Bladeless	Discounted Fee Contact VSP for Details	Discount Programs Not Available

Locate a Provider

To search for a participating provider, contact VSP's customer service or visit www.vsp.com. When completing the necessary search criteria, select Choice network.

Plan References

**Members are eligible to receive up to a $200 allowance towards non-prescription sunglasses, or non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts.*

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

Important Notes

Other lens options are available for an additional cost.

- *Standard progressive lenses $0*
- *Premium progressive lenses $95-$105*
- *Custom progressive lenses $150-$175*
- *Average 30% off other lens options*

Flexible Spending Accounts

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

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

The County offers: Health Care FSA, Limited Purpose FSA, and Dependent Care FSA

- **Health Care FSA:** Available to eligible employee who is **not** enrolled in the Cigna High Deductible Health Plan with an HSA. The Health Care FSA covers medical, dental, and vision expenses that are not paid by insurance.
- **Limited Purpose FSA:** Available to eligible employee who is enrolled in the Cigna High Deductible Health Plan with an HSA. The Limited Purpose Health Care FSA may be used for qualified dental and vision expenses.
- **Dependent Care FSA:** Covers day care expenses for qualified dependents necessary for employee and legal spouse, if married, to work.

Health Care FSA

This account allows participant to set aside a minimum of $120 up to an annual maximum of $3,300. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

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

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

Dependent Care FSA

This account allows participant to set aside a minimum of $120 up to an annual maximum of $7,500 if single or married and file a joint tax return ($3,750 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

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

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

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

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

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

**These items are eligible expenses under the Limited Purpose FSA.*

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

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Employee may carry over $660 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed. Dependent Care funds cannot be carried over.
- The Health Care FSA has a run out period at the end of the plan year (90 days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year (January 1 to December 31).
- When a plan year ends and all claims have been filed with the exception of the $660 rollover for the Health Care FSA, all unused funds will be forfeited and not returned.
- Employees may enroll in either or both of the FSAs only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility Period.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services they have not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners healthcare expenses are not eligible for reimbursement in the employee FSA as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

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

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. Cigna may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the County. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

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

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

Mobile App

Mobile app provides on-the-go access to the FSA benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- File a Claim
- Make Payments
- View Account Activity
- Upload Receipts

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the $660 carry over allowed for the Health Care FSA.* ***This rule is known as "use-it or lose-it."***

Cigna
Phone: (800) 244-6224 | www.mycigna.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The County provides Basic Term Life insurance for all eligible employees through the Hartford. Benefit-eligible employees will receive a benefit amount of $10,000.

Accidental Death & Dismemberment

Also, at no cost to employee, the County provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- Reduces by 35% of the original benefit amount at age 70
- Reduces by 50% of the original benefit amount at age 75
- Coverage cancels if employment with the County is terminated
- Eligible retirees may continue Life insurance at own expense.

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

The Hartford | Phone: (888) 563-1124 | www.thehartford.com

Voluntary Life Insurance

Voluntary Employee Life and AD&D Insurance

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

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of six (6) times annual salary or $200,000, whichever is less**.

Employee who IS currently enrolled with Voluntary Employee Life coverage may increase coverage amount in one (1) increment of $10,000, not to exceed Guaranteed Issue Amount, without submitting EOI during Open Enrollment.

Voluntary Life Insurance *(Continued)*

- Units can be purchased in increments of $10,000, but cannot exceed the lesser of six (6) times annual salary or $350,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces by 35% of the original benefit amount at age 70
  - Reduces by 50% of the original benefit amount at age 75
- Coverage cancels if employment with the County is terminated.
- Eligible retirees may continue Life insurance up to $190,000, at own expense

Voluntary Dependent Spouse / Child(ren) Life Insurance

New Hires may purchase Voluntary Dependent Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $10,000.**

- Employee must participate in the Voluntary Employee Life plan for dependent(s) to participate.
- Employee may elect coverage in flat amounts of $2,500, $5,000 or $10,000.
- Eligible unmarried dependent child(ren) may be covered starting at six (6) months of age. A $250 or $500 benefit is available for child(ren) age two (2) weeks to six (6) months.
- Maximum age covered for dependent child(ren) is age 26.

Employee Voluntary Life/AD&D Rate Table

Estimated Rate Per $10,000 (Based on EE Age)

Age Bracket *(Based On Employee Age)*	Semi-Monthly Premium	Monthly Premium
<35	$0.45	$0.90
35-39	$0.55	$1.10
40-44	$0.90	$1.80
45-49	$1.30	$2.60
50-54	$1.95	$3.90
55-59	$3.55	$7.10
60-64	$5.35	$10.70
65-69	$10.25	$20.50
70-74 *(Per $6,500)*	$10.76	$21.52
75+ *(Per $5,000)*	$8.28	$16.56

The Hartford
Phone: (888) 563-1124 | www.thehartford.com

Voluntary Short Term Disability

The County offers two (2) options for Voluntary Short Term Disability (STD) insurance to all eligible employees through The Hartford. The STD benefit pays a percentage of weekly earnings if employee becomes disabled due to an illness or non-work related injury.

Voluntary Short Term Disability (STD) Benefits Option 1

- STD provides a benefit of 66.67% of weekly earnings, up to a benefit maximum of $750 per week.
- Employee must be disabled for 29 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will begin on the 30th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 22 weeks.
- Employee deemed unable to return to work after the STD 22 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD) with completed application.
- Benefits may be reduced by other income.

Voluntary Short Term Disability (STD) Benefits Option 2

- STD provides a benefit of 66.67% of weekly earnings, up to a benefit maximum of $750 per week.
- Employee must be sick for 14 consecutive days or injured for seven (7) days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will begin on the 8th day after the employee is disabled due to non-work related injury or 15th day after the employee is disabled due to non-work related illness.
- The maximum benefit period is 26 weeks.
- Employee deemed unable to return to work after the STD 26 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD) with completed application.
- Benefits may be reduced by other income.

Current employees may purchase Voluntary Short Term Disability but would be subject to Medical Underwriting, also known as Evidence of Insurability, (EOI).

New Hires may purchase Voluntary Short Term Disability without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI).

The Hartford
Phone: (888) 277-4767 | www.thehartford.com

Long Term Disability

Long Term Disability (LTD) insurance is available to all eligible employees through The Hartford. The LTD benefit pays a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings, subject to a maximum of $5,000 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will commence on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.

The Hartford
Phone: (888) 277-4767 | www.thehartford.com

Employee Assistance Program

The County cares about the well-being of all employees on and off the job and provides a comprehensive Employee Assistance Program (EAP) through Cigna Healthcare. EAP offers the employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employees gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect the employee or family member's well-being. Coverage includes five (5) visits through Cigna Healthcare with a specialist, per person, per issue, per year, telephonic consultation, online material/tools and webinars. EAP offers counseling services on issues such as:

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

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor/manager), we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor/manager will not receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

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

Supplemental Benefits

Aflac Dental

The County offers an Aflac Dental Supplemental plan that may be purchased separately on a voluntary basis. Premiums are paid by a payroll deduction on a pre-tax basis. The Aflac Dental Supplemental Plan provides benefits for periodic checkups and cleanings, X-rays, fillings,crowns and much more. To learn more about these Aflac plans contact the local agent. Details regarding available Aflac Dental Supplemental plan and services are also available online.

Aflac Dental Essentials	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Semi-Monthly				
Age 18-70	$11.64	$20.35	$20.48	$29.32

BeneCom
Phone: (813) 996-2525 | www.benecom.com
Email: info@mybenecom.com

Aflac Short Term Disability

The County offers an Aflac Short Term Disability Supplemental plan that may be purchased separately on a voluntary basis. Premiums are paid by a payroll deduction on a post-tax basis.

BeneCom
Phone: (813) 996-2525 | www.benecom.com
Email: info@mybenecom.com

Allstate

Allstate offers a variety of supplemental plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction on a pre-tax basis. Allstate pays money directly to the employee, regardless of what other insurance plans the employee may have. To learn more about these Allstate plans and/or to schedule a personal appointment, contact the local agent. Details regarding available Allstate plans and services are also available online.

Available plans includes

- ✓ Group Accident
- ✓ Group Cancer
- ✓ Group Hospital Indemnity
- ✓ Group Critical Illness
- ✓ Group Supplemental Health/SHOP
- ✓ Group Term Life
- ✓ Short Term Disability

BeneCom
Phone: (813) 996-2525 | www.benecom.com
Email: info@mybenecom.com

Supplemental Benefits - BeneCom: Allstate *(Continued)*

Allstate Accident	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Semi-Monthly				
Age 18-80	$7.26	$12.58	$12.30	$18.49

Allstate Hospital/SHOP	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Semi-Monthly				
Age 18-35	$15.98	$30.15	$25.81	$39.43
Age 36-49	$18.72	$35.46	$29.81	$45.97
Age 50-59	$23.31	$45.63	$34.15	$55.83
Age 60-64	$31.14	$62.28	$41.22	$71.61
Age 65+	$41.72	$83.43	$51.84	$92.67

Allstate Critical Illness	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Semi-Monthly				
Age 18-29	$4.65	$7.93	$4.65	$7.93
Age 30-39	$8.09	$13.13	$8.09	$13.13
Age 40-49	$14.68	$23.12	$14.68	$23.12
Age 50-59	$23.89	$37.00	$23.89	$37.00
Age 60-64	$32.44	$49.97	$32.44	$49.97
Age 65+	$33.84	$51.70	$33.84	$51.70

Allstate Cancer	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Semi-Monthly				
Age 18-80	$12.01	$20.60	$20.60	$20.60

Allstate Life Insurance	*Contact BeneCom for Employee, Spouse, Child(ren), and Grandchild(ren) benefit options
Rates available starting at just $2.36 for employee coverage – Please see BeneCom Representative	

Allstate Hospital/GIM2	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Semi-Monthly				
Age 18-80	$6.49	$14.58	$7.60	$17.23

Legal Plan

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

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

US Legal Plan	
Semi Monthly	$9.38

BeneCom
Phone: (813) 996-2525
www.benecom.com | Email: info@mybenecom.com

Retirement

457 Deferred Compensation Plans

The County offers employee a 457 Deferred Compensation Plan for retirement savings through Nationwide Retirement Solutions. For information regarding the 457 Deferred Compensation plan, please contact Human Resources or the Nationwide service representatives listed below.

Nationwide Retirement Solutions
Phone: (877) 677-3678 I Agent: Denny Davis I Phone: (813)973-8382
Email: davd314@nationwide.com

Florida Retirement System – FRS

The FRS offers employees valuable support to help make informed decisions about personal retirement goals. The services are free, unbiased and confidential. To learn more about this plan, please contact Florida Retirement System at (844) 377-1888.

MyFRS Financial Guidance Line
Phone: (866) 446-9377 *(Mon-Fri. 8am-6pm)* | www.myfrs.com

Hernando County Wellness Center

The Wellness Center Offers Many Benefits!

Available to all employees, spouses and dependents (age 2 and up) on the medical plan.

- ✓ Completely Confidential
- ✓ Minimal Waiting Room Time
- ✓ Full-Service Primary Care
- ✓ On-Site Lab Draws
- ✓ On-Site Generic Prescriptions
- ✓ Personal Health Assessment (PHA)
  - PHA blood draw to identify risk factors
  - PHA LIVE - Video based personal PHA Summaries
  - CONFIDENTIAL PHA booklet mailed home which displays results as well as tips for improvement
  - Friendly follow-up by phone for urgent results
  - Physician follow-up in clinic
- ✓ Health Coach Services
- ✓ Wellness Program Classes
- ✓ Health Passport Wellness Program Website
- ✓ CareATC App
- ✓ CareATC Virtual Visits - Telemedicine visits and phone appointments with a CareATC provider
- ✓ Convenient Prescription Mail Service (90 Day Supply)
- ✓ Wellness Challenges

What Can be Treated?

- ✓ Adult Immunizations
- ✓ Allergies
- ✓ Asthma
- ✓ Cold and Flu
- ✓ Congestion
- ✓ Diabetes Management
- ✓ Headaches
- ✓ High Blood Pressure
- ✓ High Cholesterol
- ✓ Lab Work/Tests
- ✓ Physicals
- ✓ Tobacco Cessation
- ✓ Pre Employment Health Screenings
- ✓ Health Coaching

Location and Hours

Hernando County Wellness Center
20186 Cortez Blvd., Brooksville, FL 34601 | Phone: (352) 835-5431
Visit: www.patients.careatc.com | Download: Careatc App

Hours of Operation

Monday	7:30 am – 5:00 pm
Tuesday	7:30 am – 5:00 pm
Wednesday	7:00 am – 6:00 pm
Thursday	7:30 am – 5:00 pm
Friday	7:00 am – 5:00 pm

Notes

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

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RISK strategies | GEHRING GROUP
A RISK STRATEGIES COMPANY

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