Seminole County Clerk of the Circuit Court and Comptroller

EMPLOYEE BENEFITS GUIDE

PLAN YEAR:

JANUARY 1, 2023 – DECEMBER 31, 2023

The information in this Benefits Guide is presented for illustrative purposes only. The text contained in this Guide was taken from various plan documents and/or benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this guide, contact Human Resources. 10.23.22 ED

Brown & Brown

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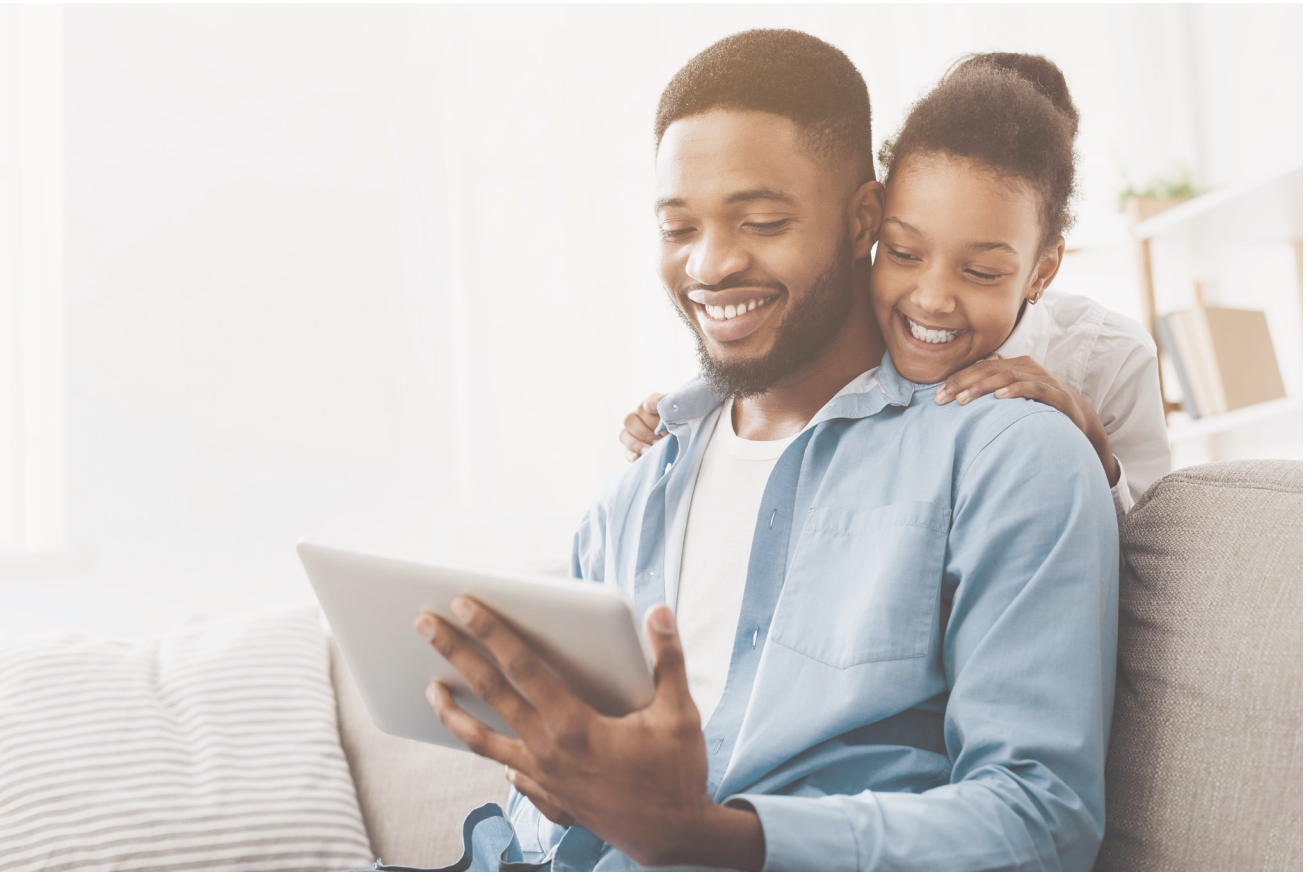
Medicare Part D Notice

If you (and/or your dependent) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 27 for more details.



Introduction

Seminole County Clerk of the Circuit Court and Comptroller offers a valuable benefits package that provides choices and flexibility for the diverse and changing needs of our employees. As a healthcare consumer, it's important you take an active role in understanding your needs, your family's needs, and the benefit options available to you.

This guide offers a comprehensive overview of your benefit options, including information on eligibility and how to enroll. We encourage you to read the information carefully and familiarize yourself with the benefits you're offered before making your selections. Throughout the year, you can use this guide as a reference.

Have a question or need more information about something in this guide?

Your benefits broker, Brown & Brown, is here to help! Reach out to your dedicated Client Care Advocate with any benefits questions, including enrolling in benefits as a new hire, prior authorizations, finding a provider, ordering ID cards, processing life events, and more. Your Client Care Advocate's contact information can be found on the Contacts page.

Brown & Brown INSURANCE®

2023 Open Enrollment Updates

Medical Insurance

Cigna is replacing UnitedHealthcare as our medical insurance carrier. We will continue to offer two medical plans that are similar to your current medical plans.

Health Savings Accounts

Health Savings Accounts (HSAs) will continue to be administered by Optum Bank. Employees that enroll in the new HSA medical plan will receive up to $2,250 throughout 2023 in employer HSA contributions.

Dental Insurance

Dental insurance will continue to be offered through MetLife. There are no changes to the plans or costs for employees.

Vision Insurance

Mutual of Omaha is replacing UnitedHealthcare as our carrier for vision insurance. The new vision plans are nearly identical to the current plans, but at a lower cost to employees.

Disability Insurance

Mutual of Omaha will continue to be our short-term and long-term disability insurance carrier. Both policies are still 100% employer-paid for benefits-eligible employees.

Voluntary Products

MetLife accident, critical illness and hospital indemnity coverage, as well as MetLife Legal, will continue to be offered with no changes to the plans or costs. IDWatchdog will also continue to be offered with no changes to the plan or costs. Pet insurance will now be offered through MetLife.

Benefits Overview

Eligibility

Full-time employees (working 30+ hours per week) are eligible to enroll in the benefits outlined in this guide.

New hires are eligible for health benefits on the 1st of the month following 60 days of employment.

New hires are eligible for life benefits on the 1st of the month following 30 days of employment.

Family members eligible for dependent coverage include:

- Legal spouse
- Natural, adopted, foster or stepchild(ren)
- Child(ren) for whom court appointed or legal guardianship has been awarded

Eligible dependent children may be covered until:

- Medical: end of the calendar year they turn age 26, or age 30 if unmarried with no dependents; a Florida resident or student; not enrolled in any other health coverage policy or plan; not entitled to Medicare benefits
- Dental: end of the month they turn age 26
- Vision: age 26 (coverage ends on birthday)
- Voluntary life: age 20 (up to age 26 if a full-time student)

A handicapped dependent child may continue coverage beyond the age limit if determined to meet plan requirements.

It is your responsibility to notify Human Resources if your dependent child no longer meets the eligibility requirements under the plan(s).

Please review your paycheck after coverage goes into effect to ensure all deductions and benefit elections are accurate.

Qualifying Life Events

Once your benefits are effective, you may not make changes to your benefits until the next open enrollment period unless you experience a qualifying life event.

Qualifying life events that allow mid-year changes include (but are not limited to):

- Marriage, divorce, legal separation
- Birth or adoption of child
- Death of spouse, child or other qualified dependent
- Loss/gain of other group coverage
- Change of dependent status
- Change in employment status (employee, spouse or child)

The type of plan change you can make to your benefits due to a life event depends on the qualifying event that you experience. For example, if you get married, you can add your spouse to coverage under your plan(s) and/or cancel coverage under your plan(s) if enrolling in your spouse's coverage. Documentation of the life event will be required by your employer to make benefit changes.

If you do not make changes within 30 days of the qualifying event, you must wait until the following open enrollment period. It is your responsibility to notify Human Resources within 30 days of the qualifying event.

How to Enroll

Enrollment will take place online via Employee Navigator. Employees are required to log in to make their elections during the open enrollment period. Enrollment instructions are included on pages 5 – 8 of this guide.

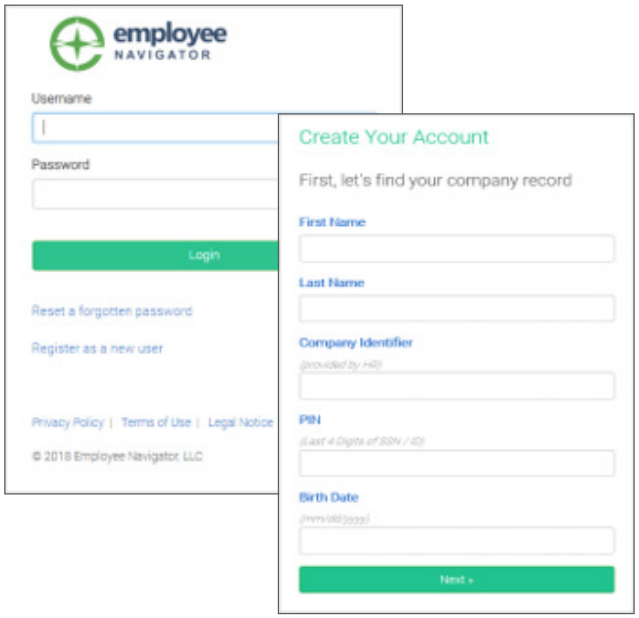
Carriers require full names, birth dates, social security numbers and home addresses for everyone enrolling in coverage, so please make sure you have all of the necessary information on hand for you and your dependents. **If you are adding any new dependents, you must also submit the following documentation to Human Resources:**

- Spouse – Marriage certificate
- Natural child(ren) – Birth certificate
- Step child(ren) – Birth certificate and marriage certificate
- Foster - Appropriate court/state documentation

Enrollment Instructions

Employee Navigator

Step 1: Register/Log in



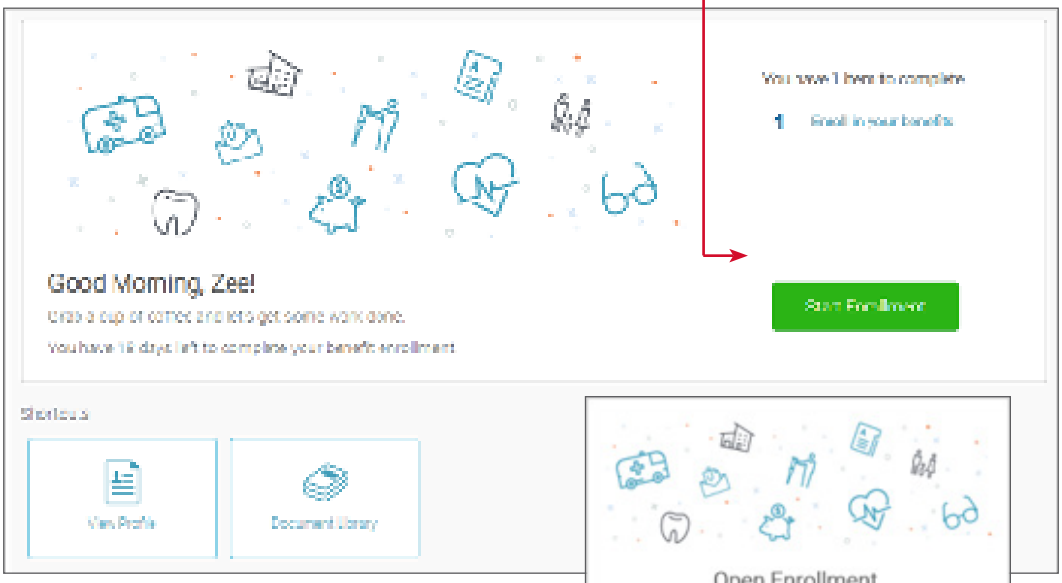
Go to employeenavigator.com and click "Login" on the top right of the page.

If you forgot your password, click "Reset a forgotten password" and follow the steps to access your account.

If logging on for the first time, select "Register as a new user" and complete the required fields. You will need the following information in order to complete the registration process:

- First name
- Last name
- Company Identifier: **SeminoleCourts**
- PIN: last 4 of your SSN
- Birth date

Once you have registered/logged in, you will be directed to your homepage. Click on "Start Enrollment."



The next page will give an overview of the enrollment process. When you're ready, click on "Get Started."

Step 2: Verify Information & Add/Update Dependents

Verify your information, along with any dependent information. To add or update a dependent, click on the dependent information option on the left menu bar. Then click "Add Dependent."

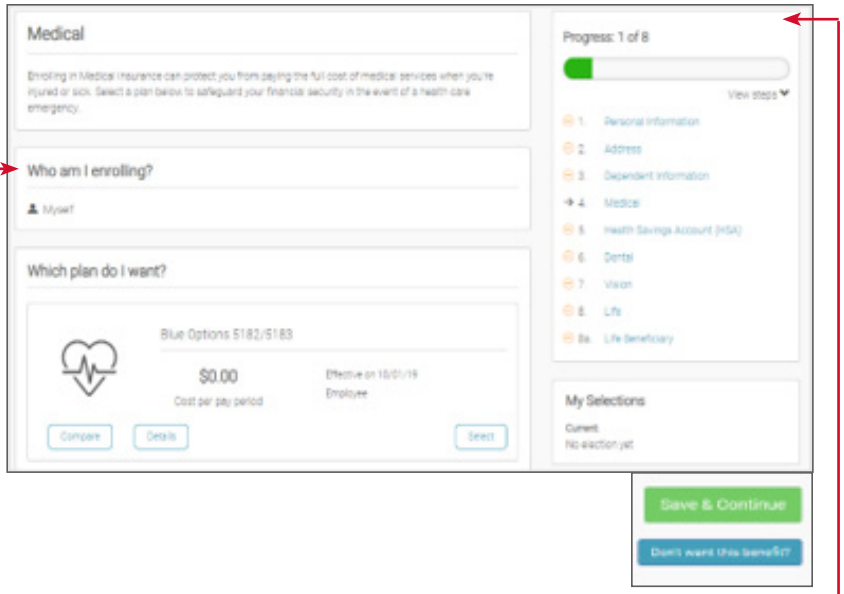
Make sure to ALWAYS click "Save & Continue" as the system will not save your elections or changes if you proceed without doing so.

Step 3: Begin Enrollment

You will then be directed to begin the benefit enrollment process. The system will show you the cost for each plan based on who you are enrolling. When you have dependents you would like to cover, they will appear under the "Who am I enrolling?" section of the page.

Select the plan you would like to enroll in (along with any dependents), then click "Save & Continue." If you wish to waive a benefit, simply scroll down to the bottom and select the "Don't Want This Benefit?" option. You will need to select a reason for waiving coverage.

Continue through the enrollment process by either waiving or enrolling in the benefits offered to you.



Enrollment Tip: If at any point during the enrollment process you wish go back to a benefit and change/view that election, click on "View Steps" on the top right hand side of the page. The drop down selection of steps will appear. A green check mark means the step has been completed. An orange circle means the step has not been completed.

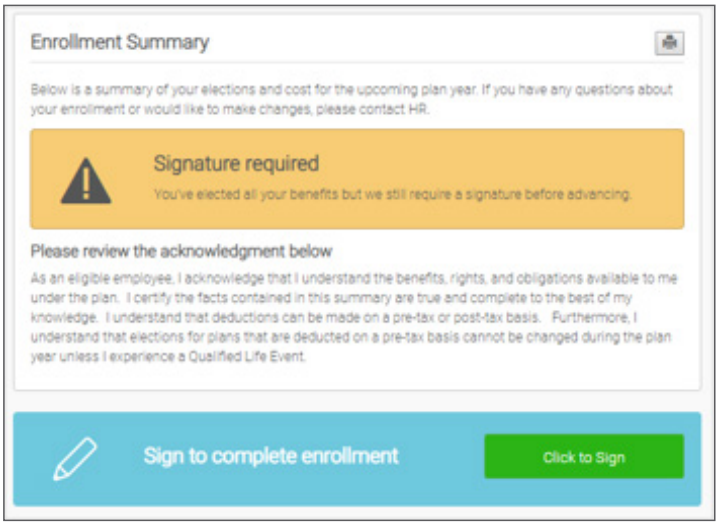
ALL steps must be completed in order to complete your enrollment process.

Step 4: Review Elections & Complete Enrollment

When you have completed electing your benefits, you will be directed to your Enrollment Summary. This page will provide you with your cost per pay amount. You can save and/or print the Enrollment Summary for your records.

You must electronically sign the Enrollment Summary in order to complete your enrollment.

After the Enrollment Summary is signed, you will receive a confirmation email from Employee Navigator. The email will include a link back to the Employee Navigator website.



Enrollment Assistance & Benefits Support

If you have questions about your benefit options or the Employee Navigator system, contact your Client Care Advocate from Brown & Brown:

Debbie Cox
321-214-2399
debbie.cox@bbrown.com

Medical Insurance

Cigna

	OAP TRADITIONAL PLAN		OAP HSA PLAN	
IN-NETWORK BENEFITS	**OAP**		**OAP**	
Employee Primary Residence	Nationwide		Nationwide	
Calendar Year Deductible	Embedded		Non-Embedded	
Individual | Family	$500	$1,000	$1,500	$3,000
The Plan Pays	100%		100%	
Calendar Year Out of Pocket Max (Includes Coinsurance, Copays & Deductible)	Embedded		Embedded	
Individual | Family	$1,500	$3,000	$3,000	$6,000
PHYSICIAN & EMERGENT CARE				
Preventive Care	$0		$0	
PCP | Specialist	$15	$30	$30 after deductible	$60 after deductible
PCP Required | Referral Required	No	No	No	No
Virtual Visits	$0		$10 after deductible	
Urgent Care	$35		$75 after deductible	
Emergency Room (In or out of network)	$350		$350 after deductible	
HOSPITALIZATION & OUTPATIENT CARE				
Inpatient	Deductible		$500 after deductible	
Outpatient	Deductible		$300 after deductible	
Physician Fees	Deductible		Deductible	
INDEPENDENT FACILITY CARE				
Labs	$0		Deductible	
X-rays	$0		Deductible	
Complex Diagnostic Imaging	Deductible		Deductible	
PRESCRIPTION DRUGS				
Prescription Drug List/Formulary	Advantage 3-Tier		Advantage 3-Tier	
Mandatory Generic	No		No	
Deductible	$0		Combined with medical deductible	
Tier 1	$10		$10 after deductible	
Tier 2	$35		$35 after deductible	
Tier 3	$70		$70 after deductible	
Mail Order - 90 day supply	3x retail copay		3x retail copay	
Specialty	$125		$125 after deductible	
OUT-OF-NETWORK BENEFITS				
Deductible Individual | Family	Emergency Benefits Only		$5,000	$10,000
The Plan Pays			50%	
Out of Pocket Max			Unlimited	
Balance Billing			Yes	
BI-WEEKLY (24) PAYROLL DEDUCTIONS				
Employee	$10.07		$0.00	
Employee + Spouse	$218.99		$7.59	
Employee + Child(ren)	$205.02		$2.20	
Employee + Family	$431.54		$115.04	

Finding a Medical Provider

When seeking medical care, always look for a provider contracted with your medical plan's provider network. The provider network is the doctors, hospitals, pharmacies, and other healthcare providers that your plan has contracted with to provide medical care to its members. Staying in-network for care will allow you to keep your healthcare costs down while best utilizing your plan.

To find an in-network provider, locate the provider search tool on the carrier's website (cigna.com) and search under the Open Access Plus, OA plus, Choice Fund OA Plus network.

Prescription Drug Coverage

A prescription drug list (PDL), also called a formulary, is the comprehensive list of medications that are covered under your medical plan. Your plan's PDL is the Advantage 3-Tier. Keep in mind that your medication might have certain requirements to be covered, such as mandatory generic, prior authorization, quantity limits or step therapy.

Follow these steps to find out how your plan covers your medication(s).

1. Go to cigna.com/druglist

2. Click 'Look Up Drug Lists for Employer Plans'

2. Select 'Advantage 3-Tier' from the drop down menu

3. Choose a search method: Type in your medication name and click Search, or look for your medication name in the alphabetical list

Medicare Part D Creditability

Both plans are Medicare Part D creditable. See the 'Notices' section in this guide for further information.

Preventive Care

Chronic diseases, such as heart disease, stroke, cancer, and diabetes, are the number one cause of death and disability in the United States and one of the highest drivers of healthcare costs.[1] Visiting your doctor regularly for preventive care services can not only help catch chronic diseases early, but help prevent them all together.

Under the Affordable Care Act, routine preventive screenings and services obtained at an in-network provider are covered at no cost to you under your health plan. For additional information concerning your preventive care and what is covered, log in to your member account on the carrier's website (cigna.com/knowledge-center/preventive-care).

MyCigna App

Access your medical plan information any time, anywhere! The MyCigna app gives you on-the-go access to your medical network, claims history, tools and support. View your member ID card, compare costs, see provider reviews, access a virtual visit or find in-network options for quick care.

1. Center for Disease Control and Prevention. (2019, October 23). About Chronic Diseases. Retrieved September 28, 2020 from https://www.cdc.gov/chronicdisease/about/index.htm

Health Savings Account

Optum Bank

Employees who elect the **OAP HSA Plan** may be eligible to open and contribute to a Health Savings Account (HSA). An HSA is a bank account which you may fund with tax-exempt dollars from your paycheck to help pay for eligible medical, dental and vision expenses, including your medical plan deductible, coinsurance and/or copays.

Once your HSA is set up, the money accumulates and grows tax-free through interest or investment earnings. Please note, your account balance will depend if you qualify to earn interest. You'll receive a debit card to access the funds and you'll have the option of either using the account to pay for current medical expenses or saving your funds for future needs. Unused HSA funds roll over from year to year, so you never have to worry about spending the money by a certain date. An HSA is also portable between employers, meaning you can take it with you if you change jobs.

The best part? In addition to making your own pre-tax HSA contributions, your employer will also contribute to your HSA. Please see the Contributions section for details.

Eligibility

In order to open and contribute to an HSA, you must meet certain eligibility requirements set by the IRS. Those requirements include:

- You must be covered by a High Deductible Health Plan (HDHP) and cannot be covered by a non-HDHP medical plan (including a Healthcare Reimbursement Flexible Spending Account)
- You cannot be enrolled in Medicare, receiving Social Security benefits or planning to within the next 6-8 months**
- You cannot be claimed as a dependent on another person's tax return
- You cannot be covered by TRICARE or receiving medical benefits from the Veteran's Administration

It is your responsibility to adhere to applicable tax regulations and/or restrictions. Please speak with a tax professional if you have questions about your individual situation.

Eligible HSA Expenses

HSAs are tax-advantaged accounts, so the IRS defines the types of expenses you can pay for with your account. You can use your HSA funds to pay for most medical, dental and vision care services, for both you and your tax-eligible dependents – even if they aren't enrolled on your medical plan! Below are examples of eligible and ineligible HSA expenses. Please note, you can use your HSA funds for dental and vision expenses, however the expenses will not count toward your medical deductible. For a full list, please visit irs.gov.

Eligible HSA Expenses

- Deductibles, coinsurance and copays
- Primary care or specialist office visits
- Urgent care visits
- Prescriptions and over-the-counter medications
- Durable medical equipment
- Chiropractic and physical therapy
- Feminine care products
- Dental expenses (e.g., cleanings, fillings, braces)
- Vision expenses (e.g., eye exams, laser eye surgery, glasses, contacts)
- Hearing aids
- COBRA and Medicare premiums

Ineligible HSA Expenses

- Dietary supplements
- Personal use items (e.g., deodorant, teeth whitening)
- Medicated shampoos, conditioners and soaps
- Non-prescription sunglasses
- Gym membership fees

**Subject to IRS maximum contribution limits*
***If you defer enrollment in Medicare, consult with a tax advisor about tax implications of HSA contributions*

Employer Contributions

The Clerk's Office will contribute up to $2,250 into the HSAs of eligible employees enrolled in the HSA medical plan in 2023. Employer HSA contributions in 2023 will be made on a quarterly basis according to the below schedule. You are only eligible for the full $2,250 employer HSA contribution if you are actively enrolled in the HSA medical plan from January 1, 2023 through December 31, 2023. To be eligible for each quarterly employer HSA contribution, at the time of each contribution, you must be:

- An active staff member*
- Enrolled in the HSA medical plan and have an open HSA with Optum Bank
- Eligible to contribute to a HSA

2023 EMPLOYER HSA CONTRIBUTION SCHEDULE**	
Contribution Date	**HSA Contribution Amount**
January 12, 2023	$562.50
April 6, 2023	$562.50
July 13, 2023	$562.50
October 5, 2023	$562.50

Employees that enroll in the HSA medical plan on or after January 1, 2023 will not be eligible for the full $2,250 employer HSA contribution. This includes new staff members whose employment starts in 2023 and current staff members enrolling mid-year due to a qualifying life event. Those employees will begin receiving the quarterly employer HSA contributions beginning on the first contribution date after their coverage starts on the HSA medical plan. For example, if your employment with the Clerk's Office starts on January 10, 2023, and you enroll in the HSA medical plan effective April 1, 2023, you will be eligible to receive the $562.50 employer HSA contributions on April 6, 2023, July 13, 2023, and October 5, 2023. You will not be eligible for the employer HSA contribution on January 12, 2023.

**Employees who have given notice of resignation or retirement to the Clerk's Office are not eligible to receive employer HSA funds. Please contact HR with questions.*
***It may take up to 48 hours from the dates listed for the payroll deposit to be reflected in your Optum Bank HSA. Additionally, employer HSA funding is not guaranteed to any employee and may be modified or discontinued based on prevailing budgetary restrictions. Any accounts not set up prior to the payment, will be completed the following period.*

Annual Contribution Limits

The IRS establishes annual HSA contribution limits for individuals contributing to an HSA. The contribution limits are based on your medical plan coverage level and include both employee and employer HSA contributions. Individuals over age 55 can contribute an additional $1,000 per year as a "catch-up" HSA contribution.

2023 IRS ANNUAL HSA CONTRIBUTION LIMITS	
Self-Only Coverage	$3,850
Family Coverage	$7,750

Opening an HSA

To open an HSA (or for more information), visit Optum Bank's website at: optumbank.com or call 866-234-8913 (group # 713098) or contact HR. **An account MUST be opened for contributions to be deposited. If an account is not opened, funds cannot be deposited.**

Medical Plan Member Resources

Cigna

Member Portal

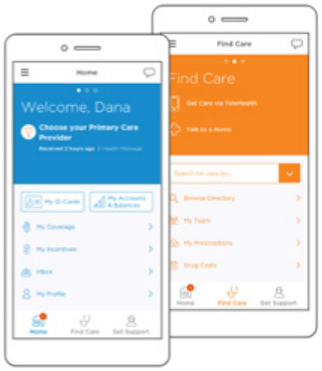
The more you know about healthcare costs and the options you have, the easier it may be for you to make better decisions. When you register for your member portal on mycigna.com, or the MyCigna app, you will have access to tools and information to help you manage and improve your health, such as:

- Find a provider
- Manage and track your claims
- Compare and buy prescriptions
- Compare and estimate treatment costs
- Access a virtual visit
- View wellness information and much more

Cigna One Guide

Your Cigna medical plan includes personalized healthcare support and useful guidance through Cigna One Guide. One Guide combines digital technology with one-on-one assistance to help you find answers to your healthcare questions, and take control of your health and health spending. Whether it's choosing a plan, finding a provider, or exploring ways to improve your health, One Guide can help.

One Guide uses data to learn about you, so it can deliver customized alerts, notifications, and other helpful messages. At the same time, it offers you the human touch when you need it most — for health coaching, specialized support, or cost-saving guidance.



Get started with Cigna One Guide today. Chat with a One Guide representative on the myCigna website (mycigna.com) or app, or connect over the phone by calling 800-244-6224.

Healthy Rewards

Looking for more healthy choices? Cigna's Healthy Rewards Program can help! Healthy Rewards® is a discount program available to Cigna customers covered under the Seminole County Clerk of the Circuit Court and Comptroller medical plan.* You can save on national and local health and wellness programs – such as Jenny Craig®, Pearle Vision®, Curves® and more.

No doctor's referral or claim forms are needed. Call the phone number listed below to find an eligible provider and schedule an appointment. Show your Cigna ID card before you pay for services and enjoy the savings.

For more information about the program, visit cigna.com/rewards (password: savings) or call 800-258-3312.

Examples of available discounts:

Fitness Club & Equipment Discounts

- American Specialty Health networks
- Fitness memberships
- Active & Fit

Weight Management & Nutrition

- Healthyroads Weight Management
- Registered dieticians
- Jenny Craig

Vision & Hearing Care

- Exams and eyewear
- Lasik vision correction
- Hearing aids

Alternative Medicine

- Acupuncture
- Chiropractor
- Massage

Mind & Body

- Gaiam Yoga equipment discounts
- Healthyroads Mind/Body program

Vitamins, Health & Wellness Products

- Drugstore.com
- Choosehealthy.com

*Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states and programs may change or be discontinued at anytime.

Patient Assurance Program

Pay $25 or less for a 30-day supply of insulin. Every time.

Managing diabetes isn't easy, but Cigna's Patient Assurance Program makes it more affordable by controlling the cost of eligible insulin products. A 30-day (or one month) supply costs no more than $25, and a 90-day (or three month) supply costs no more than $75.[1]

Covered insulin products include Basaglar, Humalog, Humulin and Levemir. Eligible Cigna members can use the program by showing their Cigna ID card at the pharmacy when they fill one of the covered insulin products. If you're already using one of the covered insulins, there are no additional steps needed to take advantage of this program. Additional insulin products may also be included. If you're currently taking an insulin that is not included, talk with your doctor about whether taking an insulin covered under the program is right for you. Only you and your doctor can decide what's best for you.

Omada for Cigna

Omada is a digital lifestyle change program designed to help you lose weight, gain energy, and reduce the risks of Type 2 diabetes and heart disease. The program surrounds you with the tools and support you need to make lasting, meaningful changes to the way you eat, move, sleep, and manage stress—one small step at a time.

You'll receive the program at no additional cost if you or your covered adult dependents are enrolled in the company medical plan offered through Cigna, are at risk for Type 2 diabetes or heart disease and are accepted into the program. Omada offers the following tools to inspire long-term healthy habits:

- A professional Omada health coach
- An interactive program to guide the journey
- Small online group of participants to keep you engaged
- Weekly online lessons to empower employees
- A wireless smart scale to monitor progress

For more information, log in to mycigna.com, call 800-244-6224 or download the Omada Health app.

Behavioral and Emotional Well-being Support

Your life is busy. Sometimes it's hard to know if what you are experiencing is depression or sadness, worry or anxiety. When these feelings become excessive, ongoing or interfere with your daily life, it's time to seek the help you need. Cigna's comprehensive support includes coverage for your emotional health, as well as tools and programs to support your general health and well-being.

A network of health care providers

- National network of clinicians – counselors, psychologists and psychiatrists
- 300+ substance use Centers of Excellence locations[2]
- Virtual counseling sessions
- Support programs for autism, eating disorders, substance use and more

Self-service digital tools and resources

iPrevail offered through Cigna is a digital therapeutics program designed by experienced health care professionals to help you take control of the stresses of everyday life. It's loaded with interactive video lessons and one-on-one coaching to help with depression and anxiety.[2]

Happify offered through Cigna is a self-directed program with activities, science-based games and guided meditations, designed to help reduce stress, gain confidence, defeat negative thoughts and boost overall health.[2]

Programs to help manage life events

- **Three face-to-face visits with a licensed behavioral health provider in Cigna's employee assistance program (EAP) network**
- Unlimited telephone counseling, live chat with an EAP advocate and access to work-life resources
- Access to legal services, including a 30-minute consultation with a network attorney for legal issues including civil, personal/family, and Internal Revenue
- Service (IRS) with a 25% discount off select fees if the network attorney is retained
- Access to financial services such as 25% off tax preparation, and a 30-minute complimentary phone consultation with a financial specialist on debt counseling, student loans and more

To access, log in to mycigna.com or call 877-231-1492.

1. Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a healthcare professional, purchased from a licensed pharmacy and medically necessary. You may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.
2. Programs and services are subject to all applicable program terms and conditions. Program availability is subject to change.

Virtual Visits

Virtual visits allow you to see and talk to a certified medical professional from your mobile device or computer without an appointment, 24/7. Most visits take about 10-15 minutes and the doctor you speak with can write a prescription, if needed, that you can pick up at your local pharmacy.

When to Use

Virtual visits can be a great option for medical care when your doctor is not available, you become ill while traveling, or anytime you're considering visiting a hospital emergency room for a non-emergency health condition.

Common conditions treated during a virtual visit include:

- Rash
- Cold/Flu
- Allergies
- Bronchitis
- Fever
- Diarrhea
- Sore throat
- Stomachache
- Pink eye
- Bladder infection
- Migraines/ Headaches

You should not use a virtual visit in the event of an emergency, when you're experiencing a complex or chronic medical condition, if the type of medical care you need requires an exam or test, or when you have an injury requiring bandaging or another type of in-person care (such as a sprain or broken bone).

Benefits of a Using Virtual Visit

- **Visits anywhere** – Install the mobile app and access healthcare from anywhere, at any time.
- **Open 24 hours** – Doctors are available 24 hours a day, 365 days a year.
- **No appointments** – Just sign in and have your visit. No more germy waiting rooms.
- **Prescriptions** – Prescriptions are sent electronically to the pharmacy of your choice.

How to Access

Cigna provides access to virtual care services through MDLIVE as part of your medical plan.

To connect with an MDLIVE virtual provider, log in to mycigna.com, locate the "Talk to a doctor or nurse 24/7" callout and click "Connect Now."

To locate a Cigna Behavioral Health provider, log in to mycigna.com, go to "Find Care & Costs" and enter "Virtual counselor" under "Doctor by Type," or call the number on the back of your Cigna ID card 24/7.

Healthcare Consumerism

Lifestyle behaviors, such as physical activity, diet and tobacco use, can play a significant role in how much you spend on healthcare. With healthcare costs continuing to rise, that means it's increasingly important that you play an active role in prioritizing your health.

An important part of prioritizing your health includes utilizing your healthcare benefits wisely. Visit your doctor regularly for preventive screenings, and take steps to better understand how your medical plan works, including how to compare quality and pricing when seeking services. Being a good consumer of your healthcare will allow you to make smarter decisions while minimizing costs.

Pharmacy Discount Programs

When shopping for household items, do you ever compare prices from one retailer to another? Then why not do the same with your prescription drugs?

Did you know...

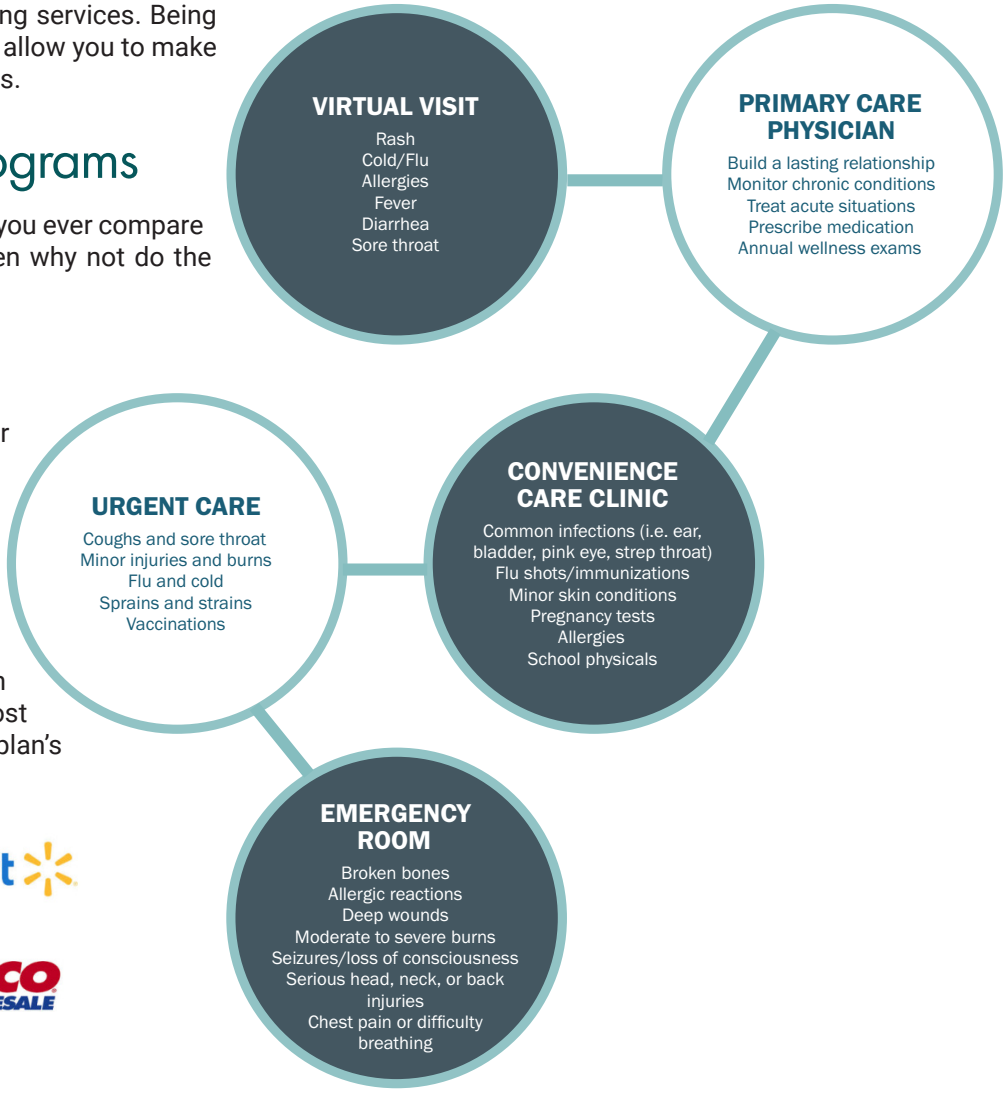
- Pharmacies such as Winn Dixie, Walmart, Sam's Club and Costco offer prescription discount programs that allow you to purchase medications for as low as $4 for a 30-day supply
- Winn Dixie pharmacies may offer select free antibiotics and maintenance medications

Keep in mind that when using certain pharmacy discount programs, your cost may not be applied to your medical plan's deductible/out-of-pocket maximum.

Publix. Walmart Winn-Dixie Sam's Club COSTCO WHOLESALE

Choose the Right Type of Care

When in need of medical care, understanding your options and making an informed choice about what type of care to seek is crucial to your personal and financial well-being. Making the wrong choice could result in spending significantly more time and money than you would have by choosing the most appropriate type of care for your situation.



Dental Insurance

MetLife

	DHMO Met 245		Low PPO		Mid PPO		High PPO	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Maximum Plan Pays Per Enrolled	Refer to DHMO Schedule of Benefits for plan details Members must select a Primary Care Dentist when enrolling** No out-of-network benefits except in an emergency		$750	$500	$1,000	$750	$1,500	$1,000
Lifetime Orthodontic Maximum			Not Covered		Not Covered		$2,000	
Coinsurance								
Preventive			100%	100%	100%	100%	100%	100%
Basic			80%	50%	80%	50%	90%	80%
Major			Not Covered		50%	25%	60%	50%
Orthodontia			Not Covered		Not Covered		50%	50%
Benefits Based on			Contracted Rates	MAC	Contracted Rates	MAC	Contracted Rates	90th Percentile
Balance Billing			No	Yes	No	Yes	No	Yes
Calendar Year Deductible (Individual/Family)			$0	$50/$150	$0	$50/$150	$0	$50/$150
Deductible Waived for Preventive			Yes		Yes		Yes	
SCHEDULE OF BENEFITS								
Routine Exams (1 every 6 months)	Refer to DHMO Schedule of Benefits for plan details Members must select a Primary Care Dentist when enrolling** No out-of-network benefits except in an emergency		Preventive		Preventive		Preventive	
Cleaning (1 every 6 months)			Preventive		Preventive		Preventive	
X-Rays								
Bitewing			Preventive		Preventive		Preventive	
Full Mouth			Basic		Basic		Basic	
Sealants			Preventive (under age 14)		Preventive (under age 19)		Preventive (under age 19)	
Fillings								
Amalgam			Basic		Basic		Basic	
Composite Resin			Basic		Basic		Basic	
Oral Surgery*			Basic		Basic		Basic	
Root Canal			Basic		Basic		Basic	
Periodontal Maintenance*			Preventive		Preventive		Preventive	
Periodontal Surgery*			Basic		Basic		Basic	
Endosteal Implants			Not Covered		Major		Major	
Crowns/Bridges/Dentures			Not Covered		Major		Major	
Orthodontia			Not Covered		Not Covered		Children & Adults	
BI-WEEKLY (24) PAYROLL DEDUCTIONS								
Employee	$6.52		$7.42		$11.14		$16.12	
Employee + Spouse	$12.37		$15.11		$22.69		$32.84	
Employee + Child(ren)	$13.03		$16.62		$24.97		$36.14	
Employee + Family	$18.57		$26.02		$39.07		$56.55	

**Coinsurance based on complexity of procedure*
***If you do not select a Primary Care Dentist, one will be assigned based on your zip code*

Finding a Dentist

Verify your provider(s) are contracted in your dental plan's network to best utilize the plan. Participating provider information can be found on the carrier's website (metlife.com/dental).

MetLife dental plan networks:

- **DHMO Met 245:** Dental HMO/Managed Care
- **PPO Plans:** PDP Plus

Dental ID Cards

DHMO Participants: You will receive a MetLife dental ID card in the mail after enrolling in coverage. You must show the ID card to your selected Primary Care Dentist in order to obtain services under the plan. Please note that current DHMO participants who are continuing coverage under the plan will not be mailed a new ID card after open enrollment. You can request a new ID card by logging into your member account on the MetLife website or app.

PPO Plan Participants: MetLife dental ID cards are not mailed out to participants on the PPO dental plans. Once your coverage under one of the PPO plans is active, you can log in to your MetLife member account on the website or app to view/print your dental ID card. Alternatively, your dentist can verify your coverage by contacting MetLife directly.

MetLife Member Portal & Mobile App

Once your dental coverage is active, register for your member account on metlife.com/dental, or on the MetLife app, and get access to your dental plan information 24/7. Find an in-network dentist, print your member ID card, view past claims and find other helpful tools and information.

Oral Health Tips

Did you know? The three oral conditions that most affect overall health and quality of life are cavities, severe gum disease, and severe tooth loss.[1] Take steps to prevent these conditions by following these oral health tips:

- Visit a dentist for routine exams and cleanings – free at in-network providers if you're enrolled in the dental plan
- Use fluoride toothpaste
- Brush and floss thoroughly to reduce dental plaque and prevent gingivitis
- Limit alcohol consumption and avoid tobacco; both can cause health risks including gum disease, oral and throat cancers and more
- Avoid foods that are high in sugars and starches and stick to eating fruits and vegetables daily, which can help with the re-mineralization of tooth surfaces

1. Center for Disease Control and Prevention. (2020, August 25). Oral Health Fast Facts. Retrieved September 28, 2020 from https://cdc.gov/oralhealth/fast-facts/index.html

Vision Insurance

Mutual Of Omaha

	Base Plan	High Plan
IN-NETWORK BENEFITS		
Vision Examination	$10 copay	$0 copay
Single, Bifocal & Trifocal Lenses	$25 copay	$10 copay
Progressive Lenses	Up to $65 copay + covered with discount	Covered with discount
Frame	$130 retail allowance (after lens copay) + 30% off overage	$150 retail allowance (after lens copay) + 30% off overage
Contact Lens Exam & Fitting	Up to $40 copay	Up to $40 copay
Elective Contact Lenses – *in lieu of lenses/frames*	$130 allowance	$150 allowance
Laser Vision Correction	Discounts available for LASIK or PRK from a provider in the U.S. Laser Network	Discounts available for LASIK or PRK from a provider in the U.S. Laser Network
Hearing Aid Discounts	Discount thru Amplifon	Discount thru amplifon
OUT-OF-NETWORK BENEFITS	Reimbursement up to	
Vision Examination	$37	$45
Single, Bifocal & Trifocal Lenses	$20 | $36 | $64	$40 | $56 | $84
Frame	$58	$66
Elective Contact Lenses – *in lieu of lenses/frames*	$89	$102
FREQUENCY (based on date of service)		
Exams	12 months	12 months
Lenses/Contacts	12 months	12 months
Frames	24 months	12 months
BI-WEEKLY (24) PAYROLL DEDUCTIONS		
Employee	$3.50	$5.00
Employee + Spouse	$7.00	$9.50
Employee + Child(ren)	$6.00	$8.50
Employee + Family	$10.00	$14.00

Finding a Vision Provider

To receive discounts and preferred member pricing, we encourage you to seek care from doctors and vision facilities that belong to the EyeMed's Insight Network. Participating provider information can be found on the carrier's website (eyedoclocator.eyemedvisioncare.com/mutual/en).

Hearing Discount Program

If you've noticed a change in your hearing, you're not alone. Hearing loss is the third most common chronic condition among Americans, but it's also the most treatable[1]. Mutual of Omaha partners with Amplifon Hearing Health Care to provide hearing aid benefits and discounted hearing screening services for employees. The national network of hearing care professionals and clinics is dedicated to helping employees hear better with custom hearing solutions from leading manufacturers and negotiated low prices.

Service features:

- Low price guarantee on hearing aids
- Discount on hearing testing and diagnostics
- Risk-free 60-day trial period on hearing aids with money-back guarantee
- One-year free follow-up care
- Three-year warranty on hearing aids
- Two year supply of free hearing aid batteries
- Assistance locating a provider

Questions?

Call Mutual of Omaha at 888-534-1747.

1. Centers for Disease Control and Prevention, 2016.

Online Vision Savings Tips

Zenni Optical and Warby Parker offer eyewear at a less expensive cost than many other eyewear retailers, but keep in mind they may not be in-network providers under the vision plan. Because the vision plan covers either glasses or contacts each year, individuals that wear both may consider utilizing the vision plan for the contact lens benefit and purchasing eyewear from one of the below retailers.

Warby Parker

Trendy prescription glasses you can try on at home before buying. Pick up to 5 frames to have mailed to you for free. If you decide to keep one (or more), purchase them online and Warby Parker will mail you a new pair with your prescription lenses in them. Return the frames within 5 days with the prepaid return label. Find Warby Parker's styles and prices online at warbyparker.com.

Zenni Optical

Affordable frames starting at just $8! Trendy, not spendy prescription glasses for men, women and children. Sunglasses and blue light blockers are also available. Find their selection and prices online at zennioptical.com.

Life Insurance

Reliance Standard

Life insurance offers peace of mind by providing financial protection to your loved ones in the event of your death. If you have family members who depend on you for financial support, life insurance can protect them from the unknown and help them through an otherwise difficult time of loss. Please be sure to add/review your beneficiary information and contact your Human Resources department should you have any changes throughout the year.

Basic Life/AD&D (Employer Paid)

Seminole County Clerk of the Circuit Court and Comptroller provides 1x annual salary (rounded to the nearest $1,000, maximum of $500,000) worth of Basic Life and Accidental Death & Dismemberment (AD&D) Insurance through Reliance Standard to all full-time employees at no cost to the employee. The basic life/AD&D insurance benefit reduces by 50% at employee's age 70.

Voluntary Life/AD&D

Employees who would like to supplement their basic life insurance benefits may purchase additional life insurance coverage. If you purchase coverage for yourself, you may also purchase coverage for your dependents. To be eligible for coverage you must be actively at work, you and your dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility). An overview of the voluntary life insurance benefit options is listed on the following page.

The voluntary life insurance benefits reduce according to the following schedule:

- Employee: Reduces by 50% at employee's age 70
- Spouse: Reduces by 50% at employee's age 70

Important Life Insurance Terms

Conversion: When you terminate employment or insurance eligibility, you may apply for an individual policy by converting the current policy in force to an individual policy. Included with Basic and Voluntary Life.

Guarantee Issue (GI): The amount of coverage available to new hires enrolling in benefits for the first time without providing Evidence of Insurability.

Evidence of Insurability: Evidence of Insurability (EOI) is a medical questionnaire used by the carrier to determine whether an applicant will be approved for or declined coverage. If enrolling in voluntary life coverage, the carrier may require EOI before some or all of your coverage is effective.

An EOI form is required if electing above the GI amount(s) for yourself and/or your spouse.

It is the EMPLOYEE'S responsibility to complete and submit an EOI form when required. Benefit coverage and payroll deductions for any amount subject to EOI will not take effect until the EOI is approved by the carrier.

Portability: When you terminate employment or insurance eligibility, you may apply for an individual policy by porting the current policy in force. This provision allows for the continuation of your current group policy, but on an individual basis. Included with Basic and Voluntary Life.

One Time Opportunity!

Included with the voluntary life insurance policy: During this open enrollment you have the opportunity to elect a benefit amount up to the Guarantee Issue (GI) without having to complete an Evidence of Insurability (EOI) form, unless you were previously declined. Should you decide to waive coverage at this time and later wish to enroll, you will have to complete an EOI for any benefit amount elected.

VOLUNTARY LIFE INSURANCE BENEFIT OVERVIEW			
	Minimum	**Guarantee Issue**	**Maximum**
Employee	$10,000	$50,000	**$500,000** ($10,000 increments)
Spouse	$5,000	$10,000	**$100,000 or 50% of employee's benefit amount**, whichever is less ($5,000 increments)
Child(ren)	**$10,000** (Birth to 13 days: $0)		

Cost of Coverage

When you enroll in this benefit, you pay the full cost through payroll deductions. Your actual payroll deduction may vary slightly due to rounding.

EMPLOYEE BI-WEEKLY (24) PAYROLL DEDUCTIONS (INCLUDES AD&D)									
Coverage Amounts	**Payroll Deduction**	**Coverage Amounts**	**Payroll Deduction**	**Coverage Amounts**	**Payroll Deduction**	**Coverage Amounts**	**Payroll Deduction**	**Coverage Amounts**	**Payroll Deduction**
$10,000	$1.65	**$110,000**	$18.15	**$210,000**	$34.65	**$310,000**	$51.15	**$410,000**	$67.65
$20,000	$3.30	**$120,000**	$19.80	**$220,000**	$36.30	**$320,000**	$52.80	**$420,000**	$69.30
$30,000	$4.95	**$130,000**	$21.45	**$230,000**	$37.95	**$330,000**	$54.45	**$430,000**	$70.95
$40,000	$6.60	**$140,000**	$23.10	**$240,000**	$39.60	**$340,000**	$56.10	**$440,000**	$72.60
$50,000	$8.25	**$150,000**	$24.75	**$250,000**	$41.25	**$350,000**	$57.75	**$450,000**	$74.25
$60,000	$9.90	**$160,000**	$26.40	**$260,000**	$42.90	**$360,000**	$59.40	**$460,000**	$75.90
$70,000	$11.55	**$170,000**	$28.05	**$270,000**	$44.55	**$370,000**	$61.05	**$470,000**	$77.55
$80,000	$13.20	**$180,000**	$29.70	**$280,000**	$46.20	**$380,000**	$62.70	**$480,000**	$79.20
$90,000	$14.85	**$190,000**	$31.35	**$290,000**	$47.85	**$390,000**	$64.35	**$490,000**	$80.85
$100,000	$16.50	**$200,000**	$33.00	**$300,000**	$49.50	**$400,000**	$66.00	**$500,000**	$82.50

SPOUSE BI-WEEKLY (24) PAYROLL DEDUCTIONS (INCLUDES AD&D)							
Coverage Amounts	**Payroll Deduction**	**Coverage Amounts**	**Payroll Deduction**	**Coverage Amounts**	**Payroll Deduction**	**Coverage Amounts**	**Payroll Deduction**
$5,000.00	$0.73	**$30,000.00**	$4.35	**$55,000.00**	$7.98	**$80,000.00**	$11.60
$10,000.00	$1.44	**$35,000.00**	$5.08	**$60,000.00**	$8.70	**$85,000.00**	$12.33
$15,000.00	$2.18	**$40,000.00**	$5.80	**$65,000.00**	$9.43	**$90,000.00**	$13.05
$20,000.00	$2.90	**$45,000.00**	$6.53	**$70,000.00**	$10.15	**$95,000.00**	$13.78
$25,000.00	$3.63	**$50,000.00**	$7.25	**$75,000.00**	$10.88	**$100,000.00**	$14.50

CHILD(REN) BI-WEEKLY (24) PAYROLL DEDUCTIONS* (AD&D INCLUDED)	
$10,000.00	$1.02

**Regardless of how many children you have*

Disability Insurance

Mutual of Omaha

In the event you become disabled from a non work-related injury or sickness, disability income benefits are provided as a source of income. You must be actively at work on the day this coverage begins. Disability payments are offset by other income sources, such as sick time and social security disability insurance (if applicable).

Short-Term Disability (Employer Paid)

Seminole County Clerk of the Circuit Court and Comptroller provides Short Term Disability (STD) insurance through Mutual of Omaha to all full-time employees at no cost.

STD BENEFIT OVERVIEW	
Benefits Begin	8th day (Accident)/15th day (Sickness)
Payable Benefit Duration	25 weeks (Accident)/24 weeks (Sickness) – *following 7/14 day elimination period*
Percentage of Income Replaced	60%, up to a maximum weekly benefit of $2,000
Pre-existing Condition Limitation	None

Long-Term Disability (Employer Paid)

Seminole County Clerk of the Circuit Court and Comptroller provides Long Term Disability (LTD) insurance through Mutual of Omaha to all full-time employees at no cost.

LTD BENEFIT OVERVIEW	
Benefits Begin	181st day (Accident/Sickness)
Payable Benefit Duration	5 years (Own Occupation)/Reducing Benefit Duration (RBD) to Social Security Normal Retirement Age (Any Occupation)
Percentage of Income Replaced	60%, up to a maximum monthly benefit of $10,000
Pre-existing Condition Limitation	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition that occurred during the 3 months prior to coverage are excluded.

Employee Assistance Program

Mutual of Omaha

The Employee Assistance Program (EAP) is offered to all employees and their families at no cost. With the EAP, you can get free and confidential counseling, and find resources for challenges or significant life changes you're facing. The EAP can help with challenges relating to emotional well-being, family and relationships, depression, legal and financial matters, healthy lifestyles, grief, work and life transitions, stress, substance abuse or addictive behaviors and more.

The EAP can help with topics including:

- Addiction
- Adoption
- Anxiety and stress
- Bankruptcy
- Budgeting
- Childcare
- Credit issues
- Depression
- Divorce
- Domestic violence
- Eldercare
- Estate planning
- Grief
- Identity theft
- Mental health
- Parenting
- Substance abuse
- Tenant's rights
- Tobacco cessation
- Will preparation

What's Included

Your EAP gives you 24/7/365 over-the-phone counseling support through Master's level counselors. Because some matters are best resolved by speaking to a licensed professional in person, in addition to 24/7 over-the-phone support, the EAP also includes **three face-to-face visits with a mental health professional at no cost to you** (per household, per year). Legal and financial counseling services are also available. If needed, the EAP professionals will assist in providing referrals to additional resources in your area for ongoing support.*

How to Access

Speak to a master's level specialist over the phone 24/7 by calling the phone number listed below, or visit the website to gain access to helpful resources.

800-316-2796

mutualofomaha.com/eap

**Services incurred by referrals are not included under the EAP and may be subject to cost.*

Voluntary Products

Accident

Group accident coverage through MetLife can help cover costs like insurance deductibles, copayments, household bills and more. Coverage is available for your spouse and dependent child(ren). Payments go directly to you – not your doctor or hospital and portable coverage is available if our employment status changes. Injury benefits include fractures, dislocations, concussions, coma, ambulance transportation, hospital admission, and more. Benefit amounts vary based on plan chosen. Please review the full benefits summary for more information.

ACCIDENT BI-WEEKLY (24) PAYROLL DEDUCTIONS		
	Low Plan	High Plan
Employee	$2.13	$4.05
Employee + Spouse	$4.50	$8.64
Employee + Child(ren)	$4.38	$8.33
Employee + Family	$5.48	$10.43

Critical Illness

Loss of income coupled with out-of-pocket expenses for individuals who experience a critical illness can be daunting. Despite having good medical insurance, there are expenses associated with a critical illness that many medical plans do not cover. Group critical Illness through MetLife pays a lump-sum benefit when the insured experiences a covered condition. Coverage is available for your spouse and your dependent child(ren). Critical Illness insurance typically covers conditions such as heart attack, kidney failure, stroke, cancer, and a major organ transplant (heart, lung, pancreas, liver & bone marrow). This coverage also pays out for a health screening/wellness benefit of $50 - $100 for covered tests.

Benefit amounts to elect from: $15,000 or $30,000. Spouse and child(ren) receive 100% of employee's benefit amount.

Payroll deductions for the group critical illness policy are based on the employee's age, coverage level and benefit amount elected. **Please see Employee Navigator for more information, including costs.**

Hospital Indemnity

Group hospital indemnity coverage through MetLife provides benefits for inpatient and outpatient services as a result of covered accidents and sickness. It offers a solution to the financial burdens created by unexpected trips to the physician's office or hospital emergency room. Payments go directly to you – not your doctor or hospital and coverage is available for your spouse and dependent child(ren).

HOSPITAL INDEMNITY BI-WEEKLY (24) PAYROLL DEDUCTIONS		
	Low Plan	High Plan
Employee	$6.81	$13.81
Employee + Spouse	$13.20	$26.78
Employee + Child(ren)	$12.32	$24.99
Employee + Family	$20.96	$42.51

Legal Plan

Attorney fees can be expensive. There are a variety of legal services available to you with the High & Low legal plans through MetLife Legal Plans. When you use a network attorney, there are no limits on the number of times you may use the plan for the services. Legal services include wills, powers of attorney, elder care issues, home and real estate, family and personal matters, and more.

Both plans include unlimited telephone and office consultations. Trials for covered matters are covered from beginning to end, regardless of length, when using a network attorney.

LEGAL PLANS BI-WEEKLY (24) PAYROLL DEDUCTIONS	
Low Plan	**High Plan**
$7.40	$12.00

Identity Theft Protection

While most consumers immediately assume that identity theft is just somebody using a stolen credit card, this should be the least of your concerns. True identity theft is prevalent, and has much more significant impact than disputing a charge with your credit card company.

ID Watchdog Core Plan: The Core Plan monitors thousands of public and private databases searching for new and updated information associated with your personal, identifiable and financial information. This plan includes monitoring of an employee's social security number, criminal records, address history, TransUnion credit and more.

ID Watchdog Platinum Plan: In addition to the Core Plan monitoring, the Platinum plan offers credit monitoring, report and scores for all three credit reporting agencies (Equifax, Experian and TransUnion). Reports and scores automatically refresh annually and any time suspicious activity is detected.

IDENTITY THEFT PROTECTION BI-WEEKLY (24) PAYROLL DEDUCTIONS		
	Core Plan	**Platinum Plan**
Employee	$3.48	$6.48
Employee + Family	$6.98	$11.48

Pet Insurance

Now more than ever, pets are playing a significant role in our lives and it is important to keep them safe and healthy. MetLife Pet Insurance can help you protect your furry family members against unplanned vet expenses for covered accidents and illnesses.

How does pet insurance work?

The process is simple and straightforward. Take your pet to the vet and pay the bill, then send your claim to MetLife. File the claim by using the online portal, e-mail, fax or mail, and MetLife process your claim within 10 days. Then, you'll be reimbursed if the claim expense is covered under the policy.

You can visit any licensed vet or emergency clinic in the US and you and your vet of choice can determine the best treatment plan and medical course of action for your pet. Each pet's premium will be unique based on the age, breed, location and gender, as well as what coverage amount you select. You pay MetLife directly for the coverage.

To get a quote or enroll, visit metlife.com/getpetquote or call 800-GET-MET8 on or after January 1, 2022.

Annual Notices

Health Insurance Marketplace Coverage Options

In 2014 a new option to buy health insurance began: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2023 and ends on December 15, 2023. You can get coverage through the Marketplace for 2024 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP). Here are some important dates:

November 1, 2023: Open Enrollment starts
December 15, 2023: Last day to enroll or change 2024 health plan
January 1, 2024: 2024 Insurance coverage begins

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 a plan from your employer that would cover you (and not any other members of your family) is more than 9.61% (2022) of your household income for the 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.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) 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.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources department. 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 online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an employee's military leave of absence. These requirements apply to medical and dental coverage for you and your dependents. They do not apply to any Life, Short-Term or Long-Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://dol.gov/vets/programs/userra/main.htm. An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http://dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://dol.gov/elaws/userra.htm.

Notice of Special Enrollment Rights

This notice is being provided to help you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

- **Loss of Other Coverage** – If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- **Marriage, Birth or Adoption** – If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.
- **Medicaid or CHIP** – If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or obtain more information, please contact the plan administrator.

The 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act of 1998

Did you know that your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information regarding this benefit, contact customer service at the number listed on the back of your medical ID card.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member to receive assistive reproductive services.

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier. For additional information, contact your plan administrator.

Premium Assistance: Medicaid & 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 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 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 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 August 1, 2022. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ | Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://health.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp | Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 Press 1 or 2 GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid-Website: https://in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI–HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx / Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov / KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx / Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: medicaid.la.gov or ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: https://dphhs.mt.gov/montanahealthcareprograms/HIPP | Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 HIPP: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://oregonhealthcare.gov/index-es.html | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://eohhs.ri.gov | Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov/ | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip | Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.org/en/famis-select / https://coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ | Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since 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 or 1-866-444-EBSA (3272)

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

Medicare Part D Notice of Creditable Coverage

Remember: Keep this 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).

Important Notice from Seminole County Clerk of the Circuit Court and Comptroller About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Seminole County Clerk of the Circuit Court and Comptroller 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. Seminole County Clerk of the Circuit Court and Comptroller has determined that the prescription drug coverage offered through Cigna is or are, 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 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.

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 coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to reenroll in our program during the next open enrollment period.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Seminole County Clerk of the Circuit Court and Comptroller and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage: Contact the person listed below. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Seminole County Clerk of the Circuit Court and Comptroller changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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 socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

CMS Form 10182-CC Updated April 1, 2011

Date:	January 1, 2023
Name of Entity/Sender:	Seminole County Clerk of the Circuit Court and Comptroller
Contact – Position/Office:	Lia Denning – Human Resource Manager
Address:	301 North Park Avenue Sanford, FL 32771
Phone Number:	407-665-4401

FAQ: What is creditable coverage?

Medicare beneficiaries (i.e., individuals eligible for Medicare) have the opportunity to receive subsidized prescription drug coverage through the Medicare Part D program. Beneficiaries who choose not to sign up at the first opportunity may have to pay more if they wait to enroll in the program after they are initially eligible. However, the prescription drug coverage on the medical plans offered by the Clerk's Office are considered creditable, which means the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage. **As a result, by remaining enrolled in one of the medical plans offered by your employer, you can continue to get the high quality care you have now as well as avoid higher payments if you sign up later for the Medicare drug benefit.**

Notice of Privacy Practices

The HIPAA Privacy Rule restricts the use and disclosure of member personal health information by "Covered Entities" and their "Business Associates." As the sponsor and funding source of your health benefits under a Cigna plan, Seminole County Clerk of the Circuit Court and Comptroller ("Plan Sponsor") is subject to the Privacy Rule as a "Covered Entity." Cigna processes claims under your plan and so is also subject to the Privacy Rule as our "Business Associate."

This Notice of Privacy Practices describes addresses how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Plan Sponsor

As a practical matter, we may rarely, if ever, come in contact with your personal health information. With limited exception, most use and disclosure of personal health information will be handled by Cigna. For that reason, you'll see that most of this Notice addresses Cigna's handling of personal health information and your related interactions with Cigna.

In the event that the Plan Sponsor comes into contact with any of your personal health information, we will not use or disclose that information in any way that is inconsistent with the restrictions and requirements described below as applicable to Cigna, to the extent those restrictions and requirements apply to us as your employer. For example, we will not use that information in connection with any benefit determinations, because that is Cigna's responsibility. And we may not use any personal health information for any employment purpose unrelated to participation in the plan. On the other hand, we could be required to respond to federal and state law enforcement in appropriate cases. In addition, you have all of the Legal Rights described below with respect to any personal health information that we may have.

If you have any questions, comments or complaints about Plan Sponsor's handling of personal health information, please contact the department, office or individual that is responsible for Human Resources at Plan Sponsor.

Insurance Company

When Cigna uses the term "personal information," we mean information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information," we mean information that identifies you and relates to your medical history (i.e., the healthcare you receive, or the amounts paid for that care).

How Cigna Uses and Discloses Personal Information

To process claims under your plan, Cigna needs personal information about you, and we obtain that information from many different sources – particularly you, your employer or benefits plan sponsor if applicable, other insurers, HMOs or third-party administrators (TPAs), and healthcare providers. In administering your health benefits, we may use and disclose personal information about you in various ways, including:

Healthcare Operations: We may use and disclose personal information during the course of administering the plan – that is, during operational activities such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. Other operational activities requiring use and disclosure include administration of stop loss; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Cigna with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and customer service.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the covered employee). In addition, we make claims information contained on our secure member website and telephonic claims status sites available to the subscriber and all covered dependents. We also use personal information to obtain payment for any mail order pharmacy services provided to you.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other healthcare providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may use personal information in providing mail order pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain healthcare operations purposes. We may use or disclose personal information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** – to Your Employer, as sponsor and funding source of your plan, subject to specified conditions. Research – to researchers, provided measures are taken to protect your privacy.
- **Business Partners** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.
- **Law Enforcement** – to federal, state and local law enforcement officials. Legal Proceedings – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

Disclosure to Others Involved in Your Healthcare

We may disclose health information about you to a relative, a friend, the subscriber of your health benefits plan or any other person you identify, provided the information is directly relevant to that person's involvement with your healthcare or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Member Services number on your ID card.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Member Services number on your ID card – or have your provider contact us.

Your Legal Rights

The federal privacy regulations give you several rights regarding your health information:

- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send health information (e.g. Explanation of Benefits (EOB) and other claim information) to a different address from that of your subscriber. We will accommodate reasonable requests.
- You have the right to ask us to restrict the way we use or disclose health information about you in connection with healthcare operations, payment and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your healthcare.
- You have the right to ask us to obtain a copy of health information that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request. You have the right to ask us to amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- You have the right to ask us to provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- You have the right to be notified following a breach involving your health information.
- You have the right to know the reasons for an unfavorable underwriting decision. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes.
- You have the right with very limited exceptions, not to be subjected to pretext interviews. (Cigna does not participate in pretext interviews.)

You may make any of the requests described above (if applicable), may request a paper copy of this notice, or ask questions regarding this notice by calling the toll-free Member Services number on your ID card.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please send your inquiry to the following address:

Cigna Medical Group
Cigna Onsite Health
25500 N. Norterra Dr.
Phoenix, AZ 85085

You may stop the paper mailing of your EOB and other claim information by visiting www.cigna.com. Then you can log in any time to view past copies of EOBs and other claim information.

You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Remember, that if you have any questions, comments or complaints about Your Employer's handling of personal health information, please contact the department, office or individual that is responsible for Human Resources at Your Employer.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization for marketing purposes that are unrelated to your benefit plan(s), before disclosing any psychotherapy notes, related to the sale of your health information, and for other reasons as required by law.

If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorizations, please call the toll-free Member Services number on your ID card.

Safeguarding Your Information

We guard your information with administrative, technical, and physical safeguards to protect it against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal law pertaining to the security and confidentiality of personal information.

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy personal information about you when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

Healthcare Glossary

Applicable Cost Share
The share of costs covered by your insurance that you pay out of your own pocket. Includes deductibles, coinsurance, and copays. Does not include premiums, balance billing amounts for non-network providers, or non-covered services.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Coinsurance
The portion of the cost for care received for which an individual is financially responsible, which is usually calculated as a percentage (such as 20%). Often coinsurance applies after a specific deductible has been met and may be subject to an individual out-of-pocket. For example, if the plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The plan pays the rest of the allowed amount.

Copayment
A payment you make at the time that selected services are rendered, and no additional payment is required. Copayments are typically flat amounts (for example, $15), covering such items as office visits, prescriptions, and emergency care.

Covered Expenses
Healthcare expenses that are covered under your health plan.

Deductible
The amount of eligible expenses you must pay, out of pocket each plan year, before the plan begins to pay. The deductible may not apply to all services.

Embedded Deductible
An embedded deductible is an individual deductible level within a family contract. For example, if there is a family deductible of $3,000 with an individual embedded deductible of $1,500, when any one individual family member reaches $1,500 in expenses, their benefit plan coverage takes effect.

Non-embedded Deductible
A non-embedded deductible requires that the entire family deductible be met before benefit plan coverage takes effect by any one or combination of family members.

Evidence of Insurability
A medical questionnaire used to determine whether an applicant will be approved or declined coverage.

Guarantee Issue
The amount available without providing an Evidence of Insurability (EOI). An EOI will be required for any amounts above this, for late enrollees or increases in insurance.

In-Network
Care received from physicians, facilities or suppliers that are contracted with the insurer to provide services on a negotiated discount basis.

Late Entrant
A member that becomes insured more than 30 days after initial eligibility or becomes insured again after previously waiving coverage.

Mandatory Generic
When you request a brand name drug when there is a generic equivalent, you pay the generic copay plus the cost difference between the brand and generic drug. Dispense as written (DAW) may be allowed. With DAW you will not be charged a cost difference.

Out-of-Network
Care received from physicians, facilities or suppliers that are not contracted with the insurer to provide services on a negotiated discount basis.

Out-of-Pocket Expense
Amount you pay toward the cost of healthcare services, may include deductibles, copays and/or coinsurance.

Out-of-Pocket Maximum
The maximum dollar amount a member is required to pay out of pocket during a benefit period. Plans may vary but deductibles and coinsurance may apply toward meeting the out-of-pocket maximum.

Preferred Provider
A provider who has a contract with your carrier/vendor to provide services to you at a discount.

Pre-existing Condition
Any Injury/Sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken in the X months prior to the day you become insured. For example: Disabilities that occur during the first 6 months of coverage due to a pre-existing condition that occurred during the 3 months prior to coverage are excluded.

Provider
Physician (medical, dental or vision), healthcare professional or facility licensed, certified or accredited as required by state law.

Prior Authorization/Pre-Service Notification
The decision by the plan or health insurer that a healthcare service, treatment plan, prescription drug, medical equipment, or other healthcare services defined in the certificate of coverage, is medically necessary. The plan may require preauthorization for certain services before receiving them, except in an emergency.

UCR (Usual, Customary & Reasonable)
The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount.

Contacts

Seminole County Clerk of the Circuit Court and Comptroller

Lia Denning
407-665-4401 | ldenning@seminoleclerk.org

Brandi Fisher
407-665-4332 | bfisher@seminoleclerk.org

Brown & Brown

Debbie Cox
Employee Benefits Client Care Advocate
321-214-2399 | debbie.cox@bbrown.com

Medical

Cigna
800-244-6224 | mycigna.com

Health Savings Account

Optum Bank
866-234-8913 | optumbank.com

Dental

MetLife
800-942-0854 | metlife.com/dental

Vision

Mutual of Omaha (EyeMed Insight Network)
1-833-279-4358 | mutualofomaha.com/vision

Disability

Mutual of Omaha
800-877-5176 | mutualofomaha.com

Employee Assistance Program

Mutual of Omaha
800-316-2796 | mutualofomaha.com/eap

Accident, Critical Illness & Hospital Indemnity

MetLife
800-438-6388 | metlife.com

Legal Plans

MetLife Legal Plans
800-821-6400 | legalplans.com

Identity Theft Protection

IDWatchdog
800-970-5182 | idwatchdog.com

Pet Insurance

MetLife
800-GET-MET8 | metlife.com/getpetquote

COBRA Administration

Medcom
800-523-7542 (Option 3) | medcombenefits.com

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