



WE'VE GOT YOU COVERED

2020

Your Benefits: We've Got You Covered!

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Broward County is pleased to offer a comprehensive benefits program that lets you select the plans that make the most sense for you and your family. Our benefits program is an important part of your overall compensation and we regularly assess the quality and cost of the benefits to ensure we offer the most competitive package possible.

This benefits guide contains important information you will need to understand about your benefit options to help you enroll in the plans that are most suitable for you and your family. You will find information on each plan including plan overviews and features. For more specific plan details, please refer to the individual plan material available on our web site at www.broward.com/benefits.

All of the following benefit plans are administered by the Human Resources Division, Employee Benefit Services Section:

<ul style="list-style-type: none"> • COBRA Coverage • Deferred Compensation Education • Dental Insurance • Donated Leave • Health Insurance • Legal Insurance • Life Insurance 	<ul style="list-style-type: none"> • Long Term Disability Insurance • Personal Income Protection Plans • Pharmacy Insurance • Retiree Continuation Coverage • Retirement • Vision Insurance • WellBeing Program
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BE A WISE HEALTH CARE CONSUMER

The County is committed to making a significant investment in the health and welfare of our employees. It is important that both the County and our employees find ways to control these costs, and we encourage everyone to be wise health care consumers. Controlling health care costs must be a partnership between you and the County. Together, we can ensure a continued quality health care program that meets all our needs in a cost-efficient way.

Part of being a wise health care consumer is asking questions of your providers if you don't understand something, getting second opinions when appropriate, and carefully reviewing your bills for accuracy. The more you do to control costs, the better off you and the County will be in the long run. The following are some useful tips:

- Use generic and/or preferred formulary drugs.
- Use urgent care facilities or walk-in clinics instead of emergency room care whenever possible.
- Practice preventive health care and make healthy lifestyle choices.

- Inform Employee Benefits when a dependent is no longer eligible for coverage.

SECTION I – EMPLOYEE AGREEMENT

When you participate in the County benefit program, you are making the following automatic affirmations:

- You authorize and request payroll deduction(s) for the benefits you have selected.
- You agree to provide documentation, as required by Broward County, evidencing dependent status, domestic partner status or student/financial status for any person covered under a Broward County insurance plan within 31 days of a request for such documentation. If your dependent does not meet the eligibility requirements of the plan or you fail to supply any requested documentation, you understand that this may cause the ineligible dependent to be removed from coverage retroactive to the enrollment date, and you will be held legally and financially responsible for the repayment of all premiums, subsidies, and benefit claims incurred or paid on behalf of your ineligible dependent.
- You understand that health, dental and vision insurance premiums and Flexible Spending Account contributions will be pre-taxed to the extent possible and that your income subject to federal income tax and Social Security withholding (FICA) will be reduced, and that this may slightly affect your Social Security benefits in the future. If insuring an Over Age Dependent between the ages 26 and 30, or a Domestic Partner or child/children of a Domestic Partner, a portion of your premium attributable to their coverage will be deducted on an after-tax basis and you will pay imputed income on the portion of the Broward County subsidy provided to offset the cost of the health plan.
- You acknowledge that you cannot stop or change benefits paid for on a pre-tax basis during the plan year unless you experience a relevant qualifying event.
- You understand that a Section 125 Flexible Spending Account (Health Care and Dependent Care) can be used only to reimburse payment of eligible expenses incurred during the plan year while participating in the plan, and that any amount remaining in either spending account that is not used during the plan year will be forfeited. Funds in one spending account cannot be used to reimburse expenses covered by another account. Expenses for which you are reimbursed cannot be claimed on your income tax return. As Over Age Dependent children ages 26 to 30 and domestic partners or children of a domestic partner do not meet the IRS definition of dependent, their coverage is not eligible for pre-tax consideration or reimbursement through either type of Section 125 Flexible Spending Account, Health Reimbursement Account under a Consumer Driven Health plan or Health Savings Account under a High Deductible Health Plan.
- You understand and agree that Broward County and the third party FSA/HRA/HSA administrator will not incur any liability resulting from your failure to read all rules pertaining to benefit enrollment or to sign or accurately complete the Enrollment/Change Form. You also understand

that elections for benefits on a pretax basis are irrevocable and cannot be changed after the established deadline date. Subsequent changes can only be made upon experiencing a relevant qualifying event.

- You agree for yourself and covered members of your family and other dependents under County insurance plans to be bound by the benefits, deductibles, coinsurance, copayments, exclusions, limitations, eligibility requirements and other terms of the plan contracts, agreements and plan documents for the plans in which you enrolled.
- You understand that Broward County, Division of Human Resources, Employee Benefit Services Section, will collect your Social Security number as allowed under section 119.071(5)(a)2, Florida Statutes, for the following purpose: to match, verify and retrieve benefit plan information as well as for the purpose of payment and audit of premiums collected. You are being provided notice of this activity pursuant to section 119.071(5)3, Florida Statutes.
- You understand that a Mandatory Insurer Reporting Law (Section 111 of Public Law 110173) requires group health plan insurers, third party administrators and plan administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the secretary of the Department of Health and Human Services, information that the secretary requires for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers and workers' compensation laws or plans. Two key elements that will be required to be reported are SSNs (or HICNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the SSN or HICN and the EIN, as applicable.
- You certify that the information you supplied on the online enrollment system or Benefit Enrollment/Change Form and other benefit documents is true and complete to the best of your knowledge.
- You understand that any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree under section 817.234, Florida Statutes. Any person committing such acts will be subject to disciplinary action by Broward County and/or any other appropriate action.

SECTION II – WELLBEING PROGRAMS

The County's WellBeing Program is committed to enhancing the physical, financial and emotional well-being of Broward County employees by providing services that motivate employees and help them reach their goals. Services are designed to empower employees with the information, tools and support they need to take charge and move toward overall optimal health. Some of our programs include:

- Donated Leave Program
- Educational Seminars on Deferred Compensation, Retirement, FRS, DROP, Social Security, Medicare, Legal Issues, Financial Awareness, etc.
- Engagement Incentive
- Financial Fairs
- Florida Prepaid College Program
- Health Fairs with on-site flu shots
- Higi Health Stations
- Online wellness program with ability to earn rewards
- On-site Nutritionist
- On-site Testing (biometric (finger-stick screenings) blood pressure, and more)
- WellBeing Incentive Programs (Pharmacy Copay Waiver, Disease Management, Online Wellness Program)
- Wellness Resource Centers
- WellBeing Seminars and Health & Benefit Fairs



DONATED LEAVE PROGRAM

Benefit-eligible employees, who meet certain criteria, may donate a portion of their accrued annual leave and sick leave to other qualified employees.

Eligible employee: Sick or annual leave may be donated/received by an employee in the event of a serious* illness or injury as defined under FMLA after all applicable paid leave is exhausted. Donated Leave may also be approved for workers' compensation illness or injury while covered under FMLA. Donated Leave for workers' compensation will only be approved for hours needed to bridge the gap in earnings between workers' compensation and the employee's regular work hours.

Eligible dependents: Annual leave only may be donated/received in the event of a serious* illness or injury approved under FMLA after all applicable paid leave is exhausted. Eligible dependents include: Employee's spouse/domestic partner, child or parent.

**A determination for donated leave will be made upon receipt and review of a completed Donated Leave Recipient Form, FMLA Health Care Provider Certification Form (BC-102-380E or F), and FMLA Designation Form (BC-102-382) approving the FMLA leave.*

RECIPIENTS:

Approved recipients of donated leave must have exhausted all available and applicable paid leave including:

- accrued sick leave
- annual leave
- Compensatory time
- job basis leave
- personal days

An employee who is not eligible for FMLA due to not meeting the 12 month and 1,250 hour requirement, or has exhausted his/her FMLA period, must request a review by the Office of Intergovernmental Affairs and Professional Standards (OIAPS) to determine his/her status as a “qualified individual with a disability” as defined under Title I of the American’s with Disability Act of 1990 (ADA), and any potential accommodations as warranted before being approved for donated leave or an extension beyond the FMLA period.

DONORS:

- may donate a maximum of 80 hours of sick leave per calendar year
- may donate a maximum of 80 hours of annual leave per calendar year
- must have a remaining balance of 160 hours to donate sick leave
- must have a remaining balance of 80 hours to donate annual leave

Application forms are available on the BC-Net under the Forms Tab, Human Resources, Employee Benefit Services Section. Contact the Employee Benefit Services Section for information about donating or receiving donated leave.

Other Provisions:

- a. **Sick/Annual Leave Accrual** - Recipients do not accrue Sick or Annual Leave while they are receiving Donated Leave.
- b. **Holiday** - If a designated holiday occurs during the recipient's period of authorized leave, the employee will receive holiday pay which will not be charged against the remaining Donated Leave balance.
- c. **Overtime** - Donated Leave will not be counted as time worked for overtime purposes. The maximum amount of Donated Leave that will be approved for any work week is the amount that would bring the hours paid to the recipient's normal work schedule.

- d. **Documentation** - Employees applying to receive Donated Leave should provide all required documentation to the Division of Human Resources two (2) weeks prior to exhausting all applicable paid leave when the need is foreseeable and such prior notice is practicable.
- e. **Leave donations** are made on an hour for hour basis. Donations require the approval of the employee's Division Director and the Director of Human Resources or his/her designee. Donated Leave is not deducted from the donor's leave balance until it is used. Once Leave has been deducted from the donor's account, it cannot be returned to the donor.
- f. **Donation of accrued leave** does not affect the donor's earning a Bonus Day where otherwise eligible.
- g. **Termination of Eligibility** - Use of Donated Leave may be terminated under any of the following conditions:
 - a. The recipient applies for and receives:
 - Retirement benefits from FRS
 - Social Security retirement or disability benefits
 - Unemployment compensation
 - Accepts other employment during the approved leave
 - b. The County determines that the recipient has abused leave, falsified information, or was otherwise not eligible for leave. Employee may be required to repay any leave previously received and may be subject to disciplinary action including termination.
 - c. A recipient is expected to notify his or her immediate supervisor immediately when released by her or his physician and to return to work as soon as the medical condition permits. A recipient who fails to advise the County of the physician's release or to return to work in a timely manner will be required to repay any leave received since the effective date of the physician's release and may be subject to disciplinary action including termination.
- h. **Return to work on intermittent basis** - If a recipient returns to work on a reduced work schedule or on an intermittent basis, Donated Leave may be used to supplement pay for time worked, subject to appropriate documentation and approval.
- i. **Termination of employment** - Should the employment of a recipient terminate for any reason, any remaining Donated Leave will not be paid out.

ENGAGEMENT INCENTIVE – HDHP PLANS

Annual qualified preventive services (provided at no cost in-network), play a key factor in early detection of chronic and life-threatening diseases. To encourage preventive screenings, employees and insured spouse/Domestic Partner must complete the approved Engagement Incentive activities (or approved alternatives) between January 1, 2019 and December 31, 2019 to receive the County funding for the HSA (or HRA account if not eligible for a HSA) in 2020.

Newly benefit-eligible employees effective for health benefits on or after January 1, 2019 will automatically receive their prorated HSA (or HRA) funding for 2019; however, they will need to complete the Engagement Incentive during 20 19 to receive HSA funding for 2020.

FLORIDA PREPAID COLLEGE PROGRAM

The Florida Prepaid College Program allows parents, grandparents and others to lock in the cost of college at today's prices. The County makes it easy for you to make your payments by offering payroll deduction.

If you are already participating in this program and would like to make your payment through payroll deduction, please contact Payroll Central at PAYROLL@broward.org or 954-357-7190 for a form. Completed form should be submitted to Payroll Central in Room 2013 of the Governmental Center.

If you are interested in The Florida Prepaid Program be aware participation is restricted to specific enrollment periods. If you would like more information on The Florida Prepaid College Program call 800-552-GRAD or go to MyFloridaPrepaid.com.

HEALTH AND BENEFIT FAIRS

Annual Health and Benefit fairs are held throughout the year at various worksites with free screenings, educational information, nutritionist consultations, massage, and much more.

HIGI HEALTH STATIONS

Knowing your numbers can save your life. The County, through UnitedHealthcare, has installed several



higi health stations at County work sites for employees to check and track their blood pressure, pulse, weight and body mass index. Higi can connect to your mobile device and allows you to track your activity. Plus you can share your information with your physician or healthcare provider. Currently, Health Stations can be found at the following locations: Aviation Department (Cabot Bldg.), Governmental Center, Government Center West, Edgar P. Mills Center, Port Everglades (Admin. Bldg.), Traffic Engineering, Transit Division – Copans Road facility, Water & Wastewater Services.

NUTRITIONIST

Employees enrolled in a UnitedHealthcare Plan can schedule a one-on-one appointment with an on-site nutritionist and/or attend scheduled seminars and events.

PHARMACY COPAY WAIVER INCENTIVE PROGRAM – CDH PLANS ONLY

The Pharmacy (Rx) Copay Waiver Program is available to employees who enroll in the CDH plans under Unitedhealthcare and Community Care Select Network Plan. To be eligible, employee and/or enrolled

spouse/domestic partner must complete a Health Survey, the voluntary biometric screening (or approved alternative) and participate in Disease Management Coaching, if applicable. The Copay Waiver does not roll over from year to year. A new application and completion of requirements must be fulfilled annually. Copay Waiver will not be retroactive so submit your Copay Waiver form early.

- Includes enrolled spouse or Domestic Partner.
- The Pharmacy Copay Waiver Incentive program for maintenance medications covers 1st (generic) and 2nd (formulary) tier drugs only for the following Disease States:
 - Respiratory (asthma)
 - Diabetes
 - Cardiovascular (cardiovascular covers hypertension, chronic kidney disease, chronic obstructive pulmonary disease, coronary artery disease and congestive heart failure)
 - 2018 Copay Waivers expire on 12/31/18. Participating employees must reapply for the 2019 Copay Waiver.

DISEASE MANAGEMENT PROGRAMS

The County's health plans are designed to encourage healthy lifestyles and engage employees in actively managing their health care. Managing chronic, long-term diseases by following medical protocols to keep the diseases under control can help the member live a more healthful and productive life. The Disease Management program managed by our health insurance carriers (UnitedHealthcare and Community Care Plan) focuses on the following six disease states:

1. Asthma
2. Chronic Obstructive Pulmonary Disease (COPD)
3. Congestive Heart Failure (CHF)
4. Coronary Artery Disease (CAD)
5. Diabetes
6. Hypertension

Participants will receive one-on-one coaching and education from Disease Management nurses and will be eligible for rewards based on compliance with following the protocols established for each disease state.

ONLINE WELLBEING PROGRAMS

The health insurance carriers provide online wellness programs that use cutting edge technology and proven techniques to engage individuals in activities promoting physical fitness, good eating habits and behavioral management. The health improvement programs provide customized wellness plans based on personal fitness goals and current state of health. The programs offer many features and programs such as:

- Health Assessment
- Custom made fitness and nutrition plans
- Charts to track your progress
- Wellness and WellBeing webinars and podcasts
- Ability to earn points by logging on and completing goals and/or downloading workout data from many devices.

Access your wellness tool by logging into your secure account through UnitedHealthcare (myuhc.com) or Community Care Plan's (ChooseCommunityCare.org) web portal.

TOBACCO CESSATION ASSISTANCE

The County is committed to well-being and has waived the copay/cost on prescription or over-the-counter generic smoking cessation products. Over-the-counter generic products will also be covered providing you have a prescription from your provider. The Tobacco Cessation Assistance program will cover two (2) attempt cycles per year per member over the age of 18. (For further explanation, please contact Employee Benefit Services.)

WELLNESS RESOURCE CENTERS

Wellness Resource Centers are currently located at the Aviation Department Administration Building (Cabot Bldg.), Governmental Center on the third floor in Room 308 next to the cafeteria, Government Center West on the third floor in Room 3300B and atrium area, Edgar P. Mills Center, Port Everglades Administration Building – First Floor, Traffic Engineering Operations Building lobby, Transit Division – Copans Road facility, Ravenswood Facility, Water and Wastewater Services – Building

The Wellness Resource Centers are designed to provide access to health, dental, vision, retirement, financial and wellness information through printed material, presentations, videos and online access at the computer stations.

WELLNESS SEMINARS AND HEALTH & BENEFIT FAIRS

The County is committed to encouraging healthier lifestyles by providing educational and preventive health care information to all of our employees through various wellness programs such as seminars, newsletters, on-site screenings, self-directed programs, health awareness campaigns and health & benefit fairs.

SECTION III – ELIGIBILITY AND DOCUMENTATION REQUIREMENTS

Employees in full-time and part-time 20-plus hour positions are eligible for benefits under the County's Section 125 Benefit Plan, subject to collective bargaining agreement provisions, if applicable.

Eligibility is determined at the point of hire based on position, and eligibility for subsequent plan years is determined using a look-back measurement method. The look-back measurement method is based on IRS final regulations under the Affordable Care Act (ACA). Effective October 12, 2014, the County began using a 12-month look-back measurement method (October through September) to determine who is a full-time employee for purposes of program eligibility.

Coverage is effective on the first of the month following 30 days of employment in a benefit-eligible position. If you have questions about eligibility, contact Employee Benefit Services at 954-357-6700 or email benefits@broward.org.

DEPENDENT ELIGIBILITY

- **Spouse***: Employee's legal spouse (opposite or same-sex)
- **Domestic Partner***: Employee's registered domestic partner (specials rules apply)

NOTE: Working Spouse/Domestic Partner (DP) Surcharge: Employees enrolling their spouse or domestic partner in the County's health plan will be required to complete a Working Spouse/DP Affidavit indicating whether their spouse/DP is employed. If employed, and if health coverage is offered through their employer, a \$20 bi-weekly surcharge will be applied. The Working Spouse/Domestic Partner Surcharge also applies to employees married to another County employee who waives County health coverage. It is your responsibility to notify Employee Benefit Services if your spouse/domestic partner gains eligibility for coverage, or loses coverage.

- **Children:**
 - ✧ **Child** – your biological child, child with a qualified medical support order or legally adopted child through the end of the calendar year in which the child turns age 26.
 - ✧ **Stepchild** – the child of your spouse/domestic partner for as long as you remain legally married/registered domestic partner to the child's parent through the end of the calendar year in which the child turns age 26.
 - ✧ **Legal guardianship** – a child for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state or federal laws or a child for whom you are grant court-ordered temporary or other custody through the end of the calendar year in which the child turns age 26.
 - ✧ **Foster child** – a child that has been placed in your home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency through the end of the calendar year in which the child turns age 26.

- ✱ **Newborn child of a covered dependent (health insurance only)** – a newborn child of an enrollee’s eligible child who is covered under County’s group health insurance at the time of the newborn child’s birth. Coverage ends at 18 months or when the parent of the child terminates coverage or is no longer eligible, whichever is earlier.

- ✱ **Children over the age of 26 with permanent intellectual or physical disabilities if** – Your covered child with intellectual or physical disabilities. This child may continue health insurance coverage after reaching age 26 and while remaining continuously insured under a Broward health plan, or the child was over the age of 26 at the time of your initial enrollment. The child must be incapable of self-sustaining employment because of the intellectual or physical disability, and be dependent on you for care and financial support.

- ✱ **Children between the ages of 26 and 30 (Over Age Dependents) (health, dental and vision insurance only)** – eligibility begins the year after an eligible child turns 26 and ends on December 31 of the year he or she turns age 30. To be eligible and remain eligible, the child must be:
 - unmarried, and
 - have no dependents of their own, and
 - are dependent on you for financial support, and They live in Florida or attend school in another state, and They have no other health insurance available to them, and
 - you pay an additional monthly premium and imputed income tax.

NOTE: If a child is covered under the Over Age Dependent provision and you cancel their coverage due to a qualifying event, the Over Age Dependent is not eligible to again be covered under this provision unless the child was continuously covered by other creditable group coverage without a gap of more than 63 days. Documentation of prior coverage will be required. If a child covered under this provision becomes a parent, the newborn will not be covered under the plan and the child/parent’s coverage will terminate at the end of the birth month. Only the Over Age Dependent will be offered COBRA coverage.

IMPORTANT: Employee must notify the Employee Benefit Services Section within 31 days of a divorce or dissolution of a domestic partnership or any other action that causes a covered dependent to not meet the eligibility guidelines. Upon loss of eligibility, the dependent can no longer remain under the group insurance plan and will be offered continuation coverage at 102 percent of the full cost under COBRA. If you experience a relevant qualifying event, it is your responsibility to notify the Employee Benefit Services Section within 31 days of the event. Beyond 31 days, the employee is responsible both legally and financially for any claims and/or expenses incurred as a result of any dependent(s) who continues to be enrolled who no longer meet the County’s eligibility requirements.

LIFE CHANGE = 31 DAY WINDOW TO MAKE CHANGE

PROOF OF DEPENDENT ELIGIBILITY

Documentation establishing your legal relationship to an enrolled dependent is required any time a dependent is added to any of your benefit plans (new hire, open enrollment or qualifying event). Under Health Care Reform, you are also required to provide their Social Security Number for reporting purposes.

Documents written in a language other than English must be accompanied by a certified translation.

The types of documentation accepted are:

DEPENDENT RELATIONSHIP	DOCUMENTATION REQUIRED
Spouse (opposite or same- sex)	Copy of Official Registered Marriage certificate (religious certificate not acceptable if married in the USA)
Domestic Partner	Copy of Domestic Partnership Registration Certificate issued by Broward County Records Division
Child(ren)* see below	Copy of Official State Birth certificate(s) (birth cards not acceptable), must show employee as parent)
Stepchild(ren)	Copy of Official State Birth certificate(s) AND Copy of Official Registered Marriage certificate
Child(ren) of Domestic Partner	Copy of Official State Birth certificate(s) AND applicable Domestic Partner Registration documentation as indicated above
Child(ren) under Legal Guardianship, Custody or Foster Care	Copy of Legal Guardianship/Custody document from Courts or Copy of Foster Care documentation from Courts
Child(ren) adopted or in the process of adoption	Copy of Legal Adoption documentation showing placement in employee's home prior to Adoption or Adoption Certificate issued through Courts
Grandchild(ren) OR other children not related	Copy of Official State Birth certificate of child(ren) AND Copy of Guardianship/ Adoption/Custody/Foster care document from Courts

Section 817.234, Florida Statutes clearly states that any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Recognition of any such person committing such fraud will be subject to appropriate action by Broward County and/or the insurance carrier.

OVER AGE DEPENDENT (CHILD AGE 26 BUT LESS THAN AGE 30 ON 01/01/2020) – DOCUMENTATION OF STUDENT STATUS OR FINANCIAL SUPPORT

You are required to sign an Over Age Dependent Affidavit and provide supporting documentation indicating whether the dependent is a student (copy of current semester enrollment) or financially dependent (copy of valid Florida drivers' license) upon the employee at the time of enrollment.

STUDENT	FINANCIALLY DEPENDENT
1. Over Age Affidavit, and 2. Proof of student status which must include ALL of the following (pre-printed by the educational institution): <ul style="list-style-type: none"> • Name of school/college/university • Name of dependent • Date(s) of semester showing enrollment in 2020 	1. Over Age Affidavit, and 2. Proof of residence: Current driver's license showing a Florida address

WHEN CAN I ENROLL?

You can enroll yourself and your eligible dependents:

- Upon employment in a benefit-eligible position or attaining benefit eligibility status. Coverage is effective on the first of the month following completion of initial 30-day eligibility period.
- Upon experiencing a relevant qualifying event, within 31 days of the date of the event (coverage will be effective the first of the month after Employee Benefit Services receives the completed paperwork with the exception of newborns, adoption, placement for Foster Care or guardianship which will start on the effective date of the qualifying event).
- During the annual Open Enrollment in the fall of each year.

WHEN DOES MY COVERAGE BECOME EFFECTIVE?

You are eligible for the following coverage effective with your **date of hire**, or date of being classified as a **benefit-eligible** employee:

- \$25,000 Basic Term Life Insurance paid by the County
- Florida Retirement System (FRS)
- Deferred Compensation (457(b) Plans
- Employee Education Benefit (tuition reimbursement assistance)
- County's Employee Assistance Program

You are eligible for the following voluntary coverages effective **first day of the month following 30 calendar days** in a benefit-eligible position:

- Health insurance
- Dental PPO or DHMO insurance
- Vision insurance
- Flexible Spending Accounts, Health Savings Account or Health Reimbursement Account (based on health plan enrollment)
- Supplemental Life & AD&D coverage for you, your spouse/domestic partner and child(ren)
- Long Term Disability
- Personal Income Protection Plans
- Pre-Paid Legal Insurance

TYPE OF ELIGIBILITY	EFFECTIVE DATE
New Hire	On the first day of the month following 30 days of employment in a benefit-eligible position
Rehire less than 30 days	First day of the month following rehire – elections remain the same, retro deductions will be taken
Rehire more than 30 days	First day of the month following 30 days of re-employment – new elections must be made
Part Time 20 (PT20) to Full-time	First day of the month following change of status date
Part Time 19 (PT19) to benefit-eligible (PT20 or Full-Time)	First day of the month following 30 days in new classification. (Must attend the Benefits session of OnBoard Broward)
Return from Leave of Absence (LOA)	First of the month following change of status date
Qualifying Event – Birth of Baby, Adoption, placement for Foster Care, Court awarded Guardianship	Date of the event. Must notify Employee Benefit Services with 31 days of the event.
Qualifying Event to add a dependent – Marriage, Domestic Partner Registration, Loss of Other Group Coverage, Qualified Medical Child Support Order (QMCSO), etc.	Within 31 days of the event (coverage effective on the first of the month following receipt and processing of paperwork)

WHEN DOES MY COVERAGE END?

TYPE of CHANGE	HEALTH, PHARMACY, DENTAL, VISION, HRA	FSA, LIFE, LTD, LEGAL
Benefit-eligible to Non-Benefit-eligible position	Last day of the month in which classification change is effective	Date of position change
Retirement	Last day of the month in which retirement occurs	Date of retirement
Separation/Termination	Last day of the month in which employment ends	Date of separation / termination
Qualifying Event to remove a dependent – Divorce, Dissolution of Domestic Partner Registration, Gaining of Other Group Coverage, Death	End of the month in which the event occurred. Must notify Employee Benefit Services with 31 days of the event. NOTE: A ineligible dependent cannot remain on County insurance. It is the employee's responsibility to notify Benefits within 31 days of their dependent becoming ineligible. If reported late, employee will be financially responsible for reimbursing the County for all pharmacy claims incurred after the ineligibility date.	Date of Event

IF I CHOOSE NOT TO ENROLL IN BENEFITS FROM THE COUNTY AND NEED THEM LATER, HOW DO I ENROLL?

If you have health, dental and/or vision benefits from another group plan and waive enrollment in the County plans, but then lose your other coverage, you will have 31 days from the qualifying event (the date of loss of your other coverage) to elect coverage and provide documentation. If there is no prior coverage, you may only enroll if you experience a relevant qualifying event, such as marriage, domestic partner registration or birth or during open enrollment in the fall of each year.

CAN I MAKE CHANGES DURING THE PLAN YEAR?

Under certain circumstances, you may be permitted to make changes to your benefit elections during the plan year, such as additions, deletions and cancellations, depending on whether you experience an eligible Qualifying Event/Change in Status as determined by the IRS Code, Section 125. If you experience a Qualifying Event/Change in Status, the election changes must be requested within 31 days from the Qualifying Event/Change in Status date (60 days for a newborn or adoption) and the change must be consistent with the type of event. Based on the event, you may add or delete dependents to your existing coverage; however, you cannot change your medical or dental plan to another plan type or carrier.

Qualifying Event/Change in Status events include, but are not limited to:

- Marriage or divorce
- Registration or dissolution of Domestic Partnership
- Death of a dependent (60 days)
- Birth or adoption (60 days)
- Legal guardianship
- Change in a dependent's eligibility
- Change in employment status for you or your dependents
- Change from part-time to full-time employment status or vice versa
- Going on unpaid leave:
 - Family and Medical Leave and Job Protected Leave Authorized leave without pay
 - Workers' Compensation disability leave
 - Military leave

WHEN AND HOW DO I REQUEST A CHANGE IN STATUS?

Contact the Employee Benefit Services Section at 954-357-6700 or email benefits@broward.org **in advance** of the event, but no later than 31 days from the date of the event.

Documentation supporting the Qualifying Event/Change in Status must be submitted with a current Enrollment/Change Form. Requests made later than 31 days from the date of the event will not be approved (exception: newborn babies and adoptions; requests must be made within 60 days of the birth/placement for adoption).

Effective date of the change in coverage due to a Qualifying Event/Change in Status:

- Coverage becomes effective on the first of the month following the date the paperwork and documentation is received and approved by the Employee Benefit Services Section. (Exception: The

only Qualifying Event/Change in Status changes that will be made retroactive are: birth*, adoption, foster care placement or court appointed guardianship.)

- **IMPORTANT:** Your **newborn child is not automatically enrolled** by the County or group health plan. You must add your newborn dependent through the Employee Benefit Services Section within 60 days, even if your current coverage includes Employee and Children, or Employee and Family coverage.
- Coverage ends on the last day of the month in which the Qualifying Event/Change in Status occurred in most situations. Supporting documentation is required and must be submitted to Employee Benefit Services within 31 days of the Change in Status date.
- Loss of other Group coverage midyear: You can enroll in a County health plan midyear if you have lost other group insurance coverage. Supporting documentation of the loss of coverage is required and must be submitted to the Employee Benefit Services Section within 31 days of the loss of coverage date.

If you experience a relevant Qualifying Event/Change in Status, it is your responsibility to notify Employee Benefit Services within 31 days of the event. Beyond 31 days, you are responsible both legally and financially for any claims and/or expenses incurred as a result of any dependent(s) who continues to be enrolled when they no longer meet the County's eligibility requirements.

WHAT AND WHEN IS THE ANNUAL OPEN ENROLLMENT?

Open Enrollment is a period of time, determined by the County, during which you are allowed to make changes to your pre-tax benefits (health, dental, vision, and Flexible Spending Accounts (Health Savings Accounts contributions can be changed at any time during the year) and after-tax prepaid legal plan, personal income protection plans and life insurance, for the following plan year. Annual pre-tax elections are irrevocable unless experiencing a Qualifying Event/Change in Status. All benefit-eligible employees are **required to reenroll or waive coverage through the online system each year** during open enrollment. The County's Open Enrollment for pre-tax and specified after-tax benefits is held annually during the last quarter of the calendar year to allow eligible employees to:

- enroll in, change or disenroll from health, dental, and/or vision coverage
- waive County health, dental, and/or vision coverage
- enroll in prepaid legal coverage (does not rollover each year)
- enroll in personal income protection plans (Cancer, Critical Illness, Hospitalization, etc.)
- enroll in or change life insurance coverage (subject to plan restrictions)
- enroll or remove dependents from health, dental or vision plans without a relevant Change in Status/Qualifying Event
- start, stop or change deductions to a Section 125 Flexible Spending Account (Health Care or Dependent Day Care), or Health Savings Account.

RETIREMENT REMINDER: If planning on retiring in 2021, the elections made during open enrollment in October 2020 or through a Qualifying Event/Change in Status prior to retirement for health, dental and vision, will be the only plans available for Retiree Continuation of Coverage. Retirees cannot elect or enroll in health, dental or vision coverage if not enrolled as an active employee at the time of retirement.

No other after-tax County benefits are subject to Open Enrollment restrictions. Other benefits may be elected or changed at any time during the year based on plan rules. Changes made during Open Enrollment go into effect the following January 1.

WHAT SHOULD I DO IF MY SPOUSE/DOMESTIC PARTNER'S OPEN ENROLLMENT IS BEFORE OR AFTER MY OPEN ENROLLMENT?

This situation is a "qualifying event." It is highly recommended that you complete your open enrollment with Broward County. Upon showing us proof of enrollment in another open enrollment plan within 31 days of the effective date of the new plan, we may allow you to make a change to your County enrollment. If you miss your 31 day opportunity, you will have to wait until another qualifying event or open enrollment occurs. To make the best decision, contact the Employee Benefit Services Section with your questions during open enrollment.



New hires are required to complete the annual open enrollment (enrollment or waiver of coverage) even if you just enrolled for December 1st. Open enrollment is a requirement each year for the following year.

SECTION IV – PRETAX HEALTH, DENTAL, VISION, AND FSA PLANS

The County offers a benefits program that gives you the opportunity to select between a variety of taxable (after-tax) and tax-free (pre-tax) benefits, allowing you to customize your benefits to meet your needs. Pre-tax benefits are offered under Section 125 of the Internal Revenue Code and is often referred to as a Cafeteria Plan.

When making your selections, the plans will fall into the following tax categories:

PRE-TAX PLANS	AFTER-TAX PLANS
<ul style="list-style-type: none"> ▪ Medical (self-insured health and pharmacy) ▪ Dental ▪ Vision ▪ Flexible Spending Accounts (FSA) ▪ Health Savings Account (HSA) ▪ Health Reimbursement Account (HRA) 	<ul style="list-style-type: none"> ▪ Optional Term Life ▪ Spouse Term Life ▪ Child Term Life ▪ Long Term Disability ▪ Pre-Paid Legal Plan

HOW DO I BENEFIT FROM A PRE-TAX PLAN?

Payroll taxes are reduced when premiums and/or HSA or FSA contributions are deducted on a pre-tax basis giving your more take-home pay. In addition, the County subsidy for the health plan is not taxable income to you under most circumstances (*See Special IRS Rules for Pre-Tax Plans below*).

SPECIAL IRS RULES FOR PRE-TAX PLANS

Under current tax law, the portion of the premium that applies to coverage for the following dependents cannot be deducted on a pretax basis and the portion of the County subsidy becomes imputed income to you:

- Domestic Partner (unless claimed on your income tax return)
- Domestic Partner children to age 30 (unless claimed on your income tax return)
- Children age 26-30 (Over Age Dependents)

Deductions on your ePay Statement will be broken out between pre-tax and taxable amounts.

As the health plan is subsidized by the County, we must calculate and tax you on the amount of the subsidy that is attributable to insuring non-IRS dependents.

The imputed income tax will be added on the Earnings side so that it is taxed, and then reversed on the Deductions side so that you are only paying taxes on that amount.

IRREVOCABLE ELECTION

Once you enroll in a pre-tax benefit plan your election is irrevocable until the next annual open enrollment unless you experience a relevant Qualifying Event. (*See Relevant Qualifying Events/Change in Status.*)

HEALTH INSURANCE

Broward County offers two types of medical plans under two carriers for you to choose from:

UnitedHealthcare (National Network)	Community Care Plan (Select (Narrow) Local Network)
<ul style="list-style-type: none"> ▪ High Deductible Base Plan ▪ High Deductible In/Out of Network Plan ▪ Consumer Driven Plan 	<ul style="list-style-type: none"> ▪ High Deductible Select Network Plan ▪ Consumer Driven Select Network Plan

The HDHP Base Plan is our core medical and pharmacy plan with all other health plans being buy-up options. The County significantly subsidizes all health plans and tiers of coverage.

OPT-OUT OF MEDICAL COVERAGE

The County offers a Waiver Credit to those employees who have other qualifying group health insurance. The Waiver Credit for Full-Time employees is \$119.23 bi-weekly and for Part-Time 20+ employees \$59.62 bi-weekly and is considered taxable income. To receive the Waiver Credit, proof of the other qualifying group health insurance must be provided every year. NOTE: Coverage through the Health Care Exchange or a Cost/Medi Sharing Plan does not qualify for the Waiver Credit.

ABOUT COMMUNITY CARE PLAN (CCP) SELECT (NARROW NETWORK) LOCAL PLANS

The CCP Select (Narrow) Local Network Plan is a community-based health plan owned by Broward Health Group and Memorial Healthcare System and administered by Community Care Plan (CCP). The CCP Select (Narrow) Local Network plan is built around a total care philosophy. Members will receive one-on-one member support through CCP's personalized Concierge Care Coordination (C3) program which helps members receive quality care at the right time and in the right place.

All services must be obtained by providers, facilities and hospitals within the following four hospital groups:

<p>Select (Narrow) Network</p>	<ul style="list-style-type: none"> → Memorial Healthcare System → North Broward Hospital Group → Holy Cross → Cleveland Clinic Florida
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Pharmacy coverage is provided through Southern Scripts.

CCP provides two plans under their Select (Narrow) Local Network, a CDH Plan, at a lower cost than the CDH Plan under UnitedHealthcare and an HDHP plan.

The CCP Select (Narrow) Local Network plan has its own wellness program, “WellSteps” focused on achieving and maintaining good health. The program is designed to educate, engage, involve and empower members to take control of their daily activities to maintain optimal health.

COMPARISON BETWEEN COMMUNITY CARE PLAN AND UNITEDHEALTHCARE

* All in-network services provided at carrier contracted rate.

Plans/Network/Services	Community Care Plan (CCP)	UnitedHealthcare (UHC)
Plans Offered	CDH* and HDHP Base *lower employee rate	CDH, HDHP Base, and HDHP with Out-of-Network Coverage
Network	Select, Local Network	National Network
Lab Services	Lab Corp and Quest Labs	Lab Corp and Quest Labs
WellBeing Reward Program	WellSteps Program	Rally Rewards Program
Condition Management Programs	CareGuardianProgram (Diabetes/Pre-Diabetes, Hypertension, Asthma/COPD, High Risk Pregnancy). New for 2020: Bariatric Program	Diabetes Health Plan, Real Appeal, Condition Management programs. New for 2020: Personal Health Support, Orthopedic Health Support with bundled payments for surgery, Bariatric Program
Virtual Visits	Through CCP	AmWell, Doctor on Demand, TeleDoc
Behavioral Health/Substance Abuse	Requires a referral from CCP prior to receiving services	No referral required
Health Advocates	Concierge Care Coordination Team	On-site Representatives, Nurse and Dietitian
Dental and Vision Services	Basic Dental and Vision Plan Riders embedded in health coverage.	Basic Dental and Vision Plan Riders embedded in health coverage.

INSURANCE TERMS

- **Premium** –The amount an employee pays per pay period for health insurance
- **Balance Bill** –The difference between the amount charged by an out-of-network provider for a covered health service and the amount a member’s health plan (insurance) pays. Out-of-network providers may balance bill members for these costs
- **Consumer Driven Health Plan (CDH):** A health plan with a higher premium and some services for a fixed copay and some services subject to an annual deductible and when met, annual coinsurance.
- **Copay** –A fixed dollar amount a member pays for covered health services under a Consumer Driven Health plan, such as a doctor’s visit or prescription.

- **Coinsurance** – The sharing of expenses for Covered Services between Insurance Plan and the Member. Coinsurance is expressed in a percentage rather than a dollar amount.
- **Deductible** – The amount a member must pay before Insurance Plan will make any payment toward Covered Services subject to the annual deductible.
- **Health Reimbursement Account (applies to HDHP Plans if not eligible for an HSA):** A Health Reimbursement Account (HRA) is a County funded pool of money available at the beginning of the year*, or prorated upon benefit eligibility, to pay eligible health, pharmacy, dental and vision care expenses for you and any enrolled dependent(s)** which have not been previously reimbursed by your plans, such as copayments, coinsurance and deductible.

* Subject to completion of the 2020 Engagement Incentive. See Health Reimbursement Account (HRA) section for details.

** HRA can only be used to reimburse expenses for dependents claimed on your income tax.

- **Health Savings Account (applies only to HDHP Plans):** Health Savings Accounts (HSAs) are like personal savings accounts, but the money in them is used to pay for qualified health, pharmacy, dental and vision care expenses. You – not your employer or insurance company – own and control the money in your Health Savings Account. The money you deposit into the account is not taxed, and it is not taxed when used to pay for qualified health care expenses (as defined by the IRS) for dependents claimed on your income tax. To be eligible for an HSA, you must be enrolled in a high deductible health plan.
- **High Deductible Health Plan (HDHP):** A health insurance plan with lower premiums and higher deductibles than a traditional health plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible).
- **In-Network** –A group of doctors, hospitals, pharmacies, and other providers who contract with the insurance companies and provide services at negotiated rates
- **Maximum Out of Pocket:** A maximum out-of-pocket expense is the “maximum” amount of money you will be responsible to pay for covered health services that are subject to a deductible and coinsurance before the plan pays 100 percent. (100 percent level based on contracted rate In-Network and usual and customary for Out-of-Network.)
- **Out-of-Network** –A group of doctors, hospitals, pharmacies, and other providers who do not contract with the insurance companies and do not provide services at negotiated rates. Members pay more out of pocket due to higher deductible and Out of Pocket limits and no contracted provider rates. Providers may balance bill even after the out-of-network, out-of-pocket maximum is reached.
- **Out-Of-Pocket Maximum** –The maximum annual out-of-pocket amount a member pays before the health plan (insurance) pays 100% of covered health services. For out-of-network services, providers may balance bill even after the out-of-network, out-of-pocket maximum is reached.
- **Participating Provider:** Individual physicians, hospitals, facilities and other healthcare providers who have a contract to provide services to its members at a negotiated discounted rate.

- **Select Network (Narrow Network) Plan:** A health plan with a community-based network of hospital groups and their associated providers and facilities.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP) (OFFERED BY CCP AND UHC)

The County offers two types of HDHP plans, a HDHP Base Plan and a HDHP In/Out of Network Plan. The plans consist of two parts – self-insured medical and pharmacy coverage and an employer-funded Health Savings Account (HSA) or Health Reimbursement Account (HRA) if not eligible for a HSA.

HDHP plans do not have copays. All services, with the exception of designated preventive exams/screenings and designated preventive prescriptions, are subject to an annual deductible, and when met, annual coinsurance. Once the Maximum Out of Pocket is met, the plan pays 100% of covered services and prescriptions for the remainder of the calendar year.

The following chart compares the major features of both HDHP plans:

2020	HDHP BASE PLAN UHC and CCP		HDHP WITH OUT-OF-NETWORK PLAN UHC ONLY	
	IN-NETWORK ONLY		IN-NETWORK	OUT-OF-NETWORK
County-Funded HSA or HRA ⁽¹⁾	Individual: \$1,200 Family: \$2,400		Individual: \$1,200 Family: \$2,400	
Annual Deductible	Individual: \$1,400 Family: \$2,800	Individual: \$1,500 Family: \$3,000	Individual: \$3,000 Family: \$6,000	
Co-insurance (after Annual Deductible is met)	Individual: \$2,025 @ 20% Family: \$4,050 @ 20%	Individual: \$1,500 @ 20% Family: \$3,000 @ 20%	Individual: \$3,000 @ 40% Family: \$6,000 @ 40%	
Maximum Out-of-Pocket	Individual: \$3,425 Family: \$6,850	Individual: \$3,000 Family: \$6,000	Individual: \$6,000 Family: \$12,000	
Preventive Exams/Screenings (When billed as Preventive)	No Cost	No Cost	Not Covered	
Preventive Prescriptions	No Cost (limited to drugs on designated Preventive Drug List)	No Cost (limited to drugs on designated Preventive Drug List)	Not Covered	
All other medical and prescription	Annual Deductible, and when met, 20% Coinsurance based on carriers' contracted rates.	Annual Deductible, and when met, 20% Coinsurance based on carrier's contracted rates.	Medical Only: Annual Deductible, and when met, 40% Coinsurance at Usual & Customary rate. Prescriptions not covered	
WellBeing Program	Employee and enrolled Spouse/DP can earn up to \$300 each per year. UHC-Rally Program CCP-WellSteps Program.	Employee and enrolled Spouse/DP can earn up to \$300 each per year. UHC-Rally Program CCP-WellSteps Program.		

HOW TO USE A HDHP

What is an annual deductible?

An annual deductible is the amount of medical and pharmacy expenses that must be paid by you during the plan year before the insurance plan will start sharing costs. However, the HDHP plans will cover designated preventive care at 100%, even prior to reaching the deductible. The in-network deductible for 2020 is:

- HDHP Base Plan: Employee Only: \$1,400 and Employee plus Dependent(s) \$2,800 In-network (IRS increased minimum deductible for 2020 from \$1,350 to \$1,400 for Employee Only and from \$2,700 to \$2,800 for Employee plus Dependent(s) coverage)
- HDHP In/Out of Network Plan: In-network - Employee Only: \$1,500 and Employee plus Dependent(s) \$3,000 In-network
Out of Network – Employee Only: \$3,000 and Employee plus Dependent(s) \$6,000

When you are covering dependents on the plan, one member can meet the deductible for the entire family or it can be met by a combination of members. The plan will not start paying at the coinsurance rate until the annual deductible for the tier of coverage is met.



Only covered medical and pharmacy expenses go toward meeting the annual deductible and coinsurance. Dental, vision and over-the-counter medications do not apply to the annual health deductible.

What is Coinsurance?

Coinsurance is the cost sharing between you and the plan that will occur after the deductible has been met. For 2020, the medical and pharmacy coinsurance amounts are

- HDHP Base Plan: 20% your responsibility and 80% plan responsibility in-network coverage only
- HDHP In/Out of Network Plan: In-network - 20% your responsibility and 80% plan responsibility, Out of Network - 40% your responsibility and 60% plan responsibility.

When you are covering dependents on the plan, one member can meet the coinsurance for the entire family or it can be met by a combination of members. The plan will not start paying 100% until the annual coinsurance for the tier of coverage is met.

What is the Out-of-Pocket maximum?

The out-of-pocket maximum is the most that you will have to pay in a year for deductible and coinsurance combined for covered medical and pharmacy benefits. It does not include premiums. For 2020, the Out-of-Pocket maximum is:

- HDHP Base Plan: \$3,425 for those with Employee Only (Individual) coverage and \$6,850 for those with dependents (Family) covered on the plan. When you are covering dependents on the plan, one family

member can reach the out-of-pocket maximum for the entire family or it can be met by a combination of family members.

- HDHP In/Out of Network Plan: In-Network - \$3,000 for those with Employee Only (Individual) coverage and \$6,000 for those with dependents (Family) covered on the plan. Out-of-Network - \$6,000 for those with Employee Only (Individual) coverage and \$12,000 for those with dependents (Family) covered on the plan. Expenses met under the In-Network coverage and the Out-of-Network coverage go toward meeting each plans deductible and coinsurance.
- When you are covering dependents on the plan, one family member can reach the out-of-pocket maximum for the entire family or it can be met by a combination of family members. Example:

	HDHP In-Network		HDHP Out of Network
Annual Deductible	\$3,000		\$6,000
Claims incurred in-netwok	-\$1,000		-\$1,000
Claims incurred out of network	-\$2,000		-\$2,500
Deductible Balance	\$0		\$2,500

When Do I Pay a Copayment?

There are no copayments associated with a HDHP, only preventive exams/screenings at no cost, or services subject to your annual deductible, and when met, 20% coinsurance.

When do I pay Coinsurance and/or a Deductible?

You must satisfy the annual deductible for all health and pharmacy services not covered under Preventive Care. Once the annual deductible is satisfied, you pay 20% and the insurance plan pays 80% coinsurance of the contracted in-network healthcare costs. Under the County’s HDHP plan, once the Out-of-Pocket maximum has been satisfied, the health plan pays 100% of contracted in-network healthcare costs and 100% of prescription costs. Please review the HDHP Benefit Summaries provided by UnitedHealthcare and Community Care Plan for a detailed list of services and costs.

How many family members must satisfy a deductible?

The deductible under the HDHP is an integrated deductible: medical and prescription costs apply to the same deductible. There are only two levels of deductible: Employee Only coverage and Employee Plus Dependent(s) coverage (Spouse/Domestic partner, children, or family). For Employee Plus Dependent(s) coverage, the family deductible must be met before the health plan will pay any benefits.

How many family members must satisfy coinsurance?

The coinsurance maximum under the HDHP also applies to medical and prescription costs. There are only two levels of coinsurance: Employee Only coverage and Employee Plus Dependent(s) coverage (Spouse/Domestic partner, children, or family). For Employee Plus Dependent(s) coverage, the family coinsurance amount must be met before the health plan will pay 100% of contracted in-network healthcare costs and 100% of

prescription costs. Please review the HDHP Benefit Summaries provided by UnitedHealthcare and Community Care Plan for a detailed list of services and costs.

HDHP Plans

- Lower payroll deduction
- First \$ health and Rx payment at carrier negotiated rates (no copays)
- Higher out of pocket max



CDH Plans

- Higher payroll deduction
- Some health copays
- Rx copays
- Lower out of pocket max

CONSUMER DRIVEN HEALTH PLAN (CDH) (CCP AND UHC)

The CDH Plan design has some medical services for set copays and some services subject to an annual deductible, and when met, annual coinsurance. The pharmacy plan is all copays.

HOW TO USE YOUR CDH PLAN

When Do I Pay a Copayment?

Copays only apply to certain services such as Primary Care Visits, Specialist Visits, Urgent Care, Emergency Room and prescriptions. Review the full Benefit Summaries provided by UnitedHealthcare and Community Care Plan for a detailed list of services and costs.

When do I pay Coinsurance and/or a Deductible?

You are subject to the annual deductible and coinsurance under the County's CDH Plans for all services not subject to a copay or covered under Preventive Services such as outpatient or inpatient facility or hospital services. Please review the Benefit Summaries provided by UnitedHealthcare and Community Care Plan for a detailed list of services and costs.

How many family members must satisfy a deductible?

Under the CDH Plans, the family deductible is equal to twice the individual deductible. Once any combination of family members has met the family deductible, all insureds will be deemed to have met their deductible.

Note: No one individual can be charged more than his/her individual annual deductible. Example:

Family Deductible is \$3,000, Individual Deductible is \$1,500,
Family Coinsurance is \$6,000, Individual Coinsurance is \$3,000

Dependent 1 incurs deductible of \$1,500 and Coinsurance/Copays of \$1,500. Dependent 1's claims are covered at 100% for the remainder of the year.

Dependent 2 and Dependent 3 incur \$300 and \$1,200 each in deductible expenses. When combined with Dependent 1's deductible, the Family Deductible of \$3,000 has been met for the remainder of the year.

How many family members must satisfy coinsurance?

Under the CDH plans, the family coinsurance maximum is equal to twice the individual coinsurance maximum. Once any combination of family members has met the family coinsurance maximum, all insureds will be deemed to have met their coinsurance maximum. Health copays will apply to the coinsurance maximum. Pharmacy copays do not integrate with the health plan. Pharmacy has its own maximum out of pocket. **Note: No one individual can be charged more than his/her individual coinsurance maximum.**

The following chart compares the major features of both CDH plans:

	CDH PLAN
COVERAGE	CDH PLAN
Preventive Care at no cost (must be billed as Preventive)	Yes
Preventive Prescriptions at no cost*	Not Applicable
Out of Network Coverage	No
Copays	PCP \$25 Specialist \$50 Urgent Care \$50 Emerg Room \$250 Rx 30 Day/90 Day Generic \$7/\$14 Preferred \$25/\$50 Non-Pref \$45/\$90 UHC Non-Pref \$50/\$100 CCP Specialty \$75/ 30 Day Only
Annual Deductible	\$1,300/\$2,600
Coinsurance/Copays	\$1,500/\$3,000
Max out of Pocket**	\$2,800/\$5,600
**Prescriptions Do Not Apply to Annual Deductible & Coinsurance and are subject to a Prescription Out of Pocket Maximum	\$3,000/\$6,000 Out of Pocket Max
HSA/HRA Funding	N/A
WellBeing Program	Employee and enrolled Spouse/DP can earn up to \$300 each per year. UHC-Rally Program CCP-WellSteps Program.

OPEN ACCESS

Although the County's plans are Open Access, which means you do not need a referral to see a specialist, it is recommended that you have a Primary or Family Medicine Physician to coordinate and be the central repository where all your health records reside.

WHY IS IT IMPORTANT TO HAVE A PRIMARY/FAMILY CARE PHYSICIAN?

Often coordination of medical treatment and/or pharmacy prescribing is greatly hindered when important and essential medical records are not maintained in one centralized location. Example: during an emergency your Primary/Family Care provider and/or family members would not be able to give complete medical history information to the treating emergency room physician.

Another example would be if your specialist wanted to confer with your Primary/Family Care provider about prior medical treatments or history, your Primary/Family Care provider would be able to provide complete information. When self-referring to specialists, it is recommended that you request your medical reports be sent to your Primary/ Family Care provider for the reasons described above.

Physicians/specialists join and leave health plans throughout the year based on their contract period and other factors; there is no guarantee that a physician, specialist, facility or hospital in the network will continue in the plan through the end of the calendar year. It is recommended that you contact the physician or specialist prior to enrollment and at the time of making an appointment to verify that they are participating in the plan.

PRIOR AUTHORIZATION

Certain medical tests and procedures require Prior Authorization by the insurer's Medical Management Department prior to receiving the service. Your physician will submit the request and medical necessity to the carrier for Prior Authorization when it is required; however, it is recommended that the member verify the Prior Authorization is in place before receiving the service as benefits that may have otherwise been covered will be denied. The following treatment or services are examples of some services that must be preauthorized:

1. Hospital confinements and Skilled Nursing Facility confinements
2. Non-emergency transportation; air ambulance
3. All non-emergency outpatient hospital services, including but not limited to, surgical, laboratory and diagnostic, except mammograms;
4. Non-emergency wound care procedures
5. Inpatient rehabilitative services
6. Outpatient rehabilitative services at a hospital

7. Durable medical equipment;
8. Prosthetics, braces, hospice
9. Pain management
10. CPAP machine (see Sleep Studies benefit).

For a current list of all services requiring prior authorization visit the health carrier's website or contact Customer Service at the number printed on the back of your health ID card.

EXCLUSIONS AND LIMITATIONS

All health plans have specific Exclusions and Limitations. It is recommended that prior to enrollment you review the list of Exclusions and Limitations for the plan you are choosing. Services that are excluded from coverage will not be covered even if there is medical necessity for the service, i.e., infertility treatments.

SURVIVOR BENEFITS

The County offers a 12-month survivor benefit for dependents enrolled in a County health plan. Under this benefit, dependents who were covered under the County at the time of the employee or retiree passing away, and who are not eligible for Medicare continue to be covered, at no charge, under the same insurance plan they were enrolled in at the time of the employee/retiree's death for a period up to 12 months. During this 12-month period, a dependent must continue to meet eligibility requirements per the conditions set forth for this benefit. This 12-month Survivor Benefit is counted towards the period of COBRA or Domestic Partner Continuation Coverage for which the Survivor and/ or dependents would be eligible and is paid for by the County.

If a plan is no longer offered, or if the survivor changes plans during open enrollment or due to a qualifying event, the survivor benefit will end and coverage may be continued under another plan at the full COBRA rate in effect at that time. **Please note:** Survivor benefits are not offered for vision or dental insurance plans.

WAIVER CREDIT

Employees waiving medical coverage with proof of other 2020 qualifying group health coverage receive \$119.23 (full-time) or \$59.62 (part-time 20) Waiver Credit per pay check. Examples of proof of 2019 health coverage:

- A copy of your insurance card (must show a date on the card proving coverage in 2020);
- Insurance coverage letter from your group insurance carrier specifying coverage in 2020;
- A letter from your spouse/domestic partner's employer that states you are enrolled for the 2020 Benefit year;
- An open enrollment confirmation statement for group health insurance specifying elections for 2020;

- Medicare card showing coverage for Part A and Part B;
- Veterans can provide a letter or other documentation from Veterans Services;
- Tricare members can provide a copy of their uniformed service ID card.

Employees who take no action to waive health coverage during open enrollment and/or do not show proof of other group health coverage will not receive the Waiver Credit. Employees enrolled in a Health Care Exchange plan, Individual Plan, Co-Op plan, Health Care Sharing plan, etc. are not eligible to receive the Waiver Credit.

HDHP HEALTH SAVINGS ACCOUNT* ENGAGEMENT INCENTIVE

Annual preventive services (provided at no cost in-network), play a key factor in early detection of chronic and life-threatening diseases. To reverse this trend and encourage preventive screenings, employees and insured spouse/Domestic Partner must complete the Engagement Incentive between January 1, 2020 and December 31, 2020 to receive the County funding for their HSA* account in 2021.

If adding a spouse or domestic partner during open enrollment or due to a Qualifying Event mid-year, additional funding is not automatic and spouse or domestic partner have a three month window to complete their Engagement Incentive (full funding if enrolled as of the first of the year, prorated if enrolled during the year).

NOTE: Newly benefit-eligible employees with coverage effective between January 1, 2020 and December 31, 2020 will automatically receive a pro-rated HSA based on month coverage starts. However, to receive funding in 2021, completion of the Engagement Incentive prior to December 31, 2020 is required.

Funding is typically deposited into the employees HSA by the end of January of each year.

* Employees who are not eligible to participate in an HSA per IRS rules will receive funding in a Health Reimbursement Account (HRA) instead.

HEALTH SAVING ACCOUNT (HSA)

As a component of the HDHP health plans, the County funds a Health Savings Account (HSA*) based on plan and tier of coverage. This account may be used to reimburse eligible medical, prescription, dental and vision expenses, for you and any enrolled, eligible dependent(s)*, that have not been reimbursed by your plan such as deductible and coinsurance. These expenses can be reimbursed up to the HSA account balance. **HSA can only be used for dependents claimed on your income tax.**

**See Over Age Dependents age 26-30 and Domestic Partner exclusions. You may also choose to "bank" your HSA funds for rollover accrual (rollovers are not subject to annual maximum contribution). The 2020 annual*

maximum contribution limit is \$3,550 for Individual Coverage; \$7,100 for Family Coverage. See your PayFlex Account Guide for detailed plan rules on usage, documentation and payback rules.

What is a health savings account (“hsa”)?

A Health Savings Account is a special type of savings account similar to an Individual Retirement Account (IRA) that offers a different way for employees to pay for their health care expenses. HSAs enable you to pay for current health expenses and/or save for future qualified health and retiree health expenses on a tax-free basis.

You must be enrolled in a High Deductible Health Plan (HDHP) to be able to take advantage of an HSA. You own and you control the money in your HSA from Day One, making it fully portable after retirement or separation from the County. Decisions on how to spend the money are made by you without interference from a third party or a health insurer. To qualify for an HSA you must meet the following requirements:

- a. be covered by a HSA-qualified High Deductible Health Plan (HDHP);
- b. must not be covered by other health insurance that is not an HDHP;
- c. cannot be enrolled in any part of Medicare;
- d. cannot be enrolled in Tricare
- e. cannot be claimed as a dependent (other than spouse) on someone else’s tax return.

Is there an annual limit on how much I can contribute?

For 2020, the maximum you may contribute is \$3,550 if you have self-only coverage, or \$7,100 if you have family coverage. Individuals 55 and older who are covered by an HDHP can make additional catch-up contributions each year until they enroll in Medicare. The additional “catch-up” contribution is \$1,000 annually. You can make contributions to your HSA on a pretax basis (i.e., before income and employment taxes are applied). You are not allowed to contribute more than the annual limit to your HSA. Contributions in excess of the annual limit may be withdrawn by the tax filing deadline without penalty (a pro-rata share of earnings on the excess amount must also be withdrawn). Excess contributions remaining in the account after the tax filing deadline must be withdrawn and are subject to a 6 percent excise tax.

HSA FUNDS CAN PAY FOR ANY “QUALIFIED HEALTH EXPENSE” INCLUDING MANY DENTAL AND VISION CARE EXPENSES

Who decides whether the money I’m spending from my HSA is for a “qualified health expense”?

The IRS has the final say, but the question may not arise unless your tax return is audited. You are responsible for reporting on your tax return the amount you withdraw from your HSA that is used for qualified health expenses and the amount that is not (and is therefore taxable). It is recommended that you familiarize yourself with what qualified health expenses are (as partially defined in IRS Publication 502) and also keep your receipts in case you need to prove your expenditures or decisions during an IRS audit. Distributions from an HSA that are not used for qualified medical expenses are includable in gross income and, for applicants under age 65, subject to an additional 10 percent tax.

The employee is responsible for how they spend their HSA money within the IRS guidelines and must report all HSA spending on annual tax returns. HSA reporting requirements are straightforward. Form 5498 is used to report total contributions made to the account during the year. Form 1099-SA is used to report distributions from your HSA. Both tax forms will be available to you through our Third Party Administrator, PayFlex.

How can I use my HSA account to pay for eligible services?

There are three ways to access your HSA funds:

- By using the PayFlex Card®, your account bank card, at the time of service/sale for immediate payment to the provider. (Note: Save your receipts; for substantiation to the IRS, if required); or
- By paying for eligible expenses with cash, check, or your personal credit card. Then withdrawing funds from your HSA to pay yourself back. You can also have your payment deposited directly into your checking or savings account; or
- By paying your provider using PayFlex's online feature to pay your provider directly from your HSA account.

What if I don't use all my HSA money before the end of the year?

The money rolls over from year to year. You do not lose the money in the HSA; it is your account and your money.

What happens to the money in my HSA if I leave my job or retire?

You take that money with you wherever you go. The HSA is in your name, it's your account. If you're enrolled in Medicare or go to another employer that doesn't have a qualified health plan, you can still use your HSA money to pay for qualified health expenses. However, under these circumstances, you are no longer eligible to contribute to your HSA. While an active County employee, the County pays the monthly Administration Fee; once you are no longer enrolled in a HDHP through the County, PayFlex will debit the monthly Administration Fee from your HSA account.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

For employees enrolled in one of the HDHP plans who do not qualify for an HSA, the County funds a Health Reimbursement Account (HRA) based on tier of coverage and completion of the annual Engagement Incentive. This account may be used to reimburse eligible health, prescription, dental and vision expenses for you and any enrolled, eligible dependent(s)* which have not been reimbursed by your plan such as coinsurance and deductible. These expenses can be reimbursed up to the HRA account balance. **HRA can only be used for dependents claimed on your income tax.**

**See Over Age Dependents age 26-30 and Domestic Partner exclusions. You may also choose to "bank" your HRA funds for rollover accrual. The accrual maximum is \$20,000. See Your PayFlex Account Guide for detailed plan rules on usage, documentation and payback rules.*

OTHER HRA HIGHLIGHTS

Unused balances rollover into the next plan year when continuously enrolled in a County HDHP plan.

Upon retirement or separation of employment, HRA balances are placed in a tax-advantaged Retirement Health Savings Plan with ICMA and can be drawn upon tax-free beginning at age 55. HRA balances are transferred approximately 180 days after retirement or separation of employment.

COUNTY FUNDED 2019 CALENDAR YEAR HAS/HRA for HDHP plans

Tier	HDHP Base Plan	HDHP OON
Employee Only	\$1,200	\$1,200
Employee + Dependents (Spouse/DP/Child(ren)/Family)	\$2,400	\$2,400

How can I use my HRA account to pay for eligible services?

There are three ways to access your HRA funds:

1. By using the PayFlex Card®, your account bank card, at the time of service/sale for immediate payment to the provider.

IMPORTANT: Expenses other than set health plan copays and prescription expenses will require supporting documentation be submitted to PayFlex within 45 days. ALL DENTAL AND VISION EXPENSES WILL REQUIRE SUPPORTING DOCUMENTATION, see your PayFlex Account Guide; or

2. By paying for eligible expenses with cash, check, or your personal credit card. Then submit a claim with your Explanation of Benefits or itemized receipts to PayFlex to pay yourself back. You can also have your reimbursement deposited directly into your checking or savings account; or
3. By paying your provider using PayFlex's online feature to pay your provider directly from your HRA account.

What if I don't use all my HRA money before the end of the year?

HRA accounts will automatically rollover in mid-January. You may use the account balance to pay for 2019 or 2020 claims incurred while covered under a County HDHP plan. Upon separation of employment remaining HRA monies are transferred to a Retirement Health Savings Plan at ICMA-RC in your name per plan guidelines.

What if I use all my HRA money before the end of the year?

Being able to use your HRA monies to offset out of pocket expense is a great plan benefit to you. However, once your monies are exhausted it would then be your responsibility to pay any eligible expenses for the remainder of the year.

HEALTH REIMBURSEMENT ACCOUNT (HRA) GUIDELINES

Vesting	No vesting requirements (Effective 01/01/2018)
Enrolling mid-year	HRA is prorated for the remainder of the year based one-twelfth of the annual amount for each full month remaining in the calendar year.
Adding new dependents	Employees enrolled in the HDHP plans with Employee Only coverage who add a dependent(s) mid-year will receive an increase equivalent to one-twelfth of the annual HRA allocation, for each full month remaining in the plan year after effective date of change. Accumulated HRA balances from prior years will not be affected. Note: newly enrolled spouse/domestic partner have three months to complete the Engagement Incentive to receive HRA funding.
Dropping dependents	The HRA account of an employee enrolled in the HRA plan who drops a dependent mid-year, thus changing their tier of coverage, will not be affected.

PHARMACY (RX) PLAN

Pharmacy benefits are provided under the County's self-insured pharmacy plan. UnitedHealthcare plans (CDH, HDHP Base and HDHP In/Out of Network Plans) utilize OptumRx (formerly Catamaran) and Community Care Plan (CCP Narrow Network Plan) utilizes Southern Scripts. The plans includes:

- An open formulary
- 90-day mandatory maintenance medication program (excluding specialty)
- Restricted generic policy
- Large network of participating pharmacies (no out of network coverage)
- Specialty pharmacy home delivery

PRESCRIPTION COSTS

Your prescription cost is based on the health plan you are enrolled in and the type of medication and the quantity purchased.

PHARMACY COVERAGE – CONSUMER DRIVEN HEALTH PLANS (CDH)		
TIER	30-DAY SUPPLY* (AT PARTICIPATING RETAIL PHARMACY)	90-DAY SUPPLY (AT PARTICIPATING RETAIL PHARMACY OR BY MAIL SERVICE)
Generic Preferred	\$7	\$14
Brand Preferred	\$30	\$60

Non-Preferred	\$45	\$90
Specialty Pharmacy	\$75	Not available
Dispense-as-Written (DAW1)	\$75	\$150

*Maintenance medication: Three 30-day retail fills allowed before mandatory 90-day supply requirement

PHARMACY COVERAGE – HIGH DEDUCTIBLE HEALTH PLANS (HDHP)	
Preventive Prescription Drugs (per the Preventive Drug List)	100% Coverage – No copayment or coinsurance
All other drugs	1. Member pays 100% of discounted drug cost which is applied to combined health and pharmacy deductible.
	2. After annual deductible is met, member pays 20% coinsurance, County pays 80% of discounted drug cost.
	3. After annual Out-of-Pocket Maximum is met, prescription drugs are paid in full (100%) by Plan.
For the OptumRx's and Community Care Plan's Preventive Drug List, Formulary and Formulary Exclusions, go to Broward.org/Benefits/Pharmacy/HDHP	

PREFERRED MEDICATION LIST (FORMULARY)

A Preferred Medication List (Formulary) is the list of prescription drugs covered under a health plan. The County self-insures pharmacy coverage through two Pharmacy Benefit Managers who are responsible for administering the pharmacy plans based on plan enrollment:

	UnitedHealthcare (CDH High, HDHP Base, HDHP In/Out of Network Plans)	Community Care Plan (CCP Narrow Network Plan)
Retail and Mail Order	OptumRx	Southern Scripts
Specialty	Optum Specialty Rx	Southern Scripts



HDHP plans: Check the Preferred Drug list first. If drug is not on the Preferred Drug list, it will not covered even if listed on the Preventive Drug List.

The OptumRx and Southern Scripts Formularies are created, reviewed and updated annually by panels of doctors and pharmacists. Your plan's Preferred Medication List (Formulary) contains a wide range of preferred generic and preferred brand-name drugs that have been approved by the Food and Drug Administration (FDA). Your doctor can use this list to choose medications for you while helping you save the most money by utilizing formulary drugs.

DISPENSE-AS-WRITTEN (DAW1)/ RESTRICTED GENERICS POLICY

Florida Statute 465.05 requires substitution of a generic equivalent for brand-name drugs, when available. If your doctor believes there is a medical need for you to have the brand name prescription listed on the Formulary for which there is a generic available, the physician must write "Dispense as Written" on the prescription.

MANDATORY 90-DAY MAINTENANCE MEDICATION PROGRAM (ALL plans)

Most maintenance medication is subject to a mandatory 90-day supply obtained through either mail or at any participating retail pharmacy.

	High Deductible Base and HDHP In/Out of Network Plans		CDH High and CCP Narrow Network Plans	
	30-Day	90-Day	30-Day	90-Day
Days Supply				
Preventive Drug List	\$0	\$0	N/A	N/A
Generic	Deductible, then 20% coinsurance		\$7	\$14
Preferred	Deductible, then 20% coinsurance		\$30	\$60
Non-Preferred	Deductible, then 20% coinsurance		\$45	\$90
DAW1	Deductible, then 20% coinsurance		\$75	\$150
Specialty	Deductible, then 20% coinsurance	N/A	\$75	N/A

If your doctor begins your treatment plan with only a 30-day prescription, you will only be able to fill it three times at a retail pharmacy. All subsequent refills must be written for a 90-day supply with appropriate refills. If your doctor feels an extra 30-day trial is needed, have them complete a written request on a prescription pad or letterhead and submit to Human Resources-Employee Benefit Services Section for review and authorization for OptumRx or Southern Scripts to override the 90-day requirement for one additional month.

Maintenance medications can be filled at local participating pharmacies or through the mail service program.

If your doctor feels it is medically necessary to write a prescription for 30 days instead of 90 days on an ongoing basis, submit the doctor's written request to Human Resources-Employee Benefit Services Section, Benefits Manager for review and authorization to override the 90-day maintenance medication requirement to the pharmacy vendor.

By law, some controlled substances cannot be written for more than 30 days, and as such, can only be purchased for 30 days at a time.



Ninety-day medications can be filled at any participating retail pharmacy or through mail-order.

BRAND VERSUS GENERIC MEDICATIONS

A drug's brand name is the name that appears in advertising. This name is protected by a patent so that only one company can produce it for 17 years. After the patent expires other companies may manufacture a "generic" that's just like the brand-name drug and that follows FDA rules for safety. A generic's color or shape may be different, but the active ingredients must be the same. Your formulary lists only FDA-approved generic medications. To gain FDA approval, a generic drug must:

- contain the same active ingredients as the innovator drug (inactive ingredients may vary)
- be identical in strength, dosage form, and route of administration
- have the same use indications
- be bioequivalent
- meet the same batch requirements for identity, strength, purity, and quality
- be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

An example of a generic medication is diazepam, which is the generic equivalent of Valium®.

IMPORTANT: If you wish to explore more cost-effective options, ask your doctor if there is a generic equivalent available within the same therapeutic class. Doing this will result in much greater cost savings for you.

PREFERRED VERSUS NON-PREFERRED MEDICATIONS

A preferred brand name drug, also known as a formulary drug, is a medication that's been reviewed and approved by a group of doctors and pharmacists within the pharmacy provider. It is chosen for the Preferred Medication List because it's been proven to be safe, effective and less expensive than another name brand. All other drugs are available at the higher non preferred copay. Note: certain drugs/medications are excluded or have quantity limits under the pharmacy plan.

SPECIALTY PHARMACY MEDICATIONS

The Specialty Pharmacy Program is used for treating complex health conditions and may require special handling for home delivery. Examples are Cystic Fibrosis, Enzyme Deficiency, Growth Hormone Deficiency, Multiple Sclerosis, Rheumatoid Arthritis, and Viral Hepatitis. For more information, UHC members should contact Briova, Catamaran's Specialty Pharmacy, CCP members should contact 866-224-5701. Specialty medications are not eligible for a 90-day supply and can only be filled for a 30-day supply. As these medications are so specialized and are very expensive, the first fill of a new specialty prescription will be shipped in two-week increments. If there are no changes to the dosage or drug after the first month, the following months will be filled and shipped as 30-day supplies.

PHARMACY ID CARDS – UNITEDHEALTHCARE PLANS ONLY

Upon enrollment in the County's health program, OptumRx will mail an ID card to the home address as listed in the County's payroll system. It is important to retain this information for reference. Member ID cards will be issued in the name of the employee. You should keep your ID card with you for verification purposes at participating pharmacies. Please note that your member ID number for pharmacy benefits is your ten-digit Employee ID number, not your health plan member ID number. Do not discard your card at the end of the plan year as new ID cards will not be issued unless there is a plan or name change.

PHARMACY ID CARDS – COMMUNITY CARE PLAN ONLY

Health and pharmacy are combined on one ID card.

PHARMACY NETWORK PROVIDERS

Most pharmacy chains are participating providers. You must present your OptumRx/Catamaran ID card or Community Care Plan card when you use your benefit at any of the participating national chains.

PRIOR AUTHORIZATION PROGRAM

Certain prescriptions require prior authorization (approval before they will be covered). Types of prior authorizations include, but are not limited to, medications where a set amount is allowed within a set timeframe and an additional amount is requested within the same timeframe, where an age limitation has been reached and/or exceeded or where appropriate utilization must be determined. OptumRx and Southern Scripts, in their capacity as pharmacy benefit managers, administers the clinical prior authorization process on behalf of Broward County.

Clinical Prior Authorization (CPA) can be initiated by the pharmacy, the physician, or you or your covered dependents. The pharmacy may call after being prompted by a medication denial with a message stating, "Prior authorization required." The pharmacy may also pass the information on to you and require you to request the prior authorization.

The categories/medications that require clinical prior authorization may include, but are not limited to: Acne (topical after age 24), ADHD/Narcolepsy (after age 19), Anabolic Steroids (all forms), Anti-Fungals, Atopic Dermatitis, Byetta, Botulinum Toxins, Fentora, Growth Hormones, Lamisil/Sporanox, Penlac and Ranexa. Upon receipt of a prescription falling into a covered category, the pharmacy vendor will contact your doctor's office and request the documentation needed for Prior Authorization.

MEDICATIONS WITH QUANTITY LIMITS

Some medications have limits on the quantities that will be covered under the County plan. Quantity limits are placed on prescriptions to make sure you receive the medication you need in the quantity considered safe. That is, you get the right amount to take the daily dose recommended by the FDA and medical studies. Some medications with quantity limits include, but are not limited to: Duragesics, Erectile Dysfunction medications, Hypnotics, Migraine Medications, Nasal Inhalers, Proton Pump Inhibitors, and Sedatives.

When you go to the pharmacy for a prescription medication with a quantity limitation, your cost will only cover the quantity allowed by the plan. You may still purchase the additional quantities, but you will pay the full cost. If your doctor feels there is a medical necessity to override the quantity limit, have him or her submit the request with medical documentation to OptumRx Clinical Prior Authorization department or Southern Scripts if enrolled in the CCP Select Network Plan.

DENTAL INSURANCE

The County currently offers two dental plans to meet your dental needs:

- Dental HMO HS195 Plan offered by CompBenefits (new Fee Schedule for 2020)
- Dental PPO offered by UnitedHealthcare (new carrier for 2020)

The dental insurance is a pretax plan; elections are irrevocable for the plan year and cannot be changed unless the change is due to a relevant qualifying event.

DHMO – COMPBENEFITS/HUMANA

Dental DHMO plans are like health HMOs. All services must be obtained from a participating dentist or specialist. No referral is needed for specialty services. Members are required to select a Primary Care Dentist (PCD)/Facility. Each family member can select a different PCD/Facility. PCD's can be changed on a monthly basis; however, the change must be made by the 15th of the month to be effective the first of the following month. Dental services are based on a Discounted Fee Schedule (see complete schedule in Provider booklet). The Discounted Fee Schedule applies to services provided by your primary dentist and specialists. Note: not all ADA (American Dental Association) codes are covered under the DHMO plan. Services received for ADA codes not covered under the Discounted Fee Schedule are provided at a 25 percent discount. This plan does not have a "Missing Tooth" exclusion. See Provider material for more details.

HOW TO USE THIS PLAN:

Your primary dentist will provide all of your routine dental care. When you visit your primary care dentist, simply present your Humana/CompBenefits identification card. You may be required to pay a set fee for some services provided by your primary care dentist. If the dental services provided are not listed as covered procedures under the plan, primary care dentists will give you a 25 percent discount off their usual fees. Should you require the services of a specialty dentist, you can choose any in-network specialty dentist under the Humana/CompBenefits HS195 DHMO Dental Plan. All in-network specialists will provide services at the fees listed in your schedule of benefits. The fees are billed by the participating dentist at the time of service, so there are no claims forms to file. You pay your dentist directly, if applicable. To find participating dentists in your area, go to Broward.org/Benefits/Pages/DentalPlanDHMO.

Website services include:

- View DHMO Summary of Benefits
- View Plan Booklet
- View claim history

- Select a new PCD
- Request a new ID card
- Print a temporary ID card

PPO – UNITEDHEALTHCARE

The PPO Plan dental network has an extensive nationwide dental network with dentists and specialists. This plan also includes an out-of-network benefit and reimburses at one of the highest usual and customary percentiles, which means less out-of-pocket cost to you. If you utilize a “participating” network dentist your savings are even greater because the participating network dentist must charge a negotiated contract rate.

The annual combined maximum benefit is \$1,500 per person in-network and \$1,000 per person out-of-network. There is a \$50 annual deductible (waived on Preventive) per person, which satisfies both your in-network and out-of-network deductible. If you reach your annual maximum, you will be eligible to receive additional services at discounted rates.

ORTHODONTIC COVERAGE

Child orthodontia – Covers children through age 18. Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: \$1,000 lifetime orthodontia maximum.

HOW TO USE THIS PLAN:

When visiting your dentist, (in-network or out-of-network), give them your UnitedHealthcare ID card to identify yourself as a PPO dental member. A “participating” network dentist will bill the dental provider for reimbursement up to their negotiated contract rate; the dentist will then bill the difference to you. (Most out-of-network dentists will also bill your dental provider, but you must request this service; otherwise you pay the bill and the dental provider reimburses you the allowable amount based on your plan when you submit the claim). To find participating dentists/specialists in your area for the PPO dental Plan, visit:

Broward.org/Benefits and select DentalPlanPPO or log onto your secure account at Humana Dental.com

DHMO AND PPO DENTAL PLAN HIGHLIGHTS

SERVICES	DHMO HS195 Humana	PPO DENTAL UnitedHealthcare
Deductible	No	\$50 Individual / \$150 Family Waived for preventive services; excludes orthodontia
Annual reimbursement benefit maximum	N/A - Member pays amount listed on Fee Schedule for covered services	\$1,500 in-network \$1,000 out-of-network
Out-of-network benefit / reimbursement	No / None	Yes / Based on usual & customary

Basis for in-network reimbursement	N/A – Member pays charge on Fee Schedule plus any applicable lab costs, and additional costs for precious (high noble) and semi-precious (noble) metal	PPO contracted fee
Waiting period for major services	None	None
Waiting period for orthodontia	None	None
Primary Care Dentist requirement	Yes	No
Routine Cleanings / Preventive (Type 1)	N/A - Member pays amount on Fee Schedule for all services	Deductible waived
Age limit on orthodontic services / Orthodontic reimbursement benefit (per person)	None / N/A - Member pays amount on Fee Schedule for all services	Covers children through age 18 Plan pays 50% (no deductible) of the covered orthodontia services, up to: \$1,000 lifetime orthodontia maximum.

Carefully review the dental plan benefit charts in each of the dental carrier's enrollment packets (DHMOHS195 and DPPO Plan). If you have questions, please call the carrier's Customer Service number located on the inside cover of this book.

Be an educated consumer! Ask your dentist to file a pretreatment estimate with your insurance carrier for services expected to be more than \$200. When the pretreatment estimate is processed prior to services being rendered, both the member and the provider receive a copy indicating to both parties the exact amount of benefits payable to the dentist and the exact amount the member will have to pay out-of-pocket.

NOTE: Pediatric dentists are considered specialists under the PPO plan and, in most cases, they will charge specialists' fees for all services.

VISION INSURANCE

The County offers a comprehensive vision plan through UnitedHealthcare.

The vision insurance is a pretax plan; elections are irrevocable for the remainder of the plan year and cannot be changed unless the change is due a relevant qualifying event.

The vision plan does not require you to select a primary care doctor or facility. You have the option of using preferred doctors in the network who have agreed to accept negotiated set fees or you can use any doctor of your choice and receive the benefit reimbursement per the out-of-network plan specifications. The plan features:

- Freedom to choose any doctor
- Extra savings when you use a participating provider
- Large panel of providers to choose from

Carefully review the vision plan benefit chart in the vision carrier's enrollment packet. You are encouraged to read the information provided by the carrier. If you have questions, please call the carrier's Customer Service number located on the inside cover of this book.

In-network covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eye glasses.

VISION PLAN HIGHLIGHTS

IN-NETWORK SERVICES	COPAYS
Exam	\$10
Materials	\$15
Retinal Screening for Diabetics	\$0
BENEFIT FREQUENCY	
Comprehensive Exam	Once every Calendar Year
Comprehensive Exam for diabetics only	Twice every Calendar Year
Spectacle Lenses	Once every Calendar Year
Frames	Once every Calendar Year
Contact Lenses (in lieu of eye glasses)	Once every Calendar Year
CHILDREN'S EYECARE PROGRAM (UP TO AGE 13)	
Second eye exam covered after exam copay	\$0
Coverage for a new pair of eyeglasses (frame and lenses) if their vision prescription changes .5 diopters or more during the benefit period.	\$0
FRAME BENEFIT	
Private Practice Provider	\$75 wholesale frame allowance

Retail Chain Provider	\$225 retail frame allowance
LENS OPTIONS	
Standard scratch-resistant coating, Standard progressive lenses, Deluxe progressive lenses, Polycarbonate lenses.	Covered in full. (Please refer to the Lens Option under the Vision Benefit Summary.)
<p><u>Covered-in-full elective contact lenses:</u> The fitting/evaluation fees, contact lenses (based on Formulary), and up to two (2) follow-up visits are covered in full (after copay). If you choose disposable contacts, up to four (4) boxes are included when obtained from a network provider.</p> <p><u>All other elective contact lenses:</u> A \$105.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (Formulary) (materials copay does not apply).</p> <p><u>Necessary contact lenses:</u> Covered in full after applicable copay.</p>	
OUT-OF-NETWORK REIMBURSEMENTS (COPAYS DO NOT APPLY)	
Exam	Up to \$40
Frames	Up to \$65
Single vision lenses	Up to \$40
Bifocal lenses	Up to \$60
Trifocal lenses	Up to \$80
Lenticular lenses	Up to \$80
Elective contacts (in lieu of eye glasses)	Up to \$105
Necessary contacts (in lieu of eye glasses)	Up to \$210
LASER VISION BENEFIT	
<p>UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at LasikPlus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.</p>	

*Additional terms, conditions, limitations, and/or exclusions may apply. Carefully review the vision plan benefit chart in the vision carrier's enrollment packet. You are encouraged to read all information provided by the carrier. If you have questions, please call the carrier's Customer Service number located on the inside cover of this book.

IMPORTANT TO REMEMBER:

- Your \$105.00 contact lens allowance is applied to the fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, you will have \$75.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- You can log on to carrier's website to print off your personalized ID card. An ID card is not required for service, but is available as a convenience to you should you wish to have an ID card to take to your appointment. If enrolled in the UHC health plan, can also use health plan ID card.
- Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must

be submitted within 12 months of date of service to the following address: UnitedHealthcare Vision, Attn. Claim Dept., P.O. Box 30978, Salt Lake City, UT 84130. FAX: 248-733-6060.

At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

FLEXIBLE SPENDING ACCOUNTS – CDH PLANS AND HDHP PLANS IF ENROLLED IN THE HEALTH REIMBURSEMENT ACCOUNT.

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) is an IRS tax-favored account you can use to pay for eligible health expenses (medical, prescription, dental, vision and approved Over-the-counter expenses) not covered by your insurance or any other plan (see rules and limitations in Your PayFlex Account Guide).

Flexible Spending Accounts feature:

- IRS approved reimbursement of eligible expenses tax-free
- Savings on Income Tax and Social Security taxes

Under current federal tax law, unless the person qualifies as a dependent as defined by the IRS, expenses for that dependent cannot be claimed under a FSA. Therefore, expenses for domestic partners, dependents of a domestic partner as well as Over Age Dependents age 26-30 cannot be reimbursed under a spending account.

USE IT OR LOSE IT RULE

FSA accounts are subject to the IRS “use or lose” rule, whereby, any amounts remaining at the end of the plan year (calendar year) are forfeited due to IRS regulations. Unreimbursed amounts left in either Account cannot be returned to you. All FSA claims must be submitted no later than 90 after the end of the plan year. For plan year 2020, FSA claims must be incurred between January 1, 2020 and December 31, 2020 and submitted for reimbursement by the deadline of March 31, 2021.

COORDINATION WITH COUNTY'S HRA

All medical, prescription, dental and vision claims will automatically be paid out of the Health Care FSA first. Claims must be incurred between 01/01/2020 and 12/31/20 and submitted to PayFlex by 03/31/21. Under IRS

regulations, unclaimed amounts are forfeited. For this reason, we encourage you to be conservative in your estimates and only consider expenses you know you will incur in 2020.

When the FSA Medical Expense Account is exhausted, medical, prescription, dental and vision claims will automatically be paid out of the HRA Account.

WHAT TYPES OF FSAs ARE AVAILABLE?

There are two types of FSA accounts, a Medical Expense FSA and a Dependent Day Care FSA:

MEDICAL EXPENSE FSA	DEPENDENT DAYCARE FSA
<p>Health expenses not reimbursed by your insurance plan may be eligible for reimbursement using your FSA Health Care Account, including but not limited to:</p> <ul style="list-style-type: none"> • Eligible health, prescription, dental and vision copays, deductible, and/or co-insurance • Some over-the-counter drugs • Eyeglasses and contacts • Dental expenses • Orthodontia 	<p>Dependent care expenses, whether for a child* or an elder, include any expenses that allow you to work, such as:</p> <ul style="list-style-type: none"> • Daycare services (child under 13, or adult) • In-home care • Nursery and pre-school • Summer day camps <p>* Child is no longer eligible on their 13th birthday.</p>
<p>Please refer to Your PayFlex Account Guide for plan details and rules.</p>	

WHICH EXPENSES ARE NOT REIMBURSABLE?

The following is a partial listing of services or expenses that are not reimbursable under a Health Care FSA. For more information, please contact PayFlex Systems USA, Inc.

- Insurance premiums, including premiums for health insurance through another source
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition
- Health or fitness club membership fees
- Health care expenses for a domestic partner or dependents of a domestic partner
- Health care expenses for an Over Age Dependent (age 26 - 30)

WHICH EXPENSES REQUIRE PROOF OF MEDICAL NECESSITY?

Some prescription drugs or health care treatments require proof of medical necessity for reimbursement from your FSA. Below is a partial list of such expenses. For more information, please contact PayFlex Systems USA, Inc.

- Acupuncture
- Massage therapy
- Drugs that may be used for non-cosmetic reasons (e.g., Retin A, or that promote hair growth)

- Drugs or treatment programs for smoking cessation that have been prescribed for a specific life threatening medical condition (e.g., emphysema)
- Drugs or treatment programs for weight loss that have been prescribed for a specific life threatening medical condition (e.g., diabetes or heart disease)

WHAT ARE THE PLAN YEAR CONTRIBUTION LIMITS?

The current annual Health Care FSA pretax contribution limit is \$2,600. If you and your spouse each have a Health Care FSA, you can each contribute \$2,600.

The Dependent Care FSA limit is \$5,000 per household/family. If you and your spouse each have a Dependent Care FSA, you are limited to \$5,000 between the two of you.

HOW TO USE YOUR FSA FUNDS

If you pay for eligible expenses with cash, check or a personal credit card, you can submit an online request for reimbursement. Or you can fill out a paper claim form and fax or mail it to PayFlex®. You may also use the HealthHub/PayFlex Card®, your account bank card, to pay for your eligible expenses. When you use the card, the funds automatically come out of your Medical Expense FSA first.

Note: Save all of your receipts. If you have an Explanation of Benefits (EOB) from your insurance plan, save that too. When you submit a claim, you'll need to submit the EOB or itemized receipt.

IMPORTANT: All dental and vision services and some medical services require itemized documentation if paid for with the PayFlex/HealthHub Card per IRS guidelines. Medical and prescription services received for one of the plan co-pays do not require supporting documentation. Failure to provide documentation by the date requested will result in your card and account being suspended until documentation is received. Amounts not substantiated at the end of the plan year will become taxable income to the employee.

SECTION V – AFTER-TAX SUPPLEMENTAL PLANS

Many additional voluntary benefit plans are available to County employees. Basic term life insurance is paid for the by County and the rest are paid for by employee on an after-tax basis.

- Life Insurance – Basic Term Life & AD&D \$25,000 – paid by the County
- Life Insurance – Optional Term Life & AD&D
 - Employee \$25,000 up to a maximum of \$300,000*–paid by the employee
 - Spouse/Domestic Partner \$12,500 – paid by the employee
 - Child/Children to age 26 \$12,500 – paid by the employee
- * Amounts above \$150,000 require medical underwriting
- Life Insurance – Special Occupation Class Paid by the County
- Long-Term Disability Paid by the employee
- Personal Income Protection Plans Paid by the employee
- Prepaid Legal Plan Paid by the employee

The following apply to the EMPLOYEE PAID insurance options listed above:

- These insurances are voluntary.
- Employees are responsible for 100 percent of the premium cost.
- Employees can apply for life and long term disability coverage without medical underwriting during the initial benefit eligibility period or at any time with medical underwriting.
- Employees can apply for coverage in Prepaid Legal Plan and Personal Income Protection Plans during benefit eligibility period or during our Annual Open Enrollment.
- Employees can cancel these insurances at any time with written notice to Employee Benefit Services.

As these are after-tax plans, coverage can be stopped at any time by submitting completed forms to Employee Benefit Services. Some re-enrollments are subject to medical underwriting.

LIFE INSURANCE – BASIC LIFE INSURANCE

The County provides \$25,000 of Group Term Life and Accidental Death and Dismemberment (AD&D) insurance at no cost to all benefit-eligible employees effective on their first day of employment in a benefit-eligible position.

- This benefit may be continued upon retirement at applicable retiree rates.

This benefit may be continued after separation of employment through a conversion policy at applicable rates. Contact The Standard for conversion information.

LIFE INSURANCE – EMPLOYEE OPTIONAL LIFE INSURANCE (STANDARD INS)

Benefit-eligible employees may elect to purchase additional group term life insurance.

- Coverage, up to \$300,000 max, is available in \$25,000 increments.
- Rates are based on the employee's age and the coverage level elected; premiums automatically increase in five-year age bands as the employee gets older.
- Premiums for optional life insurance coverage are paid on an after-tax basis.
- Coverage purchased during your initial eligibility period is not subject to medical underwriting.
- Employees are eligible to increase coverage by \$25,000 without medical underwriting during Annual Open Enrollment, provided that they do not exceed the maximum allowed coverage and have not been previously declined for an increase in coverage.
- Increases in coverage outside of the Annual Open Enrollment period, or increases greater than \$25,000 during the Annual Open Enrollment, are subject to medical underwriting.
- Under Internal Revenue Code (IRC) 79, employers are required to calculate imputed taxable income for employees that receive group life insurance coverage in excess of \$50,000 (including the County's basic life coverage). Even though you do not actually receive income, the value of contributions used to pay for the excess coverage is considered taxable income. Taxes are based on an aggregated schedule published by the IRS. Your imputed income, if any, will be reported on your W2 form.
- This insurance cannot be continued under COBRA or Domestic Partner Continuation of coverage.
- This benefit may be continued after separation of employment through a conversion policy at applicable rates. Contact The Standard for conversion information.

Benefit-eligible employees can apply for new or increased coverage at any time, but after their initial eligibility period, approval of new or increased coverage is subject to medical underwriting approved by the carrier.

Benefits for new or increased coverage will not be paid until coverage is approved by the insurance company. When the insurance company approves the new or increased coverage, coverage for the approved amount will go into effect and the Employee Benefit Services Section will begin payroll deduction of premiums. Note: If an employee is on leave that qualifies as FMLA leave, he/she may restart this coverage without medical underwriting upon return to work.

Employees can request cancellation of coverage or reduction in coverage to a lower increment of \$25,000 at any time by writing to the Employee Benefit Services Section (the change will go into effect the pay period in which the request is received and your premium will be adjusted accordingly.)

The beneficiary/ies for employee optional life insurance is/are the same as for basic life insurance. You can change beneficiaries at any time by logging on to The Standard's website (weblink found on Broward.org/Benefits/Pages/LifeIns).

COMMON QUESTIONS ASKED ABOUT EMPLOYEE OPTIONAL LIFE INSURANCE

- **Question:** What are the premiums for employee optional life insurance?

Answer: Premiums are based on age and the amount of coverage elected. Premiums are adjusted during the year if a change in age places you in a new premium bracket. Contact the Employee Benefit Services Section for current rates.

- **Question:** How do I pay premiums if I am on unpaid Leave of Absence:

Answer: Employee Benefit Services will provide you with bi-weekly coupons to continue your benefits while on leave.

- **Question:** How long can I continue my life insurance while on unpaid Leave of Absence?

Answer: Medical Leaves including Disability Leaves and Non-ADA approved Leaves – a maximum of 6 months provided all premiums are paid when due.

Medical Leaves while under approved ADA Leave (included Disability) - once FMLA is exhausted, length of approved ADA leave up to a maximum of 12 months.

Non-Medical Leaves – length of approved Leave up to a maximum of 90 days.

- **Question:** Can my life insurance be cancelled while on approved Leave?

Answer: Yes, by you or by the County if premium is not paid. Upon return to active work, you will be required to provide evidence of insurability to re-enroll.

- **Question:** Do I pay premiums if I become disabled?

Answer: No. Premiums are waived while you are totally disabled, in keeping with plan contract provisions. Waiver of Premium is not automatic; the employee must apply and be approved by Minnesota Life Insurance for waiver of premium to take effect.

- **Question:** What is the accelerated death benefit?

Answer: If your life expectancy is less than 12 months and you qualify for Waiver of Premium, the plan includes an “accelerated benefit” that allows you to receive up to 100 percent of your life insurance benefit before you die. For more information, consult your Certificate of Coverage.

LIFE INSURANCE – SPOUSE/DOMESTIC PARTNER AND CHILD LIFE INSURANCE

Benefit-eligible employees who purchase at least \$25,000 of employee optional life insurance coverage may purchase group term life insurance coverage on their spouse/domestic partner and/or dependent children.

If you purchase at least \$25,000 of employee-paid optional life insurance, you can...

- Purchase \$12,500 of group term life insurance coverage on your spouse or registered domestic partner
- Purchase \$12,500 of group term life insurance coverage (per eligible child through the end of the calendar year in which they turn age 26)
- After the initial eligibility period, coverage for any dependent, spouse or domestic partner is subject to medical underwriting.
- You are the beneficiary for both spouse/domestic partner and dependent coverage.
- This insurance cannot be paid on a pretax basis.

- This insurance cannot be continued under COBRA or Domestic Partner Continuation of Coverage but may be converted to an individual policy by contacting the insurance carrier.
- This insurance is always contingent upon carrier approval for employee optional life insurance.

COMMON QUESTIONS ASKED ABOUT LIFE INSURANCE SPOUSE/DOMESTIC PARTNER

- **Question:** What are the premiums for dependent and spouse/domestic partner life insurance?

Answer: The premiums are flat rates. See rate sheet for current rates.

- **Question:** Which dependents can I cover?

Answer: You can cover:

- your legal spouse or registered domestic partner
- your eligible dependent children (through the end of the calendar year in which they turn age 26) your spouse's or your registered domestic partner's eligible dependent children

(Eligible dependent children include stepchildren and adopted children living in your home through age 26. Children can be covered beyond age 26 if they are unmarried and incapable of self-sustaining employment because of physical disability or mental retardation. You may be required to provide documentation to verify student status, prove disability, or for dependents with a different last name.)



It is the employee's responsibility to notify Employee Benefit Services when a spouse/domestic partner or dependent child no longer meets the eligibility criteria, i.e. divorce, dissolution of DP registration, end of the year in which your child turns age 26, child under age 26 gets married, etc. In the event a claim is submitted for a non-eligible spouse/domestic partner or child, employee will only receive a refund of excess premium paid retroactive to the beginning of the current plan year.

LIFE INSURANCE - SPECIAL OCCUPATION LIFE INSURANCE

The County provides additional group term life insurance at no cost to benefit-eligible employees in certain special occupation positions:

- Security Guard/Park Rangers
- Members of the Amalgamated Mass Transit Union

Contact the Employee Benefit Services Section for additional information about this coverage.

LONG-TERM DISABILITY INSURANCE (STANDARD INS)

NOTE: *Currently in procurement process. Current agreement has been extended through June 30, 2020. Employees will be notified in advance of July 1, 2020 if there any changes to vendor or benefit.*

Long-Term Disability (LTD) insurance provides disability income for covered individuals to assure regular income if they cannot work for an extended period of time because of a covered illness or injury.

- LTD pays for 60 percent (up to \$6,000) of a covered individual's monthly predisability earnings, based on hourly rate of pay, after a 90-day benefit waiting period.
- Benefits are coordinated with Workers' Compensation, retirement benefits, Social Security and certain other types of income.

Employees can combine accrued paid leave with their LTD benefit to bring their total disability benefit up to 100 percent of their predisability earnings. If paid leave and the LTD benefit combined are more than 100 percent of the employee's predisability earnings, the LTD benefit will be reduced until the total benefit is equal to 100 percent.

You should know the following about this insurance option:

- Employees can apply for LTD at any time during the year, but after their initial eligibility period, coverage is subject to medical underwriting and Active at Work Requirements.
- Premiums are based on the employee's age and rate of pay and will automatically adjust.
- There is a 90-day benefit waiting period after you are disabled before any benefits are payable
- Since LTD premiums are on an after-tax basis, any benefits you receive will not be taxed as income to you.
- If an employee is on leave that qualifies as FMLA leave, he/she may restart this coverage without medical underwriting upon their return to work.

COMMON QUESTIONS ASKED ABOUT LONG-TERM DISABILITY INSURANCE

- **Question:** How does LTD protect my income?

Answer: In the event you are disabled according to the plan's definition, the plan pays you 60 percent of the first \$10,000 of your monthly predisability earnings, reduced by any deductible income. The minimum benefit is \$100 per month. *See the Certificate of Coverage for Definition of Disability.*

- **Question:** What if I get benefits from another source?

Answer: If you receive income from one or more of the sources listed below, the total benefits you receive from the other sources will be subtracted from the amount that would be paid under the LTD plan and the difference will be paid from the LTD plan. If the difference is less than \$100, you will receive the \$100 minimum monthly benefit.

- Any state disability income benefit law Workers' Compensation
- Federal Social Security Act
- Any other federal, state, county or municipal retirement acts or laws, including FRS Any other group policies you may have that provide disability benefits

In addition, you can use accumulated or donated paid leave to supplement your LTD benefits as long as the total of the two does not exceed 100 percent of your pre-disability earnings. If it does, your LTD benefits will be reduced to bring the total back to 100 percent.

- **Question:** What disabilities are excluded?

- **Answer:** You are not covered for a disability caused by or contributed to by an intentionally self-inflicted injury, while sane or insane. You are not covered for a disability caused or contributed to by war or any act of war.
- War means declared or undeclared war, whether civil or international, and/or any substantially armed conflict between organized forces of a military nature or armed aggression.
- **Question:** Do I pay premiums if I become disabled?
- **Answer:** No. Premiums are waived while you are receiving LTD benefits, in keeping with plan contract provisions.
- **Question:** What are the plan's limitations?

Answer: You must be under the ongoing care of a physician during the benefit waiting period

No benefits will be paid for any period of disability when you are not under the ongoing care of a physician

Payment of benefits is limited to 24 months during your entire lifetime for a disability caused by or contributed to by your use of alcohol or any drug, including hallucinogens, alcoholism or drug addiction

Benefit payments are limited to 24 months for each period of disability caused by or contributed to by a mental disorder. However, if you are confined to a hospital at the end of the 24 months, this limitation will not apply while you are continuously confined.

Consult your [Certificate of Coverage](#) for more information.

PERSONAL INCOME PROTECTION PLANS (ALLSTATE)

NOTE: *Currently in procurement process. Current agreement has been extended through June 30, 2020. Employees will be notified in advance of July 1, 2020 if there any changes to vendor or benefit.*

This insurance plan pays benefits for specified medical conditions, treatments and screenings in addition to benefits provided by the health insurance plans. Active employees can only enroll during the annual open enrollment period. Newly benefit-eligible employees may enroll during their benefit election period. Plans include:

Accident - Accident insurance can help cover some of the unexpected out-of-pocket expenses associated with an on- or off-the-job accidental injury. Coverage includes benefits for hospitalization, emergency treatment, dismemberment, intensive care, and dislocations or fractures. And, accident insurance works well with your major medical plan, closing gaps in coverage. It pays cash benefits to help you pay for copays, deductibles – or you can even use it to help cover other payments such as your mortgage or rent, utility bills, child care and more.

Cancer - coverage pays cash benefits for cancer and 29 specified diseases to help with the costs for treatment and expenses if a diagnosis occurs. You can use the benefit to help pay for everything from treatment to medical appliances to daily living expenses such as rent or groceries. Each calendar year, you can receive a cash benefit for one of the following medical tests: Bone marrow testing; blood tests for CA15-3 (breast cancer), CA125 (ovarian cancer), PSA (prostate cancer), or CEA (colon cancer); chest X-ray; colonoscopy; flexible sigmoidoscopy; Hemoccult stool analysis; mammography; Pap smear; and serum protein electrophoresis (test for myeloma). If diagnosed for the first time with cancer (except skin cancer), you can receive a one-time cash benefit. Note: Coverage subject to medical underwriting.

Critical Illness - Critical Illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness such as a major organ transplant or coronary artery bypass procedure, stroke, heart attack, etc. This coverage also pays a benefit when you are diagnosed with invasive cancer, cancer in situ, advanced Alzheimer's disease, advanced Parkinson's disease, second time with a previously paid Initial Critical Illness Benefit, and more. There is also a Wellness Benefit included in this plan which pays a benefit of \$50 for every covered family member, once per person per year, for completing one of the following covered wellness exams: chest X-ray, colonoscopy, mammogram, blood test for triglycerides, Echocardiogram, lipid panel and more. The signs pointing to a critical illness are not always clear and may not be preventable, but Critical Illness coverage from Allstate Benefits can help offer financial support in the event you are diagnosed.

Indemnity Medical - Group Indemnity Medical coverage provides cash benefits for hospital confinements, and can help as they happen. Expenses associated with a hospital stay can be financially difficult if money is tight and you are not prepared. But having the right coverage in place to help when a sickness or injury occurs can help eliminate your financial concerns and provide support at a time when it is needed most. Our coverage helps offer peace of mind when a hospitalization occurs.

You should know the following about this insurance option:

- This insurance is available to benefit eligible employees, their spouses/domestic partners and child dependents, up to age 19 (if a full-time student age 25), of the employee or their spouse/domestic partner
- Some coverage is subject to medical underwriting
- This is an individual plan, not a group plan, so coverage can be continued when employment ends with no change in rates and benefits. Contact the insurance carrier to request continuation of coverage.
- **HDHP plan participants can only enroll in the Base Plan.**

PREPAID LEGAL INSURANCE (U.S. LEGAL)

Active employees can only enroll during the annual open enrollment period. Newly benefit-eligible employees may enroll during their benefit election period.

This insurance plan provides benefits for prepaid legal services. The plan:

- permits participants to select an attorney from those affiliated with the plan in South Florida
- permits participants to select an attorney out of network

If using an affiliated attorney, bills are handled by the insurance company with no deductible or copayment. If using a nonaffiliated attorney, employees can be reimbursed for covered services subject to plan limitations.

You should know the following about this insurance option:

- Available to benefit-eligible employees, their spouse/domestic partner and child dependents, up to age 26, of the employee or their spouse/domestic partner
- This insurance can be stopped at any time; however it may not be started again until the following open enrollment period.
- Prepaid Legal is a group plan; therefore, coverage can be converted when employment ends, but with different plan benefits and rates. Contact US Legal Services for conversion information.

SECTION VI – DEFERRED COMPENSATION AND RETIREMENT PLANS

DEFERRED COMPENSATION (ICMA-RC, METLIFE, NATIONWIDE)

The County's Deferred Compensation Plan (457(b) Plan) provides an excellent way for you to invest for retirement while reducing your federal tax liability.

The 457(b) Plan is designed for long-term savings and investment towards retirement, and the Plan has limited availability to withdraw funds during employment with the County. The money accumulated in your account(s) can be distributed to you after you have terminated your employment with Orange County.

The County offers Deferred Compensation plans through three vendors:

	BRIGHTHOUSE (METLIFE)	ICMA-RC	NATIONWIDE
Type of Investments	Annuity	Investment	Investment & Annuity
Loans	No	Yes	No
Unforeseen Emergency Withdrawal	Yes	Yes	Yes
Managed Accounts	No	Yes	No
Self-directed Accounts	No	Yes	No
Roth IRA (after-tax)	No	Yes	No

Deferred compensation is an enhancement to retirement benefits allowing you to save money for your retirement today and defer income taxes on those savings until you make withdrawals from your account. It reduces your taxes each pay period through income deferral, and provides future benefits for retirement. (Sometimes it is referred to as a "457 Plan" since deferred compensation plans are permitted and administered under Section 457 of the Internal Revenue Code.)

If you are nearing retirement, IRS Code allows you to make up for contributions not deferred in previous years of employment. You can "catch up" for three consecutive calendar years prior to the calendar year of your declared normal retirement age. The total amount you can catch up is determined by subtracting what you have contributed from the maximum allowed by law. The maximum amount you can defer in a single year is a combination of your regular deferral for that year and any amounts allowed but not contributed since 1979. Each calendar year's maximum, set by the IRS, differs and is subject to change. Contact Payroll for current dollar amounts and additional information.

A Great Way to Save! Deferred compensation gives you a significant tax break:

- Contributions to your deferred compensation account are taken from your gross salary before federal with- holding taxes are calculated (Look at the table to see what a significant difference this can make!)

- Your deferred compensation contributions do not affect your reported earnings for retirement purposes
- Social Security taxes are not affected by deferred compensation contributions
- Your contributions are invested in the investment program of your choice offered by the provider you select

EXAMPLE			
Without Participation in Deferred		With Participation in Deferred Compensation	
Total to Invest	\$2,400	Total to Invest	\$2,400
28% Taxes	- \$672	No Taxes	- \$0
Total Invested	\$1,728	Total Invested	\$2,400

Without a deferred compensation plan:

- You pay taxes on income before you set any aside for savings or investments
- You have less money to save or invest after taxes are taken out

With a deferred compensation plan, your contributions are made on a pretax basis

- You can contribute more money to your saving/investment plan

You pay no income taxes on your contributions or investment earnings until you withdraw from the plan, allowing earnings to grow on a tax-deferred basis. For example, if you are in the 28 percent tax bracket, contribute \$100 per month to your deferred compensation account and earn 8 percent interest, this account would be worth \$58,902 after 20 years. In the same tax bracket, still earning 8 percent interest, but in a savings account, if you contributed \$100 each month the savings account would be worth only \$44,913 after the same 20 years.

When you withdraw money from the account (there are restrictions on when you may withdraw prior to retirement without penalty) you pay taxes on the amount you withdraw; you will most likely be in a lower tax bracket at that time and will likely pay less in taxes than you would have today. Deferred compensation has both unique restrictions and unique flexibility.

Be sure you understand that:

- Deferred compensation is a voluntary program
- Deferred compensation funds are subject to IRS regulations
- There are strict IRS restrictions on withdrawals prior to retirement
- Benefit-eligible employees can begin or stop contributions to a deferred compensation account at any time

- You must begin receiving benefit payments no later than April 1 of the calendar year following the year you reach 70½, or the year in which you actually retire, if later
- Providers and additional plan information are available from Payroll Central at 954-357-7190

Common Questions Asked about the Deferred Compensation Plan

- **Question:** When can I get my money out of the plan?

Answer: You can withdraw assets from your account without penalty under the following conditions:

Retirement

- Leaving employment for any reason (funds must be “rolled” into a qualified account to prevent IRS penalties)
- You can also withdraw assets from your account, but will pay IRS mandated penalties, in the event of an “Unforeseeable Emergency” as defined by strict IRS regulations
- Note: You must begin receiving benefit payments no later than April 1 of the calendar year following the year you reach 70½ years of age, or the year in which you actually retire, if later.

- **Question:** Who can participate and how do I get started?

Answer: Benefit-eligible employees can start a deferred compensation account at any time.

Contributions to your deferred compensation account are made through payroll deductions. While all deferred compensation plans follow the rules set by Section 457 of the IRS code, within those regulations each deferred compensation plan administrator designs plans that vary in a number of areas; be sure to review the details of any plan in which you are interested.

- The following are available from Payroll Central and directly from provider representatives
 - Information about the plan
 - Information about the providers Enrollment applications
 - Payroll deduction authorization forms

- **Question:** How do I change or stop my deferred compensation deduction?

Answer: Contact Payroll Central at 954-357-7190 or your provider representative.

- **Question:** How safe is my deferred compensation account?

Answer: You make all investment and withdrawal decisions, subject to plan and IRS provisions. Your assets will be held in a trust fund set up solely for that purpose. This protects your assets from any claims of the County’s creditors or any claims from your own creditors.

RETIREMENT

Who Is a “Retiree”?

A retiree for County benefit purposes is defined as an employee who leaves County employment and meets the FRS retirement requirement for the FRS plan they are enrolled in:

PENSION PLAN

- Normal Retirement Requirement:
 - FRS employment prior to July 1, 2011: six years of service and age 62 or 30 years of FRS service
 - FRS employment on or after July 1, 2011: eight years of service and age 65 or 33 years of FRS service
- Early Retirement
- Disability Retirement

INVESTMENT PLAN

- Normal Retirement Requirement:
 - FRS employment prior to July 1, 2011: six years of service and age 62 or 30 years of FRS service
 - FRS employment on or after July 1, 2011: eight years of service and age 65 or 33 years of FRS service

Note: If you leave employment under any other circumstances, you are NOT considered to be a “retiree” for County benefit purposes even if you later apply for, and receive, a benefit from FRS.

RETIREE BENEFITS

At the time of your separation from the County as a “retiree,” you may elect to continue the health (including pharmacy), dental, vision, and life insurance coverage that you were enrolled at the time of your retirement. You cannot elect coverage for a plan you were not enrolled in at the time of retirement. Retiree coverage can continue as long as you continue to pay the required premiums by the due date and otherwise meet plan eligibility requirements. Waiver or nonelection of a plan upon retirement or during a subsequent annual open enrollment will result in the retiree not being able to reenroll in the waived plan at a future date.

Continuation Coverage for Dependents of Retirees

Dependents insured under the retiree’s plans at the time of retirement are eligible for continuation coverage based on the following:

1. Retiree remains insured in County plan(s) under Retiree coverage – dependents can remain insured with retiree as long as they meet the current eligibility requirements and premiums are paid in a timely manner.
2. Retiree declines coverage under Retiree coverage – dependent can enroll in COBRA coverage for 18 months.

Example: Employee A insures EE + Spouse for health, dental and vision coverage as an active employee

- Employee retires on 02/14/2017
- Employee is eligible for Medicare and does not elect Retiree health coverage.
- Spouse cannot be covered under Retiree health without the Retiree, and is offered COBRA coverage for 18 months.
- Retiree and spouse can elect Retiree coverage for dental and vision coverage.

RETIREE HEALTH INSURANCE PREMIUMS

Retiree premiums are calculated at 100% of the County cost. Health insurance premiums are billed by a Third Party Administrator. After the initial two payments, retirees can elect to have their health (including pharmacy), dental or vision premium deducted from their FRS check. Partial premium payments through FRS will not be accepted. Retirees are encouraged to apply for the Health Insurance Subsidy through FRS to help offset the cost of retiree health coverage.

MOVING OUT OF SERVICE AREA

If you move outside of the service area covered under your current health and/or dental insurance plan, you must notify our Third Party Administrator so that your coverage is changed to another plan which services your new area (if available).

FRS HEALTH INSURANCE SUBSIDY

Retirees enrolled in a health plan (including Medicare) are eligible for a monthly Health Insurance Subsidy (HIS) from FRS of \$5 for each creditable year of FRS service (max 30 years). FRS will request periodic proof of other coverage. Retirees must apply for the HIS subsidy directly through FRS. Subsidy application will not be accepted by FRS prior to retirement. FRS will automatically send this form after retirement.

NOTE: Investment Plan members are not eligible for the HIS until they take a distribution.

NON-RETIREE BENEFITS

If you are not considered to be a retiree at the time of separation of employment, you are eligible to continue health (including pharmacy), dental and vision coverage (as enrolled at the time of separation) under COBRA for a maximum of 18 months in most circumstances.

You are also eligible to convert your Basic and/or Optional life insurance to an individual policy by contacting the Group Life Insurance Company within 31 days of your employment ending.

WHAT HAPPENS WHEN I BECOME AGE 65?

While you are employed by the County and covered by a County health plan, you or your covered dependents are not required to participate in Medicare at age 65. However, as a retiree, once you or your covered dependent(s) become eligible for Medicare, the Medicare eligible person(s) must enroll in Medicare Part B as health insurance claims will automatically be paid as if the member were enrolled in Medicare Part B.

As a retiree, once you become eligible for Medicare Part B, you must contact Social Security and arrange enrollment for the coverage. As a retiree with Medicare Part B, you have the following options:

- You can continue health insurance through Broward County with Medicare A & B as your primary insurance, the County as secondary
- You can cancel your County health insurance and assign your Medicare part B to an insurance company of your choice (if insuring dependents, at time of cancellation all insured dependents will be eligible for 18 months of COBRA coverage)
- You can cancel your County health insurance and purchase a supplemental insurance plan (if insuring dependents, at time of cancellation dependent will be eligible for 18 months of COBRA coverage)

MEDICARE D PRESCRIPTION INSURANCE:

The County's pharmacy plan is considered equal to or better than the current Medicare D prescription plans. Retirees canceling coverage through the Broward County health plan will not be able to re-enroll in a Broward County health plan (including prescription drug coverage) at a later date. Participants who drop or lose health coverage with Broward County and must join a Medicare drug plan within 63 continuous days after their current coverage ends to avoid paying a higher premium (a penalty).

RETIREE LIFE INSURANCE

At the time of your retirement, you may elect to continue all or some of the term life insurance in effect at the time of your retirement. You may decrease the amount of life insurance in \$25,000 increments, but cannot increase the level of coverage. Enrollment or increases to life insurance cannot be made at a later date.

Retiree Life Insurance is administered (including billing, payment and maintenance of beneficiaries) by The Standard.

RETIREE CONTINUATION OF OTHER BENEFIT PLANS:

PLAN	CONTINUATION OPTION
HSA-Health Savings Account	Employee owns HSA and takes it with them when they retire or leave County employment.
HRA-Health Reimbursement Account	After a runout period for pending claims, HRA balance is transferred to a Retirement Health Savings plan at ICMA-RC. Claims for eligible health, prescription, dental, vision and some health premiums can be submitted for reimbursement starting at age 55.
FSA- Health Care	May be continued through the end of the calendar year of retirement on an after-tax basis (under COBRA)
FSA- Dependent Care Account	Cannot be continued past termination or retirement date
Personal Income Protection Plans	May be continued through direct bill from carrier.
Legal Insurance	May be continued through direct bill from U.S. Legal Services. Contact U.S. Legal at 1-800-356-5297
Long-Term Disability Insurance	Cannot be continued past termination or retirement date
Deferred Compensation Program(457 Plan)	If enrolled in the Deferred Compensation Program (457 plan), contact your provider directly (ICMA, MetLife, or Nationwide) to arrange disbursement of your account. Contact Payroll Central for assistance at 954-357-7190.

FLORIDA RETIREMENT SYSTEM – FRS

Retirement benefits are provided to eligible employees in full-time, PT20-plus and PT19 positions based on the following:

- If you have earned FRS credited service through other public employment, all service credit earned automatically combines into one account under your name and Social Security number (over 900 other public employers in the State of Florida are also members of FRS).
- Effective January 1, 2018, employees beginning FRS employment will default to the Investment Plan and will have eight calendar months after the month of hire to make an active election between the Pension Plan and Investment Plan.
- Effective July 1, 2011, employees in full-time, PT20-plus and PT19 positions are required to contribute 3 percent of their earnings to the FRS system (with the exception of employees enrolled in the DROP program).
- Employees beginning FRS employment after July 1, 2011, have new vesting and retirement rules under the Pension Plan.

EMPLOYMENT WITH AN FRS-COVERED EMPLOYER

	INVESTMENT PLAN	PENSION PLAN
VESTING SCHEDULE FOR EMPLOYER CONTRIBUTIONS	One (1) year	<ul style="list-style-type: none"> • Six years for members first employed by an FRS employer prior to July 1, 2011 • Eight years for members first employed by an FRS employer on or after July 1, 2011
BENEFIT PAYABLE	Your account balance at the time of termination. Multiple payout options are available, including rollovers, lump sum distributions, distributions on demand, guaranteed annuity payments, or any combination of the above distribution options.	<ul style="list-style-type: none"> • Your lifetime monthly benefit calculation is based on your average final compensation multiplied by the years of creditable service multiplied by the benefit accrual rate. A monthly payment is the only distribution option (except under DROP).
DEATH BENEFITS	You can name anyone as your beneficiary.	<ul style="list-style-type: none"> • Your beneficiary designation may be limited. Only a beneficiary who qualifies as a joint annuitant (spouse, dependent children, etc.) is eligible for a continuing lifetime benefit. You may name any beneficiary to receive a time certain monthly benefit if you should die within 10 years of retirement.

	INVESTMENT PLAN	PENSION PLAN
EARLY RETIREMENT BENEFITS	Your account balance is payable at any age (tax penalties may apply). You will not be eligible for County leave payout and benefits as a retiree unless you meet the normal retirement requirement based on your FRS employment date.	<ul style="list-style-type: none"> Your benefit is either reduced or not immediately payable if you choose "early retirement" as defined by the FRS.
NORMAL RETIREMENT	Your account balance is payable at any age (tax penalties may apply). You will be eligible for County leave payout and benefits as a retiree if you meet the normal retirement requirement for the Pension Plan based on your FRS employment date.	<p>If first employed by an FRS employer prior to July 1, 2011:</p> <ul style="list-style-type: none"> Regular Class: Age 62 with six years or 30 years of service regardless of age. Special Risk: Age 55 with six years or 25 years of service regardless of age <p>If first employed by an FRS employer on or after July 1, 2011:</p> <ul style="list-style-type: none"> Regular Class: Age 65 with eight years or 33 years of service regardless of age. Special Risk: Age 60 with eight years or 30 years of service regardless of age.
REEMPLOYMENT AFTER RETIREMENT	<p>You are considered retired by FRS once you terminate FRS-covered employment and request a distribution (including a rollover) from your FRS Investment Plan account. A distribution may not be issued until you have been terminated for three calendar months (except if you have met the normal retirement requirements of the Investment Plan you may receive a one-time distribution of up to 10 percent of your account balance after one calendar month).</p> <p>If you are re-employed with a FRS employer prior to receiving a distribution of your benefits, your distribution will be cancelled and you will not be considered to have terminated.</p> <p>You must wait six calendar months after taking a distribution before you return to work in any position with an FRS- covered employer. If you return to work within 6 calendar months of any distribution, you</p>	<p>You become a Pension Plan retiree once you have terminated employment with all FRS-participating employers, established an effective retirement date through the application process, and cashed or deposited a benefit payment.</p> <p>You are considered retired as of your effective retirement date. If you participate in the Deferred Retirement Option Program (DROP), your effective retirement date is your DROP begin date. The termination and reemployment limitations apply to you beginning the calendar month after your termination date.</p> <p>If you return to FRS employment within 6 calendar months Your retirement will be voided and you will be required to repay all the Pension Plan benefits you have received, including any DROP payout.</p> <p>If you return to FRS employment during calendar months 7 to 12 Your Pension Plan benefits will be suspended for each month</p>

	INVESTMENT PLAN	PENSION PLAN
	<p>will be required to repay the distribution you received.</p> <p>If you return to work during calendar months 7 to 12, no additional Investment Plan distributions are permitted until you terminate employment or complete 12 calendar months of retirement.</p>	<p>you are employed during this period (you must notify the Division of Retirement of your employment). If your benefits are not suspended timely, you and your employer will be required to repay benefits you should not have received.</p> <p>If you return to FRS employment after 12 calendar months you will not be required to repay any prior benefits and you will continue receiving benefits from the Pension Plan without interruption.</p>
RENEWED MEMBERSHIP	You are eligible for renewed FRS membership if reemployed on or after July 1, 2017.	You are not eligible for renewed FRS membership.

If you have questions on reemployment laws or need more information, call the Division of Retirement at 1-866-446-9377, Option 3.

Eligible employees may choose between the FRS Pension Plan and the FRS Investment Plan. New hires (full-time, PT20 and PT19 employees) to FRS employment must make an election within the first 8 months of FRS eligibility. If a plan election is not made, effective January 1, 2018, the employee will automatically be enrolled in the Investment Plan.

The FRS Pension Plan takes a traditional pension approach. It provides a fixed benefit at retirement based on a formula guaranteed for life. Eligible employees vest based on their FRS employment date and it is fully portable to another FRS employer.

The FRS Investment Plan is a nontraditional pension plan. The benefit is not fixed and is based on the investment funds in the plan. Eligible employees are vested after one year of service and it is fully portable to another FRS employer or an employer outside the FRS umbrella.

DROP (DEFERRED RETIREMENT OPTION PROGRAM)

DROP provides a way for retirees in the Pension Plan to accumulate additional savings while continuing employment for up to 60 months beyond their normal retirement date. It is a payout alternative for FRS retirement benefits. Annual leave can also be cashed out upon entering DROP (this income is reported to FRS as earnings and may result in a higher retirement benefit.) Retirees in the Investment Plan are not eligible to participate in the DROP program.

Note: Enrolling in DROP does not change participants' employment status in any way. Participants may resign and the County may terminate them in the same manner as before DROP participation.

HOW DOES DROP WORK?

1. You “retire” for FRS purposes at your normal retirement date based on your FRS employment date.
2. You continue to work for a preselected period of time (up to 60 months).
3. You continue to receive a salary from the County up to the date you preselected to end participation in DROP.
 - a. You do not earn additional credit for retirement while participating in DROP.
 - b. Your monthly FRS retirement benefit is paid into your DROP account, where it earns interest and is tax deferred while you participate in DROP, instead of being paid directly to you. You do not contribute the mandatory 3% contribution.
4. When your selected DROP period ends you must terminate employment, at which time you will:
 - a. Receive your accumulated DROP benefit.
 - b. Begin to receive a FRS monthly retirement benefit – in the same amount as determined at retirement – and annual cost-of-living increases.

WHO IS ELIGIBLE FOR DROP?

All vested members of FRS who have reached normal retirement age based on their FRS employment date or attained 30 years of service in the FRS Pension Plan (as long as they choose to participate within their eligibility window.)

WHEN CAN I BEGIN DROP?

A vested FRS Pension Plan member may elect to participate in DROP for a maximum of 60 months following the date on which he/she first reaches normal retirement date (including members who are on a leave of absence or on workers’ compensation). While a member may apply for DROP up to six months before reaching his/her normal retirement date or DROP deferral date, the election to participate in DROP must be made within 12 months of first reaching the normal retirement date. A member’s normal retirement date is reached:

- FRS employment date prior to July 1, 2011: when the member is either age 62 and vested, or reaches 30 years of service prior to age 62.
- FRS employment date on or after July 1, 2011: when the member is either age 65 and vested, or reaches 33 years of service prior to age 62.

A member who reaches his/her normal retirement date based on years of service before age 57 may defer his/ her DROP election. He/she may elect to enter DROP anytime from the member’s initial eligibility date through the month he/she attains age 57 and participate for a full 60 months. (The member could also make the deferred DROP election at any time during the 12 months after the month in which he/she reaches age 57, but his/her participation period would be shortened accordingly.)

Contact the Employee Benefit Services Section for additional information about DROP eligibility and enrollment.

HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision." Special enrollment rights apply when you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact:

Broward County
Human Resources Division/Employee Benefit Services Section
115 S. Andrews Avenue, Room 514
Fort Lauderdale, FL 33315

Phone: 954-357-6700

Email: benefits@broward.org

Medicare Part D Creditable Coverage Notice

2020 Important Notice from Broward County Board of County Commissioners 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 Broward County Board of County Commissioners as an active employee or a retiree 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. Broward County Board of County Commissioners has determined that the prescription drug coverage offered by Broward County Government is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep the County's coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

The prescription drug benefit included in all the health plans offered by Broward County is as follows:

CDH Plans

Copayments	Prescription Fill Methods		
	Tier*	Retail: Up to a 30-day supply‡	90 Day at Retail Program. Up to a 90 day supply.
Generics (Tier 1)	\$7	\$14	\$14
Preferred Brands (Tier 2)	\$30	\$60	\$60
Non Preferred (Tier 3)	\$45	\$90	\$90
Specialty Medications	\$75	N/A	N/A

HDHP Base Plan and HDHP Out of Network Plan

Member Contributions	HDHP Base Plan - Single Coverage	HDHP Base Plan - Family Coverage	HDHP OON – Single Coverage	HDHP OON – Family Coverage
Annual Deductible (integrated with Medical)	\$1,400	\$2,800	\$1,500	\$3,000
Co-Insurance	20%, after Deductible is met	20%, after Deductible is met	30%, after Deductible is met	20%, after Deductible is met
Annual Out of Pocket Maximum (Integrated with Medical)	\$3,425	\$6,850	\$3,000	\$6,000
Preventative Benefit	\$0 (no deductible, co-insurance or annual Maximum)			
Retail: Up to 30 Day Supply	20%, after deductible is met			
90-Day at Retail :Up to a 90-Day Supply	20%, after deductible is met			
Mail: Up to a 90 Day Supply	20%, after deductible is met			

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 Broward County Board of County Commissioners coverage will not be affected.

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 Broward County Board of County Commissioners and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage...

Contact the person listed below for further information or call Lisa Morrison at 1-954-357-6720.

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 Broward County Board of County Commissioners 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 800-325-0778).

Newborns' Act Description of Rights

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Social Security Number Disclosure Notice

Women's Health and Cancer Rights Act (WHCRA) Notices

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

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

If you would like more information on WHCRA benefits, contact UnitedHealthcare at 866-873-3903 or Community Care Plan at 866-224-5701.