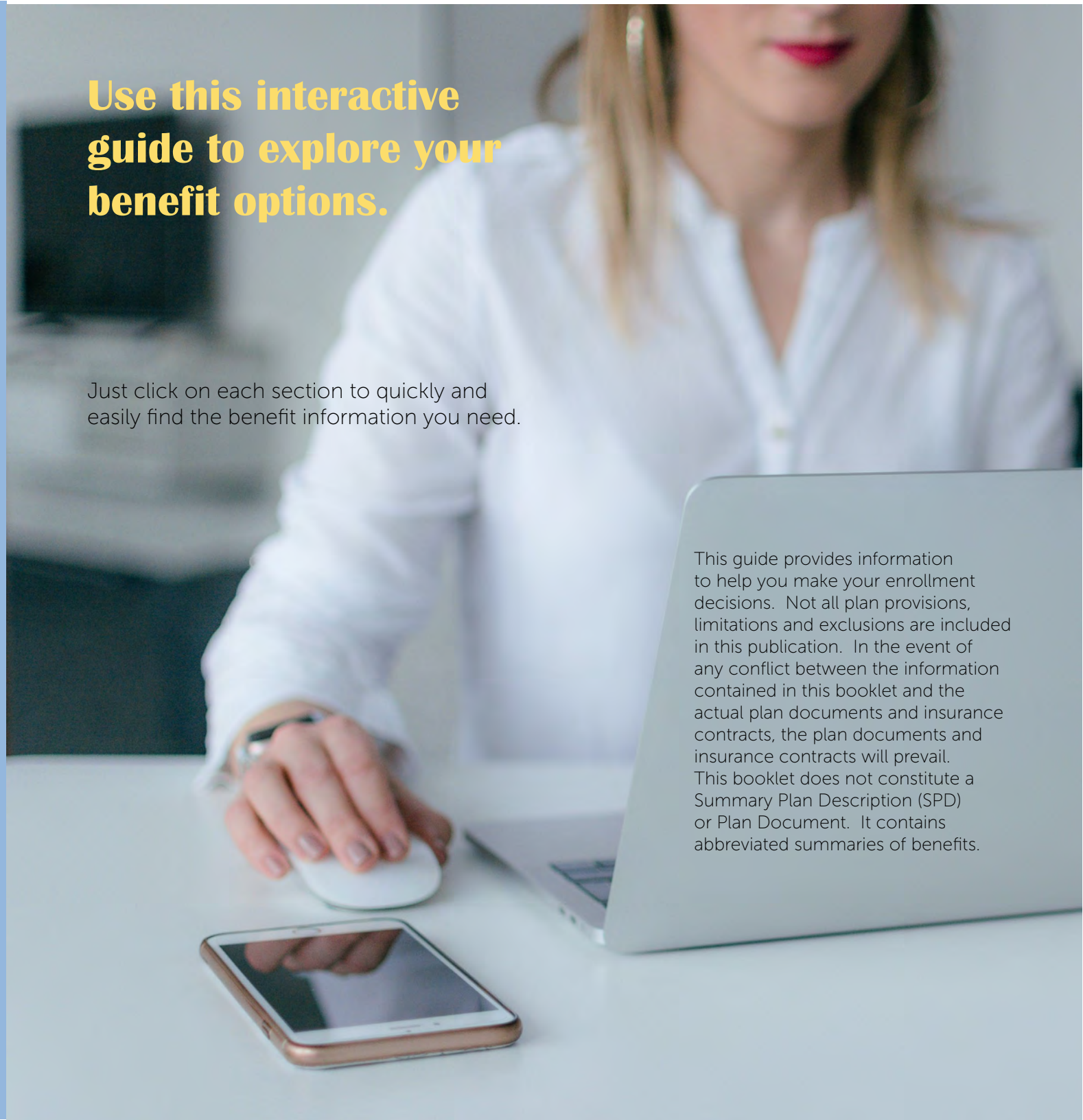
Your Guide to

BENEFITS ENROLLMENT

October 1, 2023 - September 30, 2024

Flagler County

Version 23.01



Use this interactive guide to explore your benefit options.

Just click on each section to quickly and easily find the benefit information you need.

This guide provides information to help you make your enrollment decisions. Not all plan provisions, limitations and exclusions are included in this publication. In the event of any conflict between the information contained in this booklet and the actual plan documents and insurance contracts, the plan documents and insurance contracts will prevail. This booklet does not constitute a Summary Plan Description (SPD) or Plan Document. It contains abbreviated summaries of benefits.

ELIGIBILITY INFORMATION

Flagler County offers a comprehensive group benefit program to meet the needs of you and your family.

During benefits enrollment, you have the opportunity to review your coverage needs, consider the benefit plans available to you and select those that will provide the most value to you and your family.

New Employee benefits begin on the first of the month following 30 days of employment. We ask that you enroll in your benefits within 15 days of your start date.

Open Enrollment will be held from July 10, 2023 through July 28, 2023 with elections made during this enrollment period effective October 1, 2023. **All benefits-eligible employees must complete an enrollment online including those who are not making changes and those waiving coverage.**

Benefits through Flagler County will expire at the end of the month in which you **terminate** employment or upon death, including benefits you carry for your dependents.

To Enroll

ONLINE

benefits.plansource.com

The first time you log on....

User Name: your social security number without dashes

Password: your date of birth in the YYYYMMDD format

You will be required to change your password when you log in for the first time.

Passwords are reset each year to your date of birth in the YYYYMMDD format. You will be required to reset your password during open enrollment.

ELIGIBILITY INFORMATION

Coverage Levels

You may choose to enroll in one or all of the benefit coverages. Enrollment in one type of plan is not contingent upon enrollment in another plan. You may choose from the following coverage levels for your medical, dental and vision options:

Employee

Employee + Spouse

Employee + Child(ren)

Employee + Family

Eligible Dependents

Your eligible dependents for medical, dental, vision, and voluntary life coverage include:

- A covered employee's spouse under a legally valid existing marriage.
- Your dependent child up to the end of the calendar year in which he or she reaches age 26 regardless of the following:
  - Their marital, student or employment status
  - Whether they are your tax dependent
  - Whether your home is their principal place of residence.

For this purpose, the term child includes:

- Your natural child
- Child for whom you are the legally appointed guardian with full financial responsibility
- Your stepchild
- Your legally adopted child or child placed with you for adoption
- Child named in a Qualified Medical Child Support Order
- Foster child that has been placed with you by an authorized agency, judgment, decree or other court order
- The term child includes a dependent 26 or more years of age if unmarried, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability

BENEFIT OPTIONS FOR 2023-24

Plan Choices

Medical Coverage **Medical Plan**	A medical plan administered through Florida Blue is offered. The plan is a PPO plan designed with discounted rates when you obtain medical care within the BlueOptions network of providers. You may use providers outside the network, but your deductible and coinsurance will be higher.
Prescription Coverage **Prescription Plan**	The medical plan includes prescription coverage with copays administered through OptumRx.
Health & Wellness Center **Onsite Medical Clinic**	Employees and dependents enrolled in the medical coverage have free access to the Employee Health and Wellness Center. This center, staffed by an experienced medical team, provides in person visits with the doctor and generic medications at no cost.
International Prescription **Voluntary Prescription Option**	Members, enrolled in the medical coverage, may use the international prescription drug program through CanaRx and obtain eligible medications through the mail at no cost.
Dental Coverage **Dental Plan**	A PPO dental plan administered through Florida Combined Life is offered. The plan covers preventive care at 100% with no deductible, provides coverage for basic and major services as well as out-of-network services.
Vision Coverage **Vision Plan**	The vision plan is administered by Aetna and provides coverage for eye exams, lenses, and frames and/or contact lenses, as well as discounts on Lasik eye surgery from network providers.

BENEFIT OPTIONS FOR 2023-24

Plan Choices

Life Insurance
Basic Life & AD&D
Employee Voluntary Life & AD&D
Spouse Voluntary Life
Dependent Voluntary Life

Basic Life and Accidental Death & Dismemberment (AD&D) insurance is provided at no cost to you through Standard Insurance Company. In addition, you may purchase Voluntary Life Insurance for yourself and your dependents, subject to certain requirements.

Flexible Spending Accounts
Health Care
Dependent Care

Flexible Spending Accounts (FSAs) are administered by P&A Group. This benefit gives you the opportunity to set aside pre-tax money to pay out-of-pocket costs for eligible health and dependent care expenses.

Supplemental Plans
Accident Plan
Critical Illness Plan
Hospital Indemnity Plan
Short Term Disability

Four Supplemental Plans provided through AFLAC ease the financial burden by providing funds directly to the member for covered services. The Accident Plan covers accidents both on or off the job. The Critical Illness Plan covers illnesses such as cancer, heart attacks, strokes, kidney failure, and more. An annual benefit for completing certain preventive/wellness screenings is also included in the Critical Illness Plan. The Hospital Indemnity plan provides benefits if you are hospitalized. And the Short Term Disability benefit pays you if you become hurt or sick and can no longer work.

FIND A PROVIDER

Choosing the right provider can help you save time and money.

The medical plans offered are designed to help you use the least expensive type of provider by costing you less for certain types of procedures. For example, when possible, seeking services at an urgent care facility will cost both you and the plan less than if you use an Emergency Room. You can help ensure premiums stay low by using the less expensive types of providers.

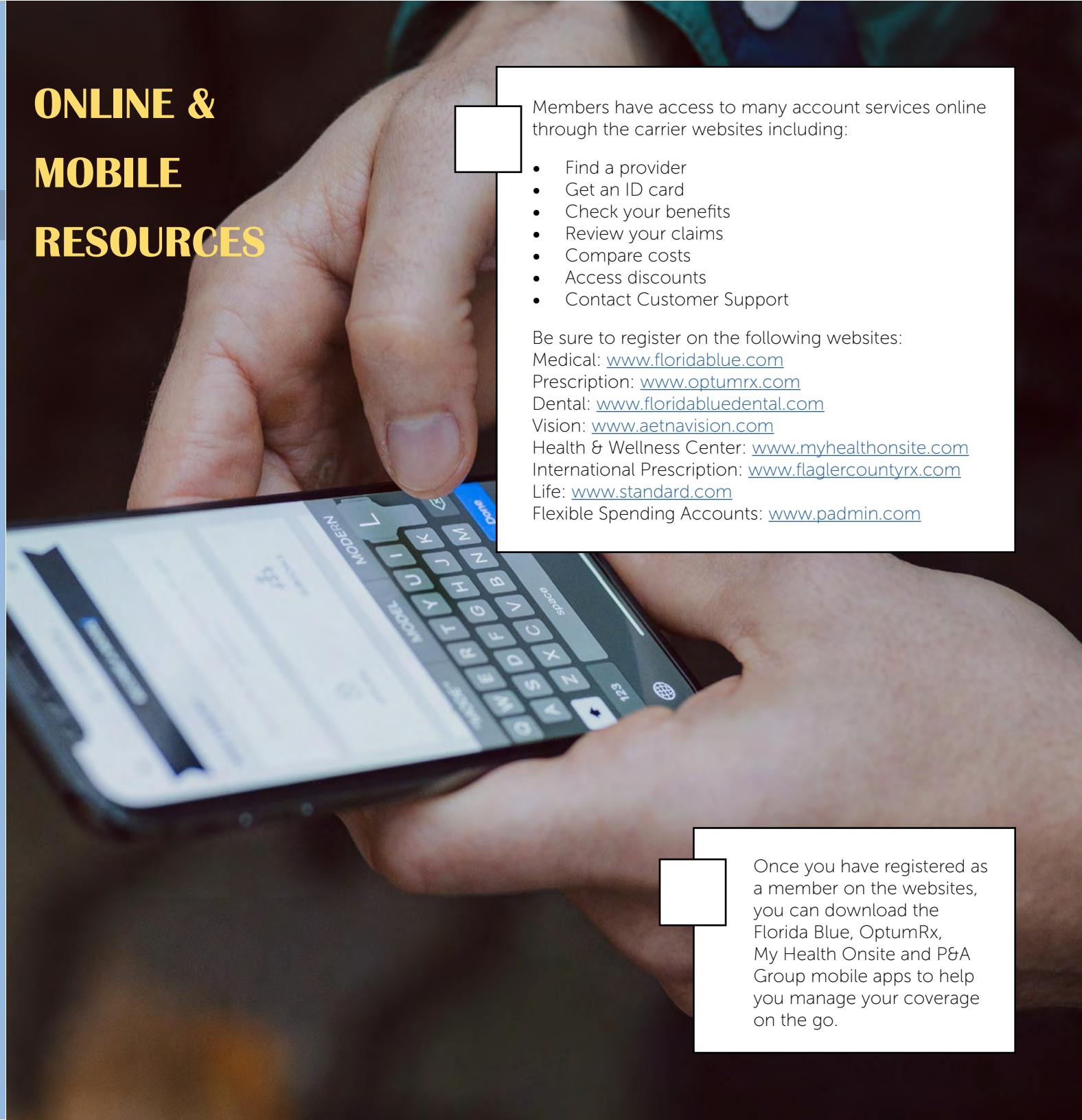
Using in-network providers is the best way to get the most out of your plan and will reduce out-of-pocket responsibility for services.

To locate in-network, contracted medical providers within the state of Florida for your Florida Blue plan, please visit www.floridablue.com. Your medical plans utilize the BlueOptions network. To locate in-network contracted medical providers outside the state of Florida, including nationwide and internationally, please visit www.bcbs.com. You will need to enter the first three letters of your medical ID number as XJB.

The group dental plan through Florida Combined Life offers nationwide access to providers. To find a provider, simply log onto www.floridablue.com and choose "Find a Doctor." You can search type of provider, location, dentist/facility name and more.

The group vision plan offered through Aetna provides access to providers nationwide. To find a provider, log onto www.aetnavision.com. Choose "Locate a Provider" and enter the search criteria to find a participating provider.

ONLINE & MOBILE RESOURCES



Members have access to many account services online through the carrier websites including:

- Find a provider
- Get an ID card
- Check your benefits
- Review your claims
- Compare costs
- Access discounts
- Contact Customer Support

Be sure to register on the following websites:
Medical: www.floridablue.com
Prescription: www.optumrx.com
Dental: www.floridabluedental.com
Vision: www.aetnavision.com
Health & Wellness Center: www.myhealthonsite.com
International Prescription: www.flaglercountyrx.com
Life: www.standard.com
Flexible Spending Accounts: www.padmin.com

Once you have registered as a member on the websites, you can download the Florida Blue, OptumRx, My Health Onsite and P&A Group mobile apps to help you manage your coverage on the go.

Health & Wellness Resources

Your employer is committed in helping you and your family be healthy and fit. As covered members, you and your dependents have access to the following benefits and resources. You are encouraged to take advantage of these tools which can help you reach your personal goals for fitness, good health and overall well-being.

Preventive Care

One of the best ways to stay healthy and mitigate health risks is to follow established guidelines around preventive care, including routine check-ups, screenings and immunizations.

Medical: Your medical plan covers in-network eligible preventive care visits, screenings and immunizations at no cost for you and your covered family members.
Dental: Your dental plan covers 100% of preventive care services in-network with no deductible for you or your covered family members.
Vision: Benefits for routine eye exams are available to you and your covered family members.

Care Consultants and Nurses on Call

Planning ahead can make important decisions easier, especially when you're dealing with a new diagnosis or managing a serious health condition. The Florida Blue Care Consultant Team will explain how your benefits work, identify helpful services, find specialists, compare health care options and explore ways you can save money. Call a Care Consultant at 888-476-2227.

When you need answers right away, call a nurse 24/7. Whether you or your family members have health concerns or general health questions, the nurse-line is available at no cost to Florida Blue members. Simply call 877-789-2583.

Prenatal Program

Available to moms-to-be, Healthy Addition Prenatal Program is a prenatal education program that is particularly important if you have a high-risk pregnancy. You can talk with nurses who will walk you through steps for a healthy pregnancy, birth, and baby. Enjoy free educational materials and complimentary gifts. To join, call 800-955-7635, option 6.

Employee Health and Wellness Center Resources

In addition to free routine checkups, sick visits and acute condition treatment, the Flagler County Employee Health Center includes free access to diabetic and nutrition counseling, 24/7 nurse by telephone for emergencies and a free Vital Health Profile (VHP) that includes labs and biometric screenings. The free wellness programs available through the Employee Health Center can provide you with education on a variety of conditions to help you take control of your health. Topics include diabetes, hypertension, nutrition, asthma, hyperlipidemia, rhabdomyloysis, tobacco cessation, stress management, healthy living, medication management, weight management, behavioral health, anxiety/depression, hyperthyroidism, hypothyroidism, COPD, PCOS and more.

Enrollment Instructions

All benefits-eligible employees must log in and complete their enrollment, including those who are not making changes or are waiving coverage including as a new hire and during open enrollment. All enrollments must be completed on-line.

Website:

Benefits.plansource.com

User Name: Social Security Number without dashes

Password: Your date of birth in the YYYYMMDD format

Passwords are reset for open enrollment. You are required to change your password when you log in.

PLANSOURCE®

Welcome Screen

- From this screen you will be able to begin the enrollment, make changes to benefits, see the benefits summary, and review benefit plan information.
- Review the timeline. Click Get Started.

Proceed through enrollment

- Review your profile and make necessary corrections by choosing the "Edit Info" button.
- Review your family and add a Family Member as needed or Edit as needed even if not covering. (We recommend that you do not remove a family member as it might cause issues in the future.)
- Now you are ready to enroll. You'll see available options in the middle of the screen and the total benefit cost per pay period will appear in the upper right hand side of the enrollment screen in your cart.
- In order to proceed through each enrollment page, use the "Shop Plans" or "Start Survey" button next to the first benefit type.
- On each benefits page, you can compare plans, edit who is covered and get information related to your benefits.
- Edit or add those who you want to cover, or add, by clicking "Edit Family Covered." Click on the benefit in which you wish to enroll. Click "Update Cart" to finalize your selection.

Confirm

- The Enrollment Confirmation page lists all the benefits you elected.
- Read through the entire page carefully and verify all the information. To review your plans and who is covered, simply click "View Plan" next to each benefit type. You can also download, email, and print your selections for your own record.
- Choose "Checkout" at the bottom of the screen.

Making Changes to Coverage

The benefit elections you make during your enrollment period remain in effect for the entire plan year (October 1 - September 30). If you experience a Qualified Life Event, you may add or drop coverage for yourself and applicable dependents from your existing plans. Your change must be consistent with the Qualified Life Event which has occurred.

You will be required to furnish documentation of the change within 30 days of the event. Supporting documentation must contain the reason for the change, the date of the event, and the family members who are effected by the event.

Examples of Qualified Life Events include:

- Birth, Adoption, Legal Guardianship, or Placement for Adoption
- Marriage, Divorce or Annulment
- Death of a Dependent
- Gain of Other Creditable Coverage
- Loss of Other Creditable Coverage

Qualified life event requests and supporting documentation must be submitted on-line in the enrollment site within 30 days of the date of your life event.

Log on to: benefits.plansource.com

Documentation should be uploaded into the enrollment site when the change is requested.

If you experience a Qualified Life Event, log on to the enrollment website as outlined in the Enrollment Instructions to execute your change. You must request the change in the enrollment site and provide the documentation within 30 days of the date of your event. If you do not request the change in the enrollment site or do not provide the documentation within 30 days, you will have to wait until the next open enrollment to add or drop yourself or your dependents.

Changes to your elections are governed by the Section 125 Plan.

Group Medical Benefits

You may elect to enroll in the group medical plan offered through FloridaBlue.

Your employer is offering affordable, minimum essential coverage as required under the employer shared responsibility requirement. Any benefits-eligible employee who goes to the Exchange (www.healthcare.gov) will be ineligible for a premium assistance tax credit due to the fact that our plan offers affordable, minimum essential coverage. You may choose to waive medical coverage but if you do, you will not be able to enroll in a medical plan until the next open enrollment unless you have a qualified life event.

Easy access to medical plan information

Florida Blue provides you easy access to your health information when you visit www.floridablue.com or download the app.

- Find a provider
- Get an ID card
- Check your benefits
- Review your claims
- Compare costs
- Access discounts
- Contact Customer Support

	PPO Medical Plan	
Medical Benefits	In-Network	Out-of-Network[1]
Calendar Year Deductibles		
Individual	$1,000	$3,000
Family Maximum	$3,000	$9,000
Calendar Year Out-of-Pocket Maximum[2]		
Individual	$4,500	$9,000
Family Maximum	$13,500	$27,000
Preventive Services[3]	No charge	50%
Physician Office Visits		
Health and Wellness Center	No Cost	n/a
Family Physicians	$35	50% after deductible
Specialists	$60	50% after deductible
Lab Tests		
in independent clinical lab	No charge	50% after deductible
Diagnostic Services (Independent Diagnostic Testing Facility)		
Advanced Imaging Tests[4]	20% after deductible	50% after deductible
Other Diagnostic Services	20% after deductible	50% after deductible

	PPO Medical Plan	
Medical Benefits	In-Network	Out-of-Network[1]
Emergency/Urgent Services		
Urgent Care Services	$75	$75 after deductible
Emergency Room	$500	$500
Ambulance Services	20% after deductible	20% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible
Mental Health		
Office Visit	No charge	50% after deductible
Outpatient	No charge	50% after deductible
Inpatient	No charge	50% after deductible
Other Provider Services		
at Hospital or ER	$100	$100
at Ambulatory Surgical Center	$60	$60
Ambulatory Surgical Center	20% after deductible	50% after deductible
Outpatient Hospital Services	20% after deductible	50% after deductible
Inpatient Hospital Services	20% after deductible	50% after deductible

1 Balance billing (billing the difference between the allowed amount and the actual charge) can occur out-of-network and will be a part of the patient responsibility.

2 Your deductible, copayments and coinsurance apply to the out-of-pocket maximum.

3 Preventive Care must be coded as wellness with no diagnosis. Age and frequency limits apply.

4 Advanced Imaging services including MRI, MRA, PET, CT and Nuclear tests, require prior authorization.

Medical Premiums

Premiums are collected on a pre-tax basis from your paycheck.

	PPO Medical Plan
Medical Benefits	Rates per month
Employee Only	$28.75
Employee & Spouse	$154.10
Employee & Child(ren)	$121.90
Family	$316.25

Reasonable Alternative: If you think you might be unable to meet the requirements under the wellness program (or if it is medically inadvisable for you to do so), you may still be able to earn the rewards offered by your employer by completing an alternative program. Please contact your HR Department or The Bailey Group and they will work with you (or if you wish, your doctor) to find you an alternative.

Pharmacy Benefits

Employees who have elected medical coverage have three options for obtaining their prescriptions. The **Health and Wellness Center** provides many generic medications, dispensed by the physician at the Center, at no cost. The **CanaRx** program is a voluntary international prescription drug program where members may obtain eligible medications through the mail at no cost. The prescription drug coverage through the **OptumRx** allows you to purchase your medications through a participating pharmacy or through the OptumRx mail order program for the copays listed below.

When you fill your prescription at a participating retail pharmacy, you may purchase up to a 30-day supply of covered medications. At the pharmacy you will need to present your prescription ID card and make the required copayment.

If you use a maintenance medication, such as blood pressure medicine for a heart condition, you should use the mail order program to receive a 90-day supply at a reduced cost to you. You will pay a copayment based on the schedule below.

	Prescription Plans	
OptumRx	Retail Pharmacy 30-day supply	Mail Order 90-day supply
Generic	$10	$25
Preferred Brand	$30	$75
Non-Preferred Brand	$50	$125
Specialty Medication	20%	20%
Drug Tiers	For more information about the OptumRx formulary list and the tier of your medication, go to www.optumrx.com.	
CanaRx	Mail Order 90-day supply	
Brand Name or Non-Preferred	No Cost	
Health & Wellness Center	Dispensed by onsite physician	
Generic	No Cost	

Use the Mail Order Program for Maintenance Medications

The OptumRx Home Delivery program allows members to purchase 90-day long-term/maintenance medications. The program offers:

- Free standard shipping
- Up to a 90-day supply of your long-term medicines delivered to your home
- 24/7 access to a pharmacist from the privacy of your home
- Ability to order your refills on-line or on the phone

Specialty Pharmacy Program

With a rare or complex medical condition (e.g. cancer, hepatitis, hemophilia, or rheumatoid arthritis), the appropriate use of specialty medications can be critical to maintaining or improving a patient's health and quality of life. The Specialty Pharmacy, BriovaRx, makes these medications accessible and cost effective for plan members. BriovaRx provides focused, specialized support to individuals with complex medical conditions that often require multiple specialty medication therapies.

Call 1-855-4Briova or log on to briovarx.com for additional information about the program or take advantage of additional resources to help you manage your condition.

Prior Authorization, Step-Therapy and Quantity Management

Certain medications may require approval through a coverage review before they will be covered. This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective. There are three different coverage management programs under your plan: Prior Authorization, Step Therapy, and Quantity Management.

- Prior Authorization - your plan's approval is needed before the medication is covered
- Step Therapy - you must try one or more lower-cost medications first
- Quantity limits - you may only get a certain amount of each prescription

If coverage is approved, you simply pay your normal copay for the medication. If coverage is not approved, you will be responsible for the full cost of the medication, or if appropriate, you can talk to your doctor about alternatives that may be covered. (You have the right to appeal the decision. Information about the appeal process will be included in the denial letter you receive.)

Special note: If your plan has a limit on the amount of medication covered, your pharmacist can fill your prescription up to the amount allowed. If the prescription exceeds the amount covered by your plan, OptumRx will alert the pharmacist whether a coverage review is available to obtain an additional amount.

Employee Health & Wellness Center

Flagler County, in partnership with My Health Onsite, is pleased to offer a FREE and CONFIDENTIAL path to wellness for all employees and their families enrolled in medical coverage. Some of the benefits and services to which you have access include:

- Vital Health Profile (VHP), a full physical exam including a 28 panel blood work test to assess health status
- Annual VHP printed booklet explaining in detail how to interpret and understand your blood work results
- My Health Onsite Health Coaches, Nutritionists and Dietitians
- My Health Onsite Connect, an online Personal Health Assistant Program
- No copayments for health center visits
- No copayments for generic medications dispensed at the health center
- Online or telephonic appointment scheduling
- Minimum 20 minute face-to-face appointment with the provider with an average wait time of less than 5 minutes

To schedule, change or cancel an appointment

log onto www.myhealthonsite.com or call 386-888-0222.

Get Paid to Go to the Doctor!

Members who complete their annual Vital Health Profile (VHP) receive a $100 incentive which is deposited in the following plan year's Flexible Spending Account (FSA). FSA money can be used to pay for medical, dental and vision expenses, as well as other IRS medically approved expenses. When you complete your VHP, you can also receive $100 additional dollars for each dependent covered under your medical plan that is under age 18 and $100 for any dependent over age 18 who has their VHP (maximum of $500).

Hours of Operation

Monday, Tuesday, Wednesday and Friday:
8:00 AM - 5:00 PM
Thursday: 10:00 AM - 7:00 PM

Blood Work:
Wednesday & Friday: 7:00AM - 10:00AM

Quick Care Visits

The first appointment each morning are reserved for "quick care" or sick visits on a first come, first serve basis. When you arrive, park in Space #1 and call 386-302-9394 to begin check-in process. (If a vehicle is parked in Space #1, the appointment has already been taken.)

Employee Wellness Passport Program

Earning wellness rewards is as easy as 1, 2, 3 or 4. Follow the path below to cash in on healthy behaviors! All Flexible Spending Account deposits will be made on October 1, 2024.

1 Follow the steps below to complete the Vital Health Profile (VHP) through the My Health Onsite Employee Health and Wellness Center by August 2, 2024 for a $100 deposit into your Flexible Spending Account (FSA). You must complete the below steps to earn the FSA deposit:

1. Blood Draw at My Health Onsite
2. Follow-up Visit with a My Health Onsite Doctor to discuss plan of care.

2 Encourage your dependents (those 19 and older) to complete their Vital Health Profile (VHP) by August 2, 2024 using the steps listed above for an additional $100 deposit into your FSA (max of $500). If you do not have any dependents on the plan, please skip this step. You will not receive the FSA deposit for your dependents' VHP completion until you complete your VHP. After your VHP is complete, you will receive $100 for each dependent under 19 on the Health Plan (max of $500). Under 19 dependents do not have to complete the VHP.

3 To earn an extra $50 in your FSA, complete the Plan of Care prescribed to you by a My Health Onsite doctor at your follow-up visit. If a Plan of Care was not prescribed to you, contact My Health Onsite for a plan recommendation. A Plan of Care is a program specialized to your health and wellness needs. The Plan of Care can be accessed online using My Health Onsite or by meeting with a health coach. This additional FSA incentive is available to employees only.

OR

4 If you do not want to complete a My Health Onsite Plan of Care, but still wish to receive an extra $50 FSA deposit, you can! Simply complete enough of the activities listed in the wellness passport brochure to earn 50 points. A minimum of 50 points must be achieved to earn $50 in your passport must be turned in to Anita Stoker no later than August 2, 2024 to qualify for the incentive.

Reasonable Alternative: If you think you might be unable to meet the requirements under the wellness program (or if it is medically inadvisable for you to do so), you may still be able to earn the rewards offered by your employer by completing an alternative program. Please contact your HR Department or The Bailey Group and they will work with you (or if you wish, your doctor) to find you an alternative.

Group Dental Benefits

You may elect to enroll in the group dental plan offered through Florida Combined Life.

You may also choose to waive dental coverage. If you do, however, you will not be able to enroll in a dental plan until the next annual enrollment period or have a qualified life event.

The dental plan gives you the flexibility to use both in-network and out-of-network providers; however, if you use an out-of-network provider, you will be responsible for filing claims and for paying any charges that exceed the plan's usual and customary charges.

Easy access to dental information
Florida Combined Life provides you easy access to your dental information when you visit www.floridabluedental.com or download the app.

- Find a provider
- Get an ID card
- Check your benefits
- Review your claims
- Contact Customer Support

	Dental Plan	
Dental Benefits	In-Network	Out-of-Network
Calendar Year Deductible Per person Per family	 $50 $100	 $50 $100
Preventive Services	100%	100% of R&C[1]
Basic Services	80%	80% of R&C[1]
Major Services[2]	50%	50% of R&C[1]
Calendar Year Benefit Maximum per person	$1,500	$1,500

Dental Premiums

Premiums are collected on a pre-tax basis from your paycheck.

	Deluxe PPO Plan
Dental Benefits	Rates per month
Employee Only	$29.90
Employee & Spouse	$65.54
Employee & Child(ren)	$52.79
Family	$97.74

1 Balance billing, billing the difference between the allowed amount or reasonable & customary (R&C) charge and the actual charge, can occur out of network and will be a part of the patient responsibility.

2 Oral Surgery for an impacted tooth is covered under basic services with a $5,000 benefit maximum per year.

Group Vision Plan

The Vision Plan is administered by Aetna and pays benefits for both in-network and out-of-network services. When you visit an in-network provider, benefits are greater and there are no claim forms to be filed. Plan participants also receive access to discounted Lasik eye surgery from in-network providers. When you use an out-of-network provider, you will be responsible for filing claims and will be reimbursed at the scheduled amounts listed below.

You may also choose to waive vision coverage. If you do, however, you will not be able to enroll in the Vision Plan until the next annual enrollment period or you have a qualified life event.

Easy access to vision information

Aetna provides you easy access to your vision information when you visit www.aetnavision.com or download the app.

- Find a provider
- Get an ID card
- Check your benefits
- Review your claims
- Contact Customer Support

	Vision Plan	
Vision Benefits	In-Network	Out-of-Network
Routine Eye Exams once every 12 months	$20 copayment	$50 allowance
Frames once every 24 months	$25 copayment $140 allowance	$140 allowance
Lenses once every 12 months	$25 copayment	Allowance: Single $60 / Bifocal $75 / Trifocals $105
Contact Lenses in Lieu of Glasses once every 12 months	$140 allowance	$105 allowance

Vision Premiums

Premiums are collected on a pre-tax basis from your paycheck.

	Vision Plan
Vision Benefits	Rates per month
Employee Only	$5.20
Employee & Spouse	$10.07
Employee & Child(ren)	$9.57
Family	$15.03

Flexible Spending Accounts (FSA)

You have the opportunity to save money in taxes by participating in the health care and/or dependent care Flexible Spending Accounts (FSA). You need to plan carefully before you participate in an FSA because you forfeit any unused funds at the end of the year, as legally required under the "use it or lose it" rule. You may only change your FSA elections during the year if you have a qualified life event that permits the change. Changes to the FSA elections are governed by your employer's Section 125 Plan.

P&A Group administers the FSA Plans.
To track your healthcare and/or dependent care FSA and download forms, log on to www.padmin.com. Be sure to check out the P&A Group mobile app as well.

	Health Care FSA	Dependent Care FSA
Annual Contributions	$3,050	$5,000 ($2,500 if you are married filing separate)
Eligible Expenses	• Out of pocket medical, prescription, dental and vision costs such as deductibles and copayments • Over-the-counter medicine (prescribed by your provider) • Non-covered medical, dental, vision and hearing care expenses	• Preschool or nursery school expenses • After-school care • Expenses for a babysitter in your home • Day Care center • Summer day camp • Adult day care center or in-home care for an adult dependent
Claims Period[1]	Expenses must be incurred between October 1, 2023 through September 30, 2024	Expenses must be incurred between October 1, 2023 through September 30, 2024
Claims Deadline[1]	Claims must be submitted by December 31, 2024	Claims must be submitted by December 31, 2024

Paying Eligible Expenses

You may pay for eligible expenses in one of two ways, using a debit card or filing a manual claim. Be sure to save your receipts even when using your debit card. The IRS requires that every expense be verified which means that you might have to provide the receipts showing the eligible expense if requested by P&A Group. If you do not submit the receipts when requested, your debit card will be deactivated until the documentation is received. Simply use the mobile app to upload a copy of the receipt or upload through the www.padmin.com website.

Re-enroll each year
You must actively enroll each year to choose how much you want to contribute to a Flexible Spending Account (FSA). If you do not enroll, your contributions and enrollment will end on September 30.

1 If you terminate employment, and still have money left in your FSA account, you have 90 days from the date of termination to submit receipts for reimbursement. Receipts must have a date of services on or after the first day of your current plan year and not after your date of termination. You may only claim up to the amount collected from your paycheck prior to your date of termination.

Life Insurance

The life and accident insurance plans through Standard Insurance Company provide financial security to your beneficiaries if you die. Your employer automatically provides a certain level of coverage to you and gives you the opportunity to purchase additional life insurance coverage for yourself and your dependents.

Beneficiary Designation

Upon enrolling, you will be required to designate a beneficiary. Your beneficiary is the person or estate that will receive the benefit payment from your coverage in the event of your death. You may update your beneficiary(ies) at any time on the on-line enrollment system.

Basic Life and AD&D Insurance

Your employer provides eligible employees with basic life insurance in the amount of 1x salary up to $50,000 at no cost to you. An equal amount of accidental death and dismemberment (AD&D) insurance is provided with your life insurance coverage. AD&D insurance protects you in case of accidental death or injury (i.e. if you lose a limb, eyesight or hearing.) In the event of your death, the life plan pays a benefit to your beneficiaries. If loss occurs in the line of duty, the accidental death and dismemberment (AD&D) insurance is twice the basic life amount.

Supplemental Life and AD&D

You may elect to purchase additional life insurance with AD&D coverage in increments of $10,000, not to exceed the lesser of $300,000. The guaranteed issue amount for this plan is $200,000, but certain restrictions apply. You are not required to provide evidence of good health if you enroll when you are first eligible. If you do not enroll when first eligible, the evidence of good health will be required when you request new or additional coverage during a subsequent enrollment period. The cost of coverage depends on your age as of October 1 each year and the amount of coverage you elect. Contributions will be taken through payroll deductions on a post-tax basis.

Age Reduction

Basic and supplemental life amounts reduce by 35% for members age 65, by 50% at age 70 and by 65% at age 75.

Life Insurance for your Dependents

If you purchase supplemental life insurance for yourself, you may also purchase coverage for your spouse and eligible dependent children (until the end of the calendar year in which they turn 26).

Spouse coverage is available in increments of $5,000 up to 50% of your supplemental coverage amount. As a new hire or newly eligible employee enrolling for spouse coverage during the initial enrollment, your spouse will be required to provide evidence of good health if requesting more than $50,000 of coverage. If you are enrolling for spouse coverage after your initial enrollment period, or increasing your amount of coverage, your spouse will be required to provide evidence of insurability. The cost of coverage is based on your spouse's age as of October 1 of each year and the amount of coverage elected.

For your eligible dependent children, you may elect coverage in the amount of either $5,000 or $10,000 per child. Children are covered for the full benefit and are not required to provide evidence of good health. Dependent children must meet the requirements listed in the eligibility section.

	Employee Voluntary Life Rates (monthly)									
Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
Under age 30	$1.02	$2.04	$3.06	$4.08	$5.10	$6.12	$7.14	$8.16	$9.18	$10.20
30-34	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	$11.00
35-39	$1.25	$2.50	$3.75	$5.00	$6.25	$7.50	$8.75	$10.00	$11.25	$12.50
40-44	$1.72	$3.44	$5.16	$6.88	$8.60	$10.32	$12.04	$13.76	$15.48	$17.20
45-49	$2.64	$5.28	$7.92	$10.56	$13.20	$15.84	$18.48	$21.12	$23.76	$26.40
50-54	$3.81	$7.62	$11.43	$15.24	$19.05	$22.86	$26.67	$30.48	$34.29	$38.10
55-59	$5.51	$11.02	$16.53	$22.04	$27.55	$33.06	$38.57	$44.08	$49.59	$55.10
60-64	$6.82	$13.64	$20.46	$27.28	$34.10	$40.92	$47.74	$54.56	$61.38	$68.20
Age Reduction: Coverage reduces by 35% for members age 65, by 50% at age 70 and by 65% at age 75. Coverage amounts and premiums listed below reflect age reduction.										
65-69	$7.96	$15.91	$23.87	$31.83	$39.78	$47.74	$55.70	$63.65	$71.61	$79.56
70-74	$9.92	$19.83	$29.75	$39.66	$49.58	$59.49	$69.41	$79.32	$89.24	$99.15
75+	$22.52	$45.04	$67.55	$90.07	$112.58	$135.10	$157.61	$180.13	$202.64	$225.16

	Spouse Voluntary Life Rates (monthly) - based on spouse's age									
Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
Under age 30	$0.62	$1.24	$1.86	$2.48	$3.10	$3.72	$4.34	$4.96	$5.58	$6.20
30-34	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$4.90	$5.60	$6.30	$7.00
35-39	$0.85	$1.70	$2.55	$3.40	$4.25	$5.10	$5.95	$6.80	$7.65	$8.50
40-44	$1.32	$2.64	$3.96	$5.28	$6.60	$7.92	$9.24	$10.56	$11.88	$13.20
45-49	$2.24	$4.48	$6.72	$8.96	$11.20	$13.44	$15.68	$17.92	$20.16	$22.40
50-54	$3.41	$6.82	$10.23	$13.64	$17.05	$20.46	$23.87	$27.28	$30.69	$34.10
55-59	$5.11	$10.22	$15.33	$20.44	$25.55	$30.66	$35.77	$40.88	$45.99	$51.10
60-64	$6.42	$12.84	$19.26	$25.68	$32.10	$38.52	$44.94	$51.36	$57.78	$64.20
Age Reduction: Coverage reduces by 35% for members age 65, by 50% at age 70 and by 65% at age 75. Coverage amounts and premiums listed below reflect age reduction.										
65-69	$7.70	$15.39	$23.09	$30.78	$38.48	$46.18	$53.88	$61.57	$69.27	$76.96
70-74	$9.72	$19.43	$29.15	$38.86	$48.58	$58.29	$68.01	$77.72	$87.44	$97.15
75+	$22.38	$44.76	$67.13	$89.51	$111.88	$134.26	$156.63	$179.01	$201.38	$223.76

Supplemental Benefits

AFLAC offers a variety of supplemental coverages to the employees at Flagler County. For information concerning these coverages, please contact:

Christopher Higgins

Cell: 386.405.7285

christopher_higgins@us.aflac.com

Aflac Customer Service: 1-800-992-3522

Aflac Group Customer Service: 1-800-433-3036

Deferred Compensation Plan (457b)

Nationwide provides a deferred compensation retirement plan to the employees at Flagler County. For more information, please contact:

Roland L. Wilson, MSM, CBC

Phone: 678-294-4926

wilsor8@nationwide.com

Nationwide® is on your side

FORTUNE 100 BEST COMPANIES TO WORK FOR

Special Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

FLORIDA - Medicaid - Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Michelle's Law

Michelle's Law protects a postsecondary student from losing full-time student status under an employer's medical coverage if the student is (i) a dependent child of a participant or beneficiary under the terms of the plan; and (ii) enrolled in a plan on the basis of being a student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence from school. A dependent covered under the law is entitled to the same benefits as if the dependent continued to be enrolled as a full-time student. The law also recognizes that changes in coverage (whether due to plan design or a subsequent open enrollment election) pass through to the dependent for the remainder of the medically necessary leave of absence.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Section 125 Qualifying Events & Benefit Election Changes

Under IRC § 125, you are allowed to pay for certain group insurance premiums with tax-free dollars. This means your premium deductions are taken out of your paycheck before federal income and Social Security taxes are calculated. You must make your benefit elections carefully, including the choice to waive coverage. Your pretax elections will remain in effect until the next annual Open Enrollment period, unless you experience an IRS-approved qualifying event. A qualifying event, also known as a "Family Status Change," is a change in your personal life that may impact you or your dependents' eligibility for benefits under your employer's plan. Qualifying events include, but are not limited to:

- Marriage, divorce or legal separation;
- Death of spouse or other dependent;
- Birth or adoption of a child;
- A spouse's employment begins or ends;
- A dependent's eligibility status changes due to age, student status, marital status, or employment status; and
- You or your spouse experience a change in work hours that affects benefit eligibility.

Please note that your qualified status change must be consistent with the event. You must notify Human Resources within 30 days of your qualifying event.

Women's Health & Cancer Rights Act of 1998 (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: all stages of reconstruction of the breast on which the mastectomy was performed;surgery and reconstruction of the other breast to produce a symmetrical appearance;prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical carrier.

Important Notice 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 your employer 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. Your Employer has determined that the prescription drug coverage offered by the medical and prescription plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Employer's coverage will not be affected. You can keep this coverage if they elect part D and this plan will coordinate with Part D coverage. For those individuals who elect Part D coverage, coverage under the entity's plan will not end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current Employer's coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact your Plan Administrator listed on the back of this booklet. 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 your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Notice of Privacy Practices

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the health plan that compiled it. However, you have certain rights with respect to the information. You have the right to:

- Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.
- Request restrictions on our uses and disclosures of your protected health information for treatment, payment and health care operations. We reserve the right not to agree to a given requested restriction.
- Request to receive communications of protected health information in confidence.
- Inspect and obtain a copy of the protected health information contained in your medical or billing records and in any other of the organization's health records used by us to make decisions about you.
- Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request: was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment; is not part of your medical or billing records; is not available for inspection as set forth above; or is accurate and complete. In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
- Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures: to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; to correctional institutions or law enforcement officials as provided by law; for national security or intelligence purposes; that occurred prior to the date of compliance with privacy standards (April 14, 2003 or April 14, 2004 for small health plans); incidental to other permissible uses or disclosures; that are part of a limited data set (does not contain protected health information that directly identifies individuals); made to plan participant or covered person or their personal representatives; for which a written authorization form from the plan participant or covered person has been received
- Revoke your authorization to use or disclose health information except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
- Receive notification if affected by a breach of unsecured PHI

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use or disclose your health information without your permission for health care providers to provide you with treatment.

Payment: We may use or disclose your health information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. Such functions may include reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

To Carry Out Certain Operations Relating to Your Benefit Plan: We may use or disclose your protected health information without your permission to carry out certain limited activities relating to your health insurance benefits, including reviewing the competence or qualifications of health care professionals, placing contracts for stop-loss insurance and conducting quality assessment activities.

To Plan Sponsor: Your protected health information may be disclosed to the plan sponsor as necessary for the administration of this health benefit plan pursuant to the restrictions imposed on plan sponsors in the plan documents. These restrictions prevent the misuse of your information for other purposes.

Health-Related Benefits and Services: We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your protected health information for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing health plan coverage, and about health-related products and services that may add value to your existing health plan.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. An example might include a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Limited Data Sets: We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets. These circumstances include public health, research, and health care operations purposes.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example: in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purposes such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

For Purposes For Which We Have Obtained Your Written Permission: All other uses or disclosures of your protected health information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

INFORMATION WE COLLECT ABOUT YOU

We collect the following categories of information about you from the following sources: Information that we obtain directly from you, in conversations or on applications or other forms that you fill out. Information that we obtain as a result of our transactions with you. Information that we obtain from your medical records or from medical professionals. Information that we obtain from other entities, such as health care providers or other insurance companies, in order to service your policy or carry out other insurance-related needs.

GENETIC INFORMATION

We will not use or disclose genetic information or results from genetic services for underwriting purposes, such as: Rules for eligibility or benefits under the health plan, the determination of premium or contribution amounts under the health plan, the application of any pre-existing condition exclusion under the health plan and other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed upon request to the address on record. If we maintain a website that provides information about our services or benefits, the new notice will be posted on that website. Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY FOR E-MAIL COMMUNICATION

If you choose to communicate with us via e-mail, please be aware of the following due to the nature of e-mail communication: (i) privacy and security of e-mail messages are not guaranteed (ii) we are not responsible for loss due to technical failures and (iii) e-mail communication should not be used for emergencies or time and content sensitive issues.

POTENTIAL IMPACT OF STATE LAW

In some circumstances, the privacy laws of a particular state, or other federal laws, provide individuals with greater privacy protections than those provided for in the HIPAA Privacy Regulations. In those instances, we are required to follow the more stringent state or federal laws as they afford the individual greater privacy protections. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of Protected Health Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights.

NOTICE OF PRIVACY PRACTICES AVAILABILITY

You will be provided a hard copy for review at the time of enrollment (or by the Privacy compliance date for this health plan). Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's website (if applicable website exists) for downloading.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our HIPAA Privacy Officer at the telephone number or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services at the telephone number or address listed below. We will take no retaliatory action against you if you make such complaints.

Health Care Reform: Affordable Care Act

Summaries of Benefits and Coverage

The Patient Protection and Affordable Care Act (PPACA) requires health plans and health insurance issuers to provide uniform summaries of benefits and coverage (SBC). These SBCs are provided by our medical insurance carrier. You can access the SBCs posted in the on-line enrollment system. Paper copies are also available, free of charge, by contacting Human Resources. This notice is provided to eligible employees. It is the responsibility of the employee to share this information with eligible dependents. You can request a copy of this notice to be sent to eligible dependents that reside at an address other than your own by contacting Human Resources and providing the separate mailing address.

Health Insurance Marketplace (Exchange)

This section provides some basic information about the new Health Insurance Marketplace and employment-based health coverage offered by your employer. The Exchange Notice of Coverage Options is available from your Human Resource Department.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. You may also be eligible for a tax credit that lowers your monthly premium. The annual open enrollment periods typically begin each year on November 1st and ends December 15th for the following year's coverage (these dates are subject to change). An individual generally cannot enroll in a QHP outside of the open enrollment period, unless a special enrollment period applies.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of the least expensive plan that meets "minimum value" standards offered by your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the 2019 calendar year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Our group medical coverage has been determined to meet affordability and "minimum" value standards as required by the Affordable Care Act. This means that employees eligible for participation in our group medical coverage are not eligible for a premium reduced policy through the Marketplace.

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an on-line application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. Contact Human Resources for additional information.

Contact Information

For Information about...	Go To...	To
Your Benefits	The Bailey Group Sherry Bugnet, Sr. Account Executive, Benefits sbugnet@mbaileygroup.com 904-461-1804	• Ask questions about benefits • Get general information • Get help with claims • Get help with enrollment
Enrolling in your benefits	PlanSource benefits.plansource.com User Name: social security number (no dashes) Initial Password: date of birth as YYYYMMDD	• Make benefit elections and life event changes • View your confirmation statement • Designate and update beneficiaries • Obtain Summary Plan Descriptions, forms and other plan information
Medical Plan	FloridaBlue Policy #64553 www.floridablue.com Customer Service: 877-352-2583 Nurse Line: 877-789-2583 Care Consultants: 888-476-2227	• Get help with your medical plan • Learn about your coverage • Find a provider • Determine the cost for treatment • Order ID cards • Access your medical claims
Prescription Drugs	OptumRx www.optumrx.com 844-265-1719	• Get help with your prescription drug coverage • Get general information • Download ID cards
Specialty Medication	Briova www.optumrx.com 855-4BRIOVA	• Obtain a specialty medication
Health & Wellness Center	My Health Onsite www.myhealthonsite.com 386-888-0222	• Make an appointment to visit the doctor at the onsite center • Cancel an appointment • See test results
International Drugs	CanaRx www.canarx.com WebID: FLAGLER 866-893-6337	• Get brand name, maintenance medications for free

For Information about...	Go To...	To
Dental	Florida Combined Life Policy #D8834X www.floridabluedental.com 888-223-4892	• Get help with dental coverages/ claims • Learn about your coverage • Find a provider • Access your dental claims • Order ID cards
Vision	Aetna Policy #285556 www.aetnavision.com 877-9-SEE-AETNA	• Get help with vision coverages/ claims • Learn about your coverage • Find a provider • Access your vision claims • Order ID cards
Life Plans	Standard Group #760469 www.standard.com 800-628-8600	• File a claim for life insurance • Check the status of an existing claim
Flexible Spending Accounts	P&A Group www.padmin.com 800-688-2611	• Access your account information/ balance • Submit claims for reimbursement • Submit substantiation documentation • View claims status
Supplemental Coverages	AFLAC Christopher Higgins christoper_higgins@us.aflac.com 386-405-7285 Customer Service: 800-992-3522 Group Customer Service: 800-433-3036	• Enroll in supplemental coverages like accident, disability and cancer plans • Learn more about your coverage • File a claim
Retirement	Nationwide Roland L Wilson, MSM, CBC wilsor8@nationwide.com 678-294-4926	• Enroll in deferred compensation retirement plan • Learn more about deferred compensation (457b) plans