Table of Contents

- Dental Insurance
  - DHMO
  - PPO
- Vision Insurance

Section IV – Supplemental Benefits – After Tax

a. Life Insurance
   - Basic
   - Optional
   - Dependent
   - Hazardous Occupation & Occupational Assault

b. Long Term Disability

c. Supplemental Income Protectors
   - Accident
   - Cancer
   - Critical Illness
   - Hospital Indemnity

d. Pre-Paid Legal Services Insurance

Section V – Saving for the Future; Today & Tomorrow

a. Today, Deferred Compensation
   - 457(b) Plan Overview
   - Vendors
     - Brighthouse
     - Mission Square
     - Nationwide

b. Tomorrow, Florida Retirement System
   - Retirement
   - Plan Options
     - Pension Plan
     - Investment Plan
   - Deferred Retirement Option (DROP)

Section VI – WellBeing Programs

a. Rally Rewards
b. Events
c. Onsite Healthcare Advocates
d. Donated Leave
e. Leave of Absence
f. FMLA
g. Parental Leave

Section VII – Employer Notices

Section VIII – Glossary

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

This benefits guide contains important information you will need to understand about your benefit options to help you enroll in the most suitable plans for you and your family. You will find information on each plan, including plan overviews and features. For more specific plan details, please refer to the individual plan material available on our website at https://www.broward.org/benefits We've Got You Covered!!!

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

▪ Health Insurance	▪ Deferred Compensation
▪ Spending Accounts	▪ Florida Retirement System
▪ Dental Insurance	▪ Retiree Continuation Coverage
▪ Vision Insurance	▪ Retirement
▪ Life Insurance	▪ WellBeing Program
▪ Long Term Disability Insurance	▪ Donated Leave
▪ Supplemental Income Protection Plans	
▪ Pre-paid Legal Services Plan	

BE A WISE HEALTH CARE CONSUMER

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

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

- Have a primary care physician.
- Use generic and/or preferred formulary drugs. https://www.broward.org/Benefits/Plans/Pages/UHC%20HDHP%20and%20Rx.aspx
- Use urgent care facilities or walk-in clinics instead of emergency room care whenever possible.
- Practice preventive health care and make healthy lifestyle choices.
- Inform Employee Benefits when a dependent is no longer eligible for coverage. https://www.broward.org/Benefits/Plans/Pages/Default.aspx

SECTION I – EMPLOYEE AGREEMENT

By accessing and using the PeopleSoft Employee Self Service portal and participating in a Broward County benefit program, you hereby acknowledge and accept the terms and conditions set forth in the following Employee Statement:

1. I authorize and request payroll deduction(s) for the benefits I have selected.

2. I agree to provide documentation, as required by Broward County including but not limited to, information evidencing dependent status, domestic partner status, student/financial status, or other benefits qualifying status for any person covered under a Broward County insurance plan at the time of enrollment. If my dependent does not meet the eligibility requirements of the plan or I fail to provide the requested documentation for my dependent, I understand that this may cause the dependent to be deemed ineligible and removed from coverage retroactive to the enrollment date. I will be legally and financially responsible for repaying all premiums, subsidies, and benefit claims incurred or paid on behalf of my ineligible dependent.

3. I understand that health, dental, and vision insurance premiums, and employee contributions to a Flexible Spending Account or Health Savings Account will be deducted on a pre-tax basis, to the extent possible. This will reduce my income subject to federal income tax and Social Security withholding (FICA), potentially affecting my future Social Security benefits. If I insure an over-age dependent between the ages of 26 and 30, a domestic partner, or a child of a domestic partner, a portion of my premium attributable to their coverage will be deducted on an after-tax basis, and I will pay imputed income tax on the portion of the Broward County subsidy provided to offset the cost of the health plan.

4. I acknowledge that I cannot stop or change benefits paid for on a pre-tax basis during the plan year unless I experience a relevant qualifying event.

5. I understand that a Section 125 Flexible Spending Account (health care and dependent day care) can only be used to reimburse payment of eligible expenses incurred during the plan year (1/1/2025-12/31/2025) while participating in the plan. Any unused amount in the health care or dependent day care account at the end of the plan year will be forfeited. Funds from one spending account cannot be used to reimburse expenses covered by another account. Expenses reimbursed through a Section 125 Flexible Spending Account cannot be claimed on my income tax return. Over-age dependent children ages 26 to 30, domestic partners, and children of a domestic partner do not meet the Internal Revenue Service (IRS) definition of a dependent, therefore their coverage is not eligible for pre-tax consideration or reimbursement through any type of Section 125 Flexible Spending Account, Health Reimbursement Account (HRA), or Health Savings Account (HSA).

6. I understand and agree that Broward County and the third-party Flexible Spending Account/Health Reimbursement Account/Health Savings Account administrator will not be liable for my failure to read and abide by all rules pertaining to these reimbursement accounts referenced herein. I also understand that elections for pre-tax benefits are irrevocable and cannot be changed after the established deadline, except for a relevant qualifying event.

7. I agree for myself and all covered members of my family and other dependents under Broward County insurance plans to be bound by the benefits, deductibles, coinsurance, copayments, exclusions, limitations, eligibility requirements, and other terms of the plan documents and contracts for the plans in which I am enrolled.

8. I understand that Broward County Division of Human Resources, Employee Benefit Services Section, will collect my Social Security number as permitted under Section 119.071(5)(a)2, Florida Statutes, for the following purposes: to match, verify, and retrieve benefit plan information, and for payment and audit of premiums collected. This notice is provided to me pursuant to Section 119.071(5)(a)3, Florida Statutes.

9. I understand that the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan administrators or fiduciaries of self-insured/self-administered group health plans to report information, as required by the secretary of the Department of Health and Human Services for the coordination of benefits. This requirement also applies to liability insurers (including self-insurers), no-fault insurers, and workers' compensation laws or plans. Two key pieces of information that are required to be reported are Social Security Numbers (SSN) or Health Insurance Claim Numbers (HICN) and Employer ID Numbers (EIN). Medicare relies on the collection of SSN or HICN, and EIN, as applicable, to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits.

10. I certify that the information I have provided through the PeopleSoft Employee Self Service portal and other benefit related documents are accurate, truthful, and complete to the best of my knowledge.

11. I understand that any person who knowingly and with the intent to injure, defraud, or deceive any insurer, submits a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree under Section 817.234, Florida Statutes. Any person committing such acts will be subject to disciplinary action by Broward County and any other appropriate action allowable under law.

SECTION II – ELIGIBILITY AND REQUIRED DOCUMENTATION

Employees in full-time and part-time 20-hour positions are eligible for benefits under the County's Section 125 Benefit Plan, subject to collective bargaining agreement provisions, if applicable. Coverage is effective on the first of the month coincident with or following 30 days of employment in a benefit-eligible position.

Employees expected to work fewer than 20 hours per week on average (part-time 19, seasonal, student, etc.) are not eligible for benefits upon hire.

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

If you have questions about eligibility, contact Employee Benefit Services at 954-357-6700 or email benefits@broward.org.

WHO IS ELIGIBLE?

- **Spouse*:** Employee's **legal** spouse.
- **Domestic Partner*:** Employee's registered domestic partner (special rules apply & will be referenced throughout the document in the relevant section(s).

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

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

Qualifying Event = 31 DAY WINDOW TO MAKE A CHANGE

- **Children:**
  - ✓ **Child** – your biological child, child with a qualified medical support order, or legally adopted child through the end of the calendar year in which the child turns age 26.
  - ✓ **Stepchild** – the child of your spouse/domestic partner for as long as you remain legally married/registered domestic partner to the child's parent through the end of the calendar year in which the child turns age 26.

- ✓ **Legal guardianship** – a child for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state or federal laws or a child for whom you are granted court-ordered temporary or other custody through the end of the calendar year in which the child turns age 26.

- ✓ **Foster child** – a child that has been placed in your home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency through the end of the calendar year in which the child turns age 26.

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

✓ **Disabled Dependent** – unmarried dependent with intellectual or physical disabilities are eligible to continue coverage after they reach age 26 if:

- they are enrolled in the Plan before they turn age 26; and
- they are incapable of self-sustaining employment because of intellectual or physical disability; and
- the required documentation supporting the intellectual or physical disability* has been reviewed and confirmed by Employee Benefit Services prior to their 26th birthday, and
- they are chiefly dependent on you for care and financial support.

*Letter of disability from Social Security is required.

Note: Upon your **initial enrollment** in a County health plan; you have a dependent over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria, you may enroll that dependent under your coverage at that time with proof of prior creditable group coverage within the last 63 days. If you do not enroll the dependent at your initial enrollment, you will not be able to add the child to your coverage later.

- **Over Age Dependents - (health, dental, and vision insurance only)** – eligibility begins after the end of the **calendar** year in which the child turns 26 through the end of the **calendar** year in which he/she turns 30. To be eligible and remain eligible, the child must be:
  - unmarried, and
  - have no dependents of their own, and
  - dependent on you for financial support, and live in Florida or attend school in another state, and have no other health insurance available to them, and
  - *IMPORTANT*: you pay an additional $20 biweekly premium **and** imputed income tax based on the value of the County subsidy.

  You are required to sign an Over Age Dependent Affidavit **and** provide supporting documentation indicating whether the dependent is a student (copy of ***current semester enrollment***) or financially dependent (copy of valid Florida drivers' license) upon the employee at the time of enrollment. You will also be required to provide this information on an annual basis during the County's open enrollment period.

  NOTE: If a child is covered under the Over Age Dependent provision and you cancel their coverage due to a qualifying event, the Over Age Dependent is not eligible to again be covered under this provision unless the child was continuously covered by other creditable group coverage without a gap of more than 63 days. Documentation of prior coverage will be required. If a child covered under this provision

becomes a parent, the newborn will not be covered under the plan, and the child/parent's coverage will terminate at the end of the birth month. Only the Over Age Dependent will be offered COBRA coverage.

REQUIRED DOCUMENTATION

Documentation establishing your legal relationship to an enrolled dependent is required any time a dependent is added to any of your benefit plans (new hire, open enrollment, or qualifying event). You will be required to upload the documents at the time of enrollment via PeopleSoft Employee Self Service. Under Health Care Reform, you are also required to provide their Social Security number for reporting purposes. A certified translation must accompany documents written in a language other than English.

The types of documentation accepted are:

Dependent Relationship	DOCUMENTATION REQUIRED
Legal Spouse	Copy of Official Registered Marriage certificate (religious certificate not acceptable if married in the USA).
Domestic Partner	Copy of Domestic Partnership Registration certificate issued through the Tri-County records (Miami-Dade, Broward County and Palm Beach)
Child(ren)	Copy of Official State Birth certificate(s) listing the employee as the parent (birth cards not acceptable).
Stepchild(ren)	Copy of Official State Birth certificate(s) **AND** a copy of Official Registered Marriage certificate.
Child(ren) of Domestic Partner	Copy of Official State Birth certificate(s) AND applicable Domestic Partner Registration documentation as indicated above.
Child(ren) under Legal Guardianship, Custody or Foster Care	Copy of Legal Guardianship/Custody document from Courts or copy of Foster Care documentation from Courts.
Child(ren) adopted or in the process of adoption	Copy of Legal Adoption documentation showing placement in employee's home prior to adoption or Adoption certificate issued through Courts.
Grandchild(ren) OR other children not related	Copy of Official State Birth certificate of child(ren) AND a copy of Guardianship/ Adoption/Custody/Foster care document from Courts
Over Age Dependent	Student Status OR Financial Support **Student** - Over Age Affidavit, AND Proof of student status, which must include ALL the following (pre-printed by the educational institution): • Name of school/college/university • Name of dependent • Date(s) of semester showing enrollment in the current year. **Financial Support -** Over Age Affidavit, AND proof of residence: current driver's license showing a Florida address.

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

BENEFITS COVERAGE

❖ When can I enroll?

You can enroll yourself and your eligible dependents:

- Upon employment in a benefit-eligible position or attaining benefit eligibility status. Coverage is effective on the first of the month coincident with or following completion of initial 30-day eligibility period.
- Upon experiencing a relevant qualifying event, within 31 days (60 days of birth or adoption) of the date of the event (coverage will be effective the first of the month after Employee Benefit Services receives the completed paperwork except for newborns, adoption, placement for Foster Care or guardianship which will start on the effective date of the qualifying event).
- During the annual Open Enrollment in the fall of each year.

TYPE Of ELIGIBILITY	EFFECTIVE DATE
New Hire	On the first day of the month following 30 days of employment in a benefit-eligible position.
Rehire less than 30 days	First day of the month following rehire – elections remain the same, retro deductions will be taken**.**
Rehire more than 30 days	First day of the month following 30 days of re-employment – new elections must be made.
Part-time 20 (PT20) to Full-time	First pay period following a change of status date
Part-time 19 (PT19) to benefit-eligible (PT20 or Full-time)	First day of the month following 30 days in the new classification. (Must attend the Benefits session of OnBoard Broward)
Return from Leave of Absence (LOA)	First of the month following a change of status date.
Qualifying Event – Birth of Baby, Adoption, placement for Foster Care, Court awarded Guardianship	Date of the event. Must notify Employee Benefit Services within 60 days of birth or adoption.
Qualifying Event – Marriage, Domestic Partner Registration, Loss of Other Group Coverage, Qualified Medical Child Support Order (QMCSO), etc.	Within 31 days of the event (coverage effective on the first of the month following receipt and processing of paperwork)

❖ When does my coverage BEGIN?

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

- $50,000 Basic Term Life and Accidental Death & Dismemberment (AD&D) Insurance paid by the County.
- Florida Retirement System (FRS)
- Deferred Compensation (457(b) Plans
- Employee Education Benefit (tuition reimbursement assistance)
- County's Employee Assistance Program

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

- Health, dental and/or vision insurance
- Health Savings Account, Health Reimbursement Account or Flexible Spending Accounts (based on health plan enrollment)
- Supplemental Term Life & Accidental Death & Dismemberment (AD&D) Insurance
- Supplemental Life coverage for your spouse/domestic partner and child(ren) if you are enrolled in Supplemental Life
- Long Term Disability
- Supplemental Income Protection Plans
- Pre-Paid Legal Insurance

❖ When does my coverage END?

TYPE of CHANGE	HEALTH, DENTAL, VISION, HRA	FSA, LIFE, LTD, LEGAL
Benefit-eligible to non-Benefit-eligible position	Last day of the month in which classification change is effective	Date of position change
Retirement	Last day of the month in which retirement occurs	Date of retirement
Separation/Termination	Last day of the month in which employment ends	Date of separation/termination
Qualifying Event to remove a dependent – Divorce, Dissolution of Domestic Partner Registration, Gaining of Other Group Coverage, Death.	End of the month in which the event occurred. Must notify Employee Benefit Services with 31 days of the event.	Date of Event

IMPORTANT: An ineligible dependent cannot remain on County insurance. It is the employee's responsibility to notify Benefits within 31 days of their dependent becoming ineligible. If reported late, the employee will be financially responsible for reimbursing the County for all claims incurred after the ineligibility date.

❖ Survivor Benefits

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

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

❖ What happens if a do not enroll in the County's benefits and need them later? Can I enroll later?

There are various reasons why you may not want to enroll in the County's benefits. For example, if you have health, dental, and/or vision benefits from another creditable group plan and waive enrollment in the County plans but then lose your other coverage, you will have 31 days from the qualifying event (the date of loss of your other coverage) to elect coverage and provide documentation. If there is no prior coverage, you may only enroll if you experience a relevant qualifying event, such as marriage, domestic partner registration, or birth or during open enrollment in the fall of each year.

❖ Can I make changes to my enrollment during the plan year? What is a Qualifying Event?

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

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

- Marriage or divorce
- Registration or dissolution of Domestic Partnership
- Death of a dependent (60 days)
- Birth or adoption (60 days)
- Legal guardianship
- Change in a dependent's eligibility
- Change in employment status for you or your dependents
- Change from part-time to full-time employment status or vice versa
- Going on unpaid leave:

- Family and Medical Leave and Job Protected Leave Authorized leave without pay
- Workers' Compensation disability leave
- Military leave

IMPORTANT:
If you experience a change in status, contact the Employee Benefit Services Section at 954-357-6700 or email benefits@broward.org **in advance** of the event, but no later than 31 days from the date of the event. Documentation supporting the qualifying event/change in status must be submitted with a current Enrollment/Change Form. Requests made later than 31 days from the date of the event will not be approved (exception: newborn babies and adoptions; requests must be made within 60 days of the birth/placement for adoption).

What is the effective date of the change in coverage due to a Qualifying Event/Change in Status?

Coverage becomes effective on the first of the month following the date the paperwork and documentation are received and approved by the Employee Benefit Services Section. (Exception: The only qualifying event/change in status changes that will be made retroactive are birth*, adoption, foster care placement, or court-appointed guardianship.)

IMPORTANT: Your **newborn child is not automatically enrolled** by the County or group health plan. You must add your newborn dependent through PeopleSoft Employee Self Service Benefit within 60 days, even if your current coverage includes Employee and Children or Employee and Family coverage.

Health Savings Account – if you were enrolled in Employee Only coverage and enroll the child, due to the change in the tier of coverage, the County will fund a pro-rated portion of the annual HSA Engagement Incentive effective the first of the month the child 's coverage begins.

Coverage ends on the last day of the month in which the qualifying event/change in status occurred *in most situations.* Supporting documentation is required and must be submitted to Employee Benefit Services within 31 days of the Change in Status date.

Loss of other Group coverage midyear: You can enroll in the County's health plan midyear if you have lost other group insurance coverage. Supporting documentation of the loss of coverage is required and must be submitted to the Employee Benefit Services Section within 31 days of the loss of coverage date.

IMPORTANT: If you experience a relevant qualifying event/change in status, it is your responsibility to notify Employee Benefit Services within 31 days of the event (60 days for a newborn or adoption). Beyond 31 days, you are legally and financially responsible for any claims and/or expenses incurred as a result of any dependent(s) who continues to be enrolled when they no longer meet the County's eligibility requirements.

❖ What and when is Open Enrollment?

Open Enrollment is a period, determined by the County, during which you are allowed to make changes to your pre-tax benefits (health, dental, vision, and employee spending accounts (Flexible Spending Accounts Medical and/or Dependent Care, Health Savings Accounts contributions) and after-tax prepaid legal plan, personal income protection plans and life insurance, for the following plan year. Annual pre-tax elections are irrevocable unless experiencing a qualifying event/change in status. All benefit-eligible employees are **required to reenroll**

or waive coverage through PeopleSoft Employee Self Service each year during open enrollment. The County's Open Enrollment for pre-tax and specified after-tax benefits is held annually during the last quarter of the calendar year to allow eligible employees to:

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

Note: Employees can apply for Life, Long Term Disability, and Supplemental Income Plans at any time during the year with Evidence of Insurability. Carrier may approve or deny coverage based on their underwriting guidelines.

RETIREMENT REMINDER: If planning on retiring in the current year, the elections made during open enrollment in October/November or through a Qualifying Event/Change in Status prior to retirement for health, dental, and vision will be the only plans available for Retiree Continuation of Coverage.

Retirees cannot elect or enroll in health, dental, or vision coverage if not enrolled as an active employee at the time of retirement.

What should I do if my spouse/domestic partner's Open Enrollment is before or after my Open Enrollment?

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

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

SECTION III – CORE BENEFITS – BEFORE TAX

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

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

BEFORE TAX PLANS	AFTER TAX PLANS
▪ Medical (self-insured health and pharmacy) ▪ Dental ▪ Vision ▪ Flexible Spending Accounts (FSA) ▪ Health Savings Account (HSA) ▪ Health Reimbursement Account (HRA)	▪ Optional Term Life ▪ Spouse Term Life ▪ Child Term Life ▪ Long Term Disability ▪ Pre-Paid Legal Plan ▪ Personal Income Protection Plans

❖ How do I benefit from a before tax plan?

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

❖ What are the special IRS rules for before tax plans?

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

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

Deductions on your ePay Statement will be broken out between pre-tax and taxable amounts (imputed income).
As the County subsidizes the health plan, we must calculate and tax you on the subsidy amount attributable to insuring non-IRS dependents.
The imputed income tax will be added on the Earnings side so that it is taxed and then reversed on the Deductions side so that you are only paying taxes on that amount.

❖ What is an irrevocable election?

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

HEALTH INSURANCE AND EMPLOYEE SPENDING ACCOUNTS

HEALTH INSURANCE - UNITEDHEALTHCARE

❖ High Deductible Health Plan (HDHP) Out-of-Network

Broward County offers two types of health plans under UnitedHealthcare for you to choose from:

UnitedHealthcare (National Network)	
▪ High Deducible Out of Network (**HDHP OON**)	▪ Lower payroll deduction, but higher cost at time use for non-preventive care services.
▪ Consumer-Driven Health Plan (**CDHP**)	▪ Higher payroll deduction, some copays.

The HDHP Out-of-Network is our core health and pharmacy plan, and the CDH plan being buy-up option. The County significantly subsidizes all health plans and tiers of coverage.

The County offers a HDHP Out of Network Plan. The plan consists of two parts – self-insured health and pharmacy coverage and an employer-funded Health Savings Account (HSA) or Health Reimbursement Account (HRA) if not eligible for an HSA.

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

The following chart is an overview of the major features of the HDHP OON plan:

2025	HDHP OUT-OF-NETWORK PLAN - UHC	
	IN-NETWORK	**OUT-OF-NETWORK**
County-Funded HSA or HRA[(1)]	Individual: $1,200 Family: $2,400	
Annual Deductible	Individual: $1,650 Family: $3,300	Individual: $3,000 Family: $6,000
Co-insurance (after Annual Deductible is met)	Individual: $1,775 @ 20% Family: $3,550 @ 20%	Individual: $3,000 @ 40% Family: $6,000 @ 40%
Maximum Out-of-Pocket	Individual: $3,425 Family: $6,850	Individual: $6,000 Family: $12,000
Preventive Exams/Screenings	No Cost to employee when billed as PREVENTIVE	Not Covered

Preventive Prescriptions	No Cost (limited to drugs on designated Preventive Drug List)	Not Covered
All other Medical and Prescription	Annual Deductible, and when met, 20% Coinsurance based on carrier's contracted rates.	Medical Only: Annual Deductible, and when met, 40% Coinsurance at Usual & Customary rate. Prescriptions not covered
WellBeing Program	Employee and enrolled Spouse/DP can earn up to $300 each per year. UHC-Rally Program	

This plan also has:

- An annual eye exam at no cost at a participating optometrist.
- A Discount dental plan is included at participating dental providers.

❖ How does a High Deductible Health Plan (HDHP) Out of Network work?

The HDHP Out-of-Network is comprised of 3 costs you should familiarize yourself with. Here is how the cost of care in a HDHP works:

Deductible:

+ Amount **you pay *before*** *the plan starts sharing costs*. **You pay** this at doctor visits (PCP/Specialist/Virtual, ER, Urgent Care).
+ The deductible re-sets every January 1 (the start of the plan year).
+ Preventive care is covered at 100% which means you do not have to pay the deductible. Examples of Preventive Care Services:
    - Annual Checkup
    - Well Woman Exams, and
    - Other exams based on your age.
+ In compliance with IRS guidelines, the 2025 deductible for is:

	HDHP OUT-OF-NETWORK PLAN - UHC	
	IN-NETWORK	**OUT-OF-NETWORK**
Annual Deductible	Individual: $1,650 Family: $3,300	Individual: $3,000 Family: $6,000

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

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

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

Coinsurance:

+ Percentage (20%) of costs **you pay after** the plan **deductible** is met.
+ If you have dependents on your plan, all family members' out-of-pocket costs count towards the deductible and coinsurance. The plan will not start paying 100% until the annual coinsurance for the tier of coverage is met.
+ The medical and pharmacy coinsurance amounts in 2025 are:

	HDHP OUT-OF-NETWORK PLAN - UHC	
	IN-NETWORK	**OUT-OF-NETWORK**
Co-insurance (After Annual Deductible is met)	Individual: $1,775 @ **20%** Family: $3,550 @ **20%**	Individual: $3,000 @ **40%** Family: $6,000 @ **40%**

Max-Out-of-Pocket:

+ Amount **you pay** before your plan covers all costs. In other words, this is the most you will pay in a plan year for deductible and coinsurance combined for covered medical and pharmacy benefits.
+ When you are covering dependents on the plan, one family member can reach the out-of-pocket maximum for the entire family, or a combination of family members can meet it.
+ It does not include premiums.
+ The Out-of-Pocket maximum is:

2025	HDHP OUT-OF-NETWORK PLAN - UHC	
	IN-NETWORK	**OUT-OF-NETWORK**
Maximum Out-of-Pocket	Individual: $3,425 Family: $6,850	Individual: $6,000 Family: $12,000

+ Expenses are met under the In-Network coverage, and the Out-of-Network coverage goes toward meeting each plan's deductible and coinsurance. For example:

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

Please review the HDHP OON Benefit Summaries provided by the UnitedHealthcare Plan for a detailed list of services and costs; https://www.broward.org/Benefits/Plans/Pages/UHC%20HDHP%20and%20Rx.aspx

Out-of-Network Coverage:

With the High Deductible Health Plan, you can use any doctor, clinic, hospital, or health care facility you want in the national network. There is coverage if you need to go out-of-network. However, seeing an out-of-network provider will likely cost you more.

You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).

Visit https://www.whyuhc.com/broward/health-plans/comparison-table for more information about what is covered and the costs you will incur based on in or out-of-network plan usage.

EMPLOYEE SPENDING ACCOUNTS – TOTAL ADMINSTRATIVE SERVICES CORPORATION (TASC)

❖ Health Savings Account

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

The 2025 annual maximum contribution limit is $4,300 for Individual Coverage; $8,550 for Family Coverage. See your TASC Account Guide for detailed plan rules on usage, documentation, and payback rules (https://www.broward.org/Benefits/Plans/Pages/Health%20Savings%20Account.aspx)

What is a health savings account ("HSA")?

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

You must be enrolled in a High Deductible Health Plan (HDHP) to take advantage of an HSA. You own, and you control the money in your HSA, making it fully portable after retirement or separation from the County. You decide how to spend the money without interference from a third party or a health insurer.

To qualify for an HSA, you must meet the following requirements:

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

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

For 2025, the maximum you may contribute is $4,300 if you have self-only coverage or $8,550 if you have family coverage. Individuals 55 and older covered by an HDHP can make additional catch-up contributions each year until they enroll in Medicare. The additional "catch-up" contribution is $1,000 annually. You can contribute to your HSA on a pre-tax basis (i.e., before income and employment taxes are applied). You are not allowed to contribute more than the annual limit to your HSA. Contributions more than the annual limit may be withdrawn by the tax filing deadline without penalty (a pro-rata share of earnings on the excess amount must also be withdrawn). Excess contributions remaining in the account after the tax filing deadline must be withdrawn and are subject to a 6 percent excise tax.

Does the County contribute to the health savings account (HSA)?

Yes, the County makes annual contributions to the HSA account.

COUNTY FUNDED 2025 CALENDAR YEAR HSA/HRA for HDHP plan

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

To have the full County contribution you must be benefits eligible January 1, otherwise the County contributes a pro-rated amount:

Benefits Eligible	HDHP OON	
	EE	EE + DEP(S)
JAN	$ 1,200.00	$ 2,400.00
FEB	$ 1,100.00	$ 2,200.00
MAR	$ 1,000.00	$ 2,000.00
APR	$ 900.00	$ 1,800.00
MAY	$ 800.00	$ 1,600.00
JUN	$ 700.00	$ 1,400.00

JUL	$ 600.00	$ 1,200.00
AUG	$ 500.00	$ 1,000.00
SEP	$ 400.00	$ 800.00
OCT	$ 300.00	$ 600.00
NOV	$ 200.00	$ 400.00
DEC	$ 100.00	$ 200.00

Who decides whether the money I am spending from my HSA is for a "qualified health expense"?

The IRS has the final say, but the question may not arise unless your tax return is audited. You are responsible for reporting on your tax return the amount you withdraw from your HSA used for qualified health expenses and the amount that is not (and is therefore taxable). It is recommended that you familiarize yourself with what qualified health expenses are (as partially defined in IRS Publication 502) and keep your receipts if you need to prove your expenditures or decisions during an IRS audit. Distributions from an HSA that are not used for qualified medical expenses are includable in gross income and, for applicants under age 65, subject to an additional 20 percent tax.

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

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

There are three ways to access your HSA funds:

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

HSA FUNDS CAN PAY FOR ANY "QUALIFIED HEALTH EXPENSE," INCLUDING MANY DENTAL AND VISION CARE EXPENSES.

What if I do not use all my HSA money before the end of the year?

Unlike other employee spending accounts, you **do not** lose the money in the HSA, the funds roll over from year to year.

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

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

❖ HEALTH REIMBURSEMENT ACCOUNT (HRA)

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

The accrual maximum is $20,000. See Your TASC Account Guide for detailed plan rules on usage, documentation, and payback rules.

Other HRA Highlights

Unused balances rollover into the next plan year when continuously enrolled in a County HDHP plan. Upon retirement or separation of employment, HRA balances are placed in a tax-advantaged Retirement Health Savings Plan with MissionSquare and can be drawn upon tax-free beginning at age 55. HRA balances are transferred approximately 180 days after retirement or separation of employment.

COUNTY FUNDED 2025 CALENDAR YEAR HSA/HRA for HDHP plan

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

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

There are three ways to access your HRA funds:

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

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

2. By paying for eligible expenses with cash, check, or your personal credit card. Then submit a claim with your Explanation of Benefits or itemized receipts to TASC to pay yourself back. You can also have your reimbursement deposited directly into your "My Cash" account; or

3. By paying your provider using TASC's online feature to pay your provider directly from your HRA account.

What if I do not use all my HRA money before the end of the year?

HRA accounts will automatically rollover in mid-January. You may use the account balance to pay for 2024 or 2025 claims incurred while covered under a County HDHP plan.

HRA Guidelines

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

❖ ENGAGEMENT INCENTIVE (HSA/HRA) High Deductible Health Plan Only

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

If adding a spouse or domestic partner during **open enrollment or due to a qualifying event mid-year**, additional funding is automatic, however, the spouse or domestic partner must complete the annual Engagement Incentive in the current year to receive the following year's funding (full funding if enrolled as of the first of the year, prorated if enrolled during the year).

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

Funding is *typically deposited* into the employee's HSA/HRA by the end of January of each year.

* Employees who are not eligible to participate in an HSA per IRS rules will receive funding in a Health Reimbursement Account (HRA) instead. To review HSA eligibility please see the requirements in the "What is an HSA" section of this ebook.

❖ Consumer Driven Health Plan (CDH)

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

Highlights of the CDH Plan

- Preventive services, when billed by Provider as Preventive, covered 100% in-network.
- Some services received for a *copay* (Primary, Specialist, Urgent Care, Emergency Room). Review the full Benefit Summaries provided by the UnitedHealthcare Plan for a detailed list of services, costs, and exclusions.
- Some services subject to the annual *deductible/co-insurance* (Outpatient or inpatient services/ procedures).
- Behavioral Health/Substance Abuse out-patient services first 20 visits covered at no cost, then $25 copay.
- Diagnostic tests at a participating freestanding facility capped at $100 per test.
- An annual basic eye exam at no cost at a participating optometrist.
- The discount dental plan (Solstice) included at participating dental providers.
- **NO OUT OF NETWORK COVERAGE** (you are covered when traveling for a medical emergency).

How many family members must satisfy a deductible?

Once any combination of family members has met the family deductible, all insureds will be deemed to have met their deductible. **Note: No one individual can be charged more than his/her individual annual deductible.**

How many family members must satisfy coinsurance?

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

The following chart compares the major features of the CDH plan:

Coverage	CDH PLAN
Preventive Care at no cost (must be billed as Preventive)	Yes
Preventive Prescriptions at no cost*	Not Applicable
Out of Network Coverage	No

Copays	PCP $25 Specialist $50 Urgent Care $50 Emerg Room $250
Pharmacy (30 & 90-Day Supply)	Generic $7/$14 Preferred $25/$50 Non-Pref $45/$90 UHC Specialty $75/ 30 Day Only
Annual Deductible	$1,300/$2,600
Coinsurance/Copays	$1,500/$3,000
Max out of Pocket**	**$2,800/$5,600**
****Prescriptions Do Not Apply to Annual Deductible & Coinsurance and are subject to a Prescription Out of Pocket Maximum**	**$3,000/$6,000 Out of Pocket Max**
WellBeing Program	Employee and enrolled Spouse/DP can earn up to $300 each per year. UHC-Rally Program

IMPORTANT: The Consumer Driven Health Plan is only eligible for a Medical Flexible Spending Account

❖ Flexible Spending Accounts

Flexible Spending Account – Health Care

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

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

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

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

Coordination with the County's HRA

All medical, prescription, dental and vision claims will automatically be paid out of the Medical FSA first. Claims must be incurred between January 1 and December 31 and submitted to TASC by March 31st of the following year. *Under IRS regulations, unclaimed amounts are forfeited*. For this reason, we encourage you to be conservative in your estimates and only consider expenses you know you will incur in the plan year.

When the Health Care FSA Account is exhausted, medical, prescription, dental and vision claims will automatically be paid out of any available funds in the HRA Account.

Types of FSA's

HEALTH CARE FSA	DEPENDENT DAY CARE FSA
Health care expenses not reimbursed by your insurance plan may be eligible for reimbursement using your FSA Medical Account, including but not limited to: • Eligible medical, prescription, dental and vision copays, deductible, and/or co-insurance • Some over-the-counter drugs • Eyeglasses and contacts • Dental expenses such as orthodontia	Dependent day care expenses, whether for a child or older*, include any expenses that allow you to work, such as: • Day care services (child under 13, or adult) * • In-home care • Nursery and pre-school • Summer day camps * Eligible dependents are your dependent children under age 13 or your disabled dependent (child or adult) that is incapable of caring for him/herself. ***Children 13 yrs. or older are NOT eligible dependents for the Dependent Care FSA.***

Please refer the TASC Account Guide for plan details and rules:

https://www.broward.org/Benefits/Plans/Pages/FlexibleSpendingAccount.aspx

Non-reimbursable Expenses

The following is a *partial listing* of services or expenses that are not reimbursable under a Medical FSA. For more information, please contact TASC.

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

Proof of Medical Necessity

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

- Acupuncture

- Massage therapy
- Drugs that may be used for non-cosmetic reasons (e.g., Retin A, or that promote hair growth)
- Drugs or treatment programs for smoking cessation that have been prescribed for a specific life-threatening medical condition (e.g., emphysema)
- Drugs or treatment programs for weight loss that have been prescribed for a specific life-threatening medical condition (e.g., diabetes or heart disease)

Contribution Limits
The medical FSA pre-tax contribution limit will be based on IRS Guidelines. If you and your spouse each have a Medical FSA, you can each contribute up to the limits set by the IRS.

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

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

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

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

❖ Important Health & Pharmacy Plan Features

Open Access
Both County's health plans are Open Access which means members do not to select a Primary Care Physician (PCP) and NO referral is needed to see most network specialists. However, members are encouraged (but not required) to see a primary care or family medicine physician for routine care. Physicians listed under the Primary Care and Family Medicine category on MyUhc.com have a lower copay/cost than physicians listed as a Specialist. Here are some good reasons to have a Primary Care Physician:

- Often coordination of medical treatment and/or pharmacy prescribing is greatly hindered when important and essential medical records are not maintained in one centralized location. For example: during an emergency, your Primary/Family Care provider and/or family members would not be able to give complete medical history information to the treating emergency room physician.
- Another example would be if your specialist wanted to confer with your Primary/Family Care provider about prior medical treatments or history, your Primary/Family Care provider would be able to provide complete information. When self-referring to specialists, it is recommended that you

request your medical reports be sent to your Primary/ Family Care provider for the reasons described above.

Prior Authorizations

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

1. Hospital confinements and Skilled Nursing Facility confinements
2. Non-emergency transportation; air ambulance
3. All non-emergency outpatient hospital services, including but not limited to, surgical, laboratory, and diagnostic, except mammograms.
4. Non-emergency wound care procedures
5. Inpatient rehabilitative services
6. Outpatient rehabilitative services at a hospital
7. Durable medical equipment
8. Prosthetics, braces, hospice
9. Pain management
10. CPAP machine (see Sleep Studies benefit).

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

Exclusions & Limitations

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

Pharmacy Features

Pharmacy benefits are provided under the County's self-insured health plan. UnitedHealthcare plans (CDH and HDHP Out of Network Plan) utilize Optum Rx, and the plans include:

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

Prescription Costs

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

PHARMACY COVERAGE – CONSUMER-DRIVEN HEALTH PLANS (CDH)		
TIER	**30-DAY SUPPLY*** (AT PARTICIPATING RETAIL PHARMACY)	**90-DAY SUPPLY** (AT PARTICIPATING RETAIL PHARMACY OR BY MAIL SERVICE)
Generic Preferred	$7	$14
Brand Preferred	$30	$60
Non-Preferred	$45	$90
Specialty Pharmacy	$75	Not available
Dispense-as-Written (DAW1)	$75	$150
For the Optum Rx Preventive Drug List, Formulary, and Formulary Exclusions, go to https://www.broward.org/Benefits/Plans/Pages/UHC%20CDH%20and%20Rx.aspx		

**Maintenance medication: It is recommended that you get a 90-day supply for maintenance medication.*

PHARMACY COVERAGE – HIGH DEDUCTIBLE HEALTH PLAN (HDHP - OON)	
Preventive Prescription Drugs – *per the Preventive Drug List:	100% Coverage – No copayment or coinsurance
All other drugs	1. Member pays 100% of discounted drug cost, which is applied to combined health and pharmacy deductible.
	2. After the annual deductible is met, the member pays 20% coinsurance, County pays 80% of the discounted drug cost.
	3. After the annual Out-of-Pocket Maximum is met, prescription drugs are paid in full (100%) by the Plan.
*For the UnitedHealthcare's Preventive Drug List, Formulary, and Formulary Exclusions, visit: https://www.whyuhc.com/broward/pharmacy-plans	

Preferred Medication List (FORMULARY)

A Preferred Medication List (Formulary) is the list of prescription drugs covered under a health plan.

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

The drug formulary is created, reviewed, and updated annually by panels of doctors and pharmacists. Your plan's Preferred Medication List (Formulary) contains a wide range of preferred generic and

preferred brand-name drugs that have been approved by the Food and Drug Administration (FDA). Your doctor can use this list to choose medications for you while helping you save the most money by utilizing formulary drugs.

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

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

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

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

BRAND VERSUS GENERIC MEDICATIONS

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

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

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

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

PREFERRED VERSUS NON-PREFERRED MEDICATIONS

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

SPECIALTY PHARMACY MEDICATIONS

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

PHARMACY NETWORK PROVIDERS

Most pharmacy chains are participating providers. You must present your UHC ID card when you use your benefit at any participating national chain.

PRIOR AUTHORIZATION PROGRAM

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

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

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

MEDICATIONS WITH QUANTITY LIMITS

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

When you go to the pharmacy for prescription medication with a quantity limitation, your cost will only cover the quantity allowed by the plan. You may still purchase the additional quantities, but you will pay the full cost. If your doctor feels there is a medical necessity to override the quantity limit, have them submit the request with medical documentation to Optum Rx Clinical Prior Authorization department.

HEALTH PLAN COMPARISON

HDHP OON Plan

- Lower payroll deduction
- First $ health & Rx payment at provider's negotiated rates (no copays)
- Higher out of pocket max
- Out-of-Network Benefit

CDH Plan

- Higher payroll deduction
- Some health copays
- Rx copays
- Lower out of pocket max
- NO Out-of-Network coverage.
- NO HSA/HRA, only Medical FSA.

❖ Opt-Out-of-Health Insurance (Waiver Credit)

The County offers a Waiver Credit to those benefit eligible employees who have other **eligible** group health insurance. To receive the Waiver Credit, proof of the other eligible group health insurance must be ***provided every year***.

Employees who waive health coverage AND provide proof of other eligible health coverage receive **taxable earnings**:

Full-time Employee	$100/Pay Period
Part-Time (PT20) Employee	$50/Pay Period

Other eligible plans are other employer group plan, Medicare, Medicaid, Tricare or Veterans.

Please note, Health Care Exchange and Medi-Share plans NOT eligible for waiver credit.

If you are waiving the health coverage you MUST complete & send the Proof of Other Group Health Ins. Form which can be found here:

https://bc-net/forms/Pages/formsNew.aspx

Examples of proof of other eligible group health insurance:

- A copy of your insurance card (must show a date on the card proving coverage in the current year).
- Insurance coverage letter from your group insurance carrier specifying coverage in the current year.
- A letter from your spouse/domestic partner's employer that states you are enrolled for the current year benefit year.
- An open enrollment confirmation statement for group health insurance specifying elections for the current year.
- Medicare card showing coverage for Part A and Part B.
- Veterans can provide a letter or other documentation from Veterans Services.
- Tricare members can provide a copy of their uniformed service ID card.
- Medicaid

Under an eligible opt-out arrangement, Medicaid members can provide a copy of documentation showing current coverage and covers the period when the coverage would start or upon new hire eligibility.

Employees who take no action to waive health coverage during open enrollment and/or do not show proof of other eligible health coverage will not receive the Waiver Credit.

Employees enrolled in a Health Care Exchange plan, Individual Plan, Co-Op plan, Health Care Sharing plan, etc., are not eligible to receive the Waiver Credit.

DENTAL INSURANCE

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

- Dental HMO HS195 Plan offered by Humana/CompBenefits
- Dental PPO offered by UnitedHealthcare

Dental insurance is a pre-tax plan; elections are irrevocable for the plan year and cannot be changed unless the change is due to a relevant qualifying event.

❖ DHMO – HUMANA

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

Orthodontic coverage
Orthodontia treatment – Covers adults and children. Member pays the discounted fee. See Humana Dental Plan Summary HS195MB for details at Broward.org/benefits.

How to use this plan:
Your primary dentist will provide all your routine dental care. When you visit your primary care dentist, simply present your Humana/CompBenefits identification card. You may be required to pay a set fee for some services provided by your primary care dentist. If the dental services provided are not listed, you may be eligible for up 25 % discount. Members may contact participating providers to determine if any discounts apply. Should you require the services of a specialty dentist, you can choose any in-network specialty dentist under the Humana/CompBenefits HS195 DHMO Dental Plan. All in-network specialists will provide services at the fees listed in your schedule of benefits. The participating dentist bills the fees

at the time of service, so there are no claims forms to file. You pay your dentist directly, if applicable. To find participating dentists in your area, go to Broward.org/Benefits/Pages/DentalPlanDHMO.

Website services include:

- View DHMO Summary of Benefits
- View Plan Booklet
- View claim history
- Select a new PCD/locate provider and facilities.
- Request a new ID card.
- Print a temporary ID card.

To find participating dentists/specialists in your area for the DHMO dental Plan, visit: Broward.org/Benefits and select Dental - HMO or log onto your secure account at https://www.humana.com/logon/

Be an educated consumer! Ask your dentist to provide you a pre-treatment plan. This is an estimate that is processed prior to services being rendered, both the member and the provider receive a copy indicating to both parties the exact amount of benefits payable to the dentist and the exact amount the member will have to pay out-of-pocket.

❖ PPO – UNITEDHEALTHCARE

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

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

Benefits include:

- Large network in Florida and nationally
- 3rd regular cleaning at no cost
- Max Builder Program
- No waiting periods for major services and orthodontia
- On-site Healthcare Advocates

Orthodontic coverage
Child orthodontia – Covers children through age 19 (recommend banding by age 17). The plan pays 50 percent (no deductible) of the covered orthodontia services, up to $ 1,000-lifetime orthodontia maximum.

Consumer MaxMultiplier
You can earn up to $500 to add to your $1,500 annual maximum. The Consumer MaxMultipler program rewards you for keeping up with your dental care by adding dollars to next year's annual maximum. For more information, please visit https://www.broward.org/Benefits/Plans/Pages/DentalPPO.aspx and click on Max Multipler where you will find the detailed program rules.

How to use this plan:
When visiting your dentist (in-network or out-of-network), give them your UnitedHealthcare ID card to identify yourself as a PPO dental member.

A "participating" network dentist will bill the dental provider for reimbursement up to their negotiated contract rate; the dentist will then bill the difference to you. (Most out-of-network dentists will also bill your dental provider, but you must request this service; otherwise, you pay the bill, and the dental provider reimburses you the allowable amount based on your plan when you submit the claim).

To find participating dentists/specialists in your area for the PPO dental Plan, visit:

https://www.broward.org/Benefits/Plans/Pages/DentalPPO.aspx

Please note the PPO dental network name is National Options PPO 20

❖ Dental Plans Highlights

SERVICES	DHMO Humana/CompBenefits	PPO DENTAL UnitedHealthcare
Deductible	No	$50 Individual / $150 Family Waived for preventive services; excludes orthodontia
Annual reimbursement benefit maximum	N/A - Member pays amount listed on Fee Schedule for covered services	$1,500 in-network $1,000 out-of-network
Out-of-network benefit / reimbursement	No / None	Yes / Based on usual & customary
Basis for in-network reimbursement	N/A – Member pays charge on Fee Schedule plus any applicable lab costs, and additional costs for precious (high noble) and semi-precious (noble) metal	PPO contracted fee
Waiting period for major services	None	None
Waiting period for orthodontia	None	None
Primary Care Dentist requirement	Yes	No

Routine Cleanings / Preventive (Type 1)	N/A - Member pays the amount on Fee Schedule for all services	Deductible waived
Age limit on orthodontic services / Orthodontic reimbursement benefit (per person)	None / N/A - Member pays the amount on Fee Schedule for all services	Covers children through age 19 (recommend banding by age 17) Plan pays 50% (no deductible) of the covered orthodontia services, up to: $ 1,000-lifetime orthodontia

Be an educated consumer! Ask your dentist to provide you a pre-treatment plan. This is an estimate that is processed prior to services being rendered, both the member and the provider receive a copy indicating to both parties the exact amount of benefits payable to the dentist and the exact amount the member will have to pay out-of-pocket.

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

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

VISION INSURANCE – HUMANA

The County offers a comprehensive pre-tax vision plan, and elections are irrevocable for the remainder of the plan year. They can be changed only if the change is due to a relevant qualifying event.

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

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

Carefully review the vision plan benefit chart in Humana's vision enrollment brochure. You are encouraged to read the information provided by the carrier. If you have questions, please call Customer Service number.

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

❖ VISION PLAN HIGHLIGHTS

Please visit https://our.humana.com/broward-county/ to review the Vision Summary of Benefits.

* Additional terms, conditions, limitations, and/or exclusions may apply. Carefully review the vision plan benefit chart in the vision carrier's brochures. You are encouraged to read all information provided by the carrier. If you have questions, please call the carrier's Customer Service.

❖ IMPORTANT TO REMEMBER:

- You can log on to carrier's website to print off your personalized ID card.
- At a participating network provider, you will receive a 20% discount on an additional pair of eyeglasses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that Humana Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. **Not all providers offer this discount**. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.
- Discount does not apply to EyeMed Provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers.
- Certain brand name vision materials may not be eligible for a discount if the manufacturer imposes a no discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.
- Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: *First American Administrators, Inc. Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111*

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

SECTION IV – SUPPLEMENTAL BENEFITS – AFTER TAX

Broward County offers many additional, voluntary and employee paid plans such as life insurance, long term disability, income protection plans, and legal insurance. Since these are after-tax plans, coverage can be stopped at any time by submitting completed forms to Employee Benefit Services. Some re-enrollments are subject to medical underwriting.

LIFE INSURANCE – THE STANDARD

Life insurance can help you provide for your family when you can't. The County provides Group Additional Life and Accidental Death and Dismemberment (AD&D) insurance.

You are covered under Basic Life insurance if you are a benefit eligible employee. A benefit eligible employee is:

1. An active Broward County employee who is regularly working at least 20 hours each week

❖ Basic Life Insurance

All benefit-eligible employees are provided with $50,000 in life and AD&D by the County at no-cost effective on the first day of employment.

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

❖ Optional/Additional Term Life Insurance

You may also become insured under the optional/additional group policy. You may apply for term Life Insurance in multiples of $25,000, from $25,000 to $300,000 with a **Guarantee Issue Amount of $150,000 if you apply when it is first offered to you.** For any benefit more than the Guarantee Issue amount you will be required to undergo Evidence of Insurability.

If you decide to not take the optional/additional life policy when you first become benefits eligible you can apply later, however, you will be subject to Evidence of Insurability.

During the annual open enrollment period certain Evidence of Insurability requirements will be waived with respect to optional/additional life insurance. If you are insured for an amount of optional/additional life insurance, you can increase your coverage by $25,000 every year, but not to exceed the plan maximum of $300,000.

Increases in coverage outside of the Annual Open Enrollment period or increases greater than $25,000 during the Annual Open Enrollment, are subject to medical underwriting.

This insurance cannot be continued under COBRA or Domestic Partner Continuation of coverage. This benefit may be continued after separation of employment through a conversion policy at applicable rates. Contact The Standard for conversion information.

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

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

The beneficiary/ies for employee optional life insurance is/are the same as for basic life insurance. You can change beneficiaries at any time by logging on to The Standard's website, https://www.standard.com/bendes/

If you choose to purchase additional life insurance coverage, you'll have access to competitive group rates, you will also have the convenience of having your premium deducted from your paycheck. **The cost of your premium depends on factors such as your age and the benefit amount. As the employee gets older premiums automatically increase in five-year age bands.**

Frequently asked questions:

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

  Premiums are based on age and the amount of coverage elected. The rates are age banded, and your premium will change on January 1 after you change age bands.

  For example:
  Your birthday is August 29, and you turn 50 – nothing changes until January 1 when your rate would change from the 45-49 age band to the 50-54 age band.

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

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

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

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

  Medical Leaves while under approved ADA Leave (including Disability) - once FMLA is exhausted, length of approved ADA leave up to a maximum of 12 months.
  Non-Medical Leaves – length of approved Leave up to a maximum of 90 days.

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

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

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

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

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

  If your life expectancy is less than 12 months and you qualify for Waiver of Premium, the plan includes an "accelerated benefit" that allows you to receive up to 100 percent of your life insurance benefit before you die. For more information, consult your Certificate of Coverage by visiting https://www.standard.com/mybenefits/broward_county/#

❖ Dependent Life Insurance

If you buy additional life and AD&D insurance for yourself for at least $25,000.00, you may also buy life coverage for your **eligible child(ren**) and/or spouse or registered domestic partner. The maximum amount of coverage you may apply for dependent life insurance is $12,500.00.

Dependent Eligibility criteria:

- **Spouse or Domestic Partner:**

  1. A person to whom you are **legally** married; or
  2. A Domestic Partner means an individual with whom you have completed and registered an affidavit of declaration of domestic partnership.

- **Children:**

  1. Your child(ren) from live birth through the end of the calendar year in which your child reaches age 26 or
  2. Your disabled child(ren) who is continuously incapable of self-sustaining employment because of mental or physical handicap.
  3. Your adopted child(ren)
  4. Your stepchild, foster child, dependent grandchild, and the child of your spouse, if living in your home
  5. A child(ren) living in your home from whom you are the court appointed legal guardian.

If you decide to not buy the spouse/domestic partner life policy when your eligible spouse/domestic partner first become eligible you can apply later, however, your eligible spouse/domestic partner will be subject to Evidence of Insurability.

The premium cost are flat rates, please visit to see current dependent life insurance rates https://www.broward.org/Benefits/Documents/OPTIONAL%20LIFE%20RATES%2001-2020.pdf

IMPORTANT:
Evidence of Insurability is never required for Dependents Life Insurance for your child(ren).
You must request the payroll deduction be discontinued when your last eligible child reaches age 26 at the end of the calendar year. In the event a claim is submitted for a non-eligible dependent, the employee will only receive a refund of excess premium paid retroactive to the beginning of the current plan year.

You must have optional life insurance for yourself *if you want to purchase dependent life coverage for your spouse or registered Domestic Partner and/or your child(ren)*

❖ Hazardous & Occupational Assault Life Insurance

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

- Security Guard
- Park Ranger
- A member of the Amalgamated Mass Transit Union

The amount of the death benefit is $100,000. Contact Employee Benefits Services for more information.

LONG TERM DISABILITY

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

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

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

Important Information:

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

Frequently asked questions:

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

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

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

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

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

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

- **What disabilities are excluded?**

  You are not covered for a disability caused by or contributed to by an intentionally self-inflicted injury while sane or insane. You are not covered for a disability caused or contributed to by war or any act of war. War means declared or undeclared war, whether civil or international and/or any substantially armed conflict between organized forces of a military nature or armed aggression.

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

  No. Premiums are waived while you are receiving LTD benefits, in keeping with plan contract provisions.

- **What are the plan's limitations?**

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

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

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

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

For more information, please visit https://www.standard.com/mybenefits/broward_county/#, here you can find information about the LTD premium and the certificate of coverage.

SUPPLEMENTAL INCOME PROTECTION PLANS (ALLSTATE)

These insurance plans pay benefits for specified medical conditions, treatments, and screenings in addition to benefits provided by the health insurance plans. Active employees can only enroll during the annual open enrollment period. After-tax plans can be cancelled at any time by employee request. However, re-enrollment of some plans may later be subject to medical underwriting.

Newly benefit-eligible employees may enroll during their benefit election period. Plans include:

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

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

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

- **Hospital Indemnity** – When you live your life well-protected, you can focus on the things you love, like family, travel or planning for your future. You don't need to worry about the costs

associated with a hospital stay if the need arises, and Allstate Benefits can help. Hospital Indemnity Insurance pays benefits directly to you for First Day Hospital Confinement, Daily Hospital Confinement, and Intensive Care Unit Confinement. Major medical insurance doesn't always cover everything. Hospital Indemnity Insurance can help pay for leftover costs.

Important Information:

- This insurance is available to benefit eligible employees, their spouses/domestic partners, and dependents children, up to age 26 (if a full-time student aged 30).
- Some coverage is subject to medical underwriting.
- This is an individual plan, not a group plan, so coverage can be continued when employment ends with no change in rates and benefits. Contact the insurance carrier to request the continuation of coverage.
- HDHP plan participants can only enroll in the Base Plan. (Plan 1)

PREPAID LEGAL INSURANCE (U.S. LEGAL SERVICES)

This plan provides benefits for pre-paid legal services such as contracts/agreements, divorce litigation, will writing, child support and more. This benefit is available to benefit-eligible employees, their spouse/domestic partner, and child dependents, up to age 26, of the employee or their spouse/domestic partner.

The plan allows participants to select an attorney from those affiliated with the plan in South Florida or select an attorney out of network.

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

Important Information:

- Newly benefit-eligible employees: Can enroll during their eligibility period.
- This insurance can be stopped at any time; however, it may not be started again until the following open enrollment period for an effective date of January 1.
- Prepaid Legal is a group plan; therefore, coverage can be converted when employment ends, but with different plan benefits and rates. Contact US Legal Services for conversion information.

SECTION VI – SAVING FOR THE FUTURE

Start planning for your future today!

A retirement plan is a valuable benefit of employment. We know that retirement planning is personal, and it's different for each person with different income sources, life situations, saving styles and goals. However, the sooner you start the better off you will be. Used effectively, a deferred compensation plan can deliver a long-term impact on your financial well-being.

Here's a brief overview of what is deferred compensation and the advantages of opening an account with one of the 3 vendors that Broward County partners with.

DEFERRED COMPENSATION

❖ Overview

A deferred compensation plan is another name for a 457(b)-retirement plan, or short for "457 plan". A 457(b) plan allows you to save and invest money for retirement with tax benefits.

What is a 457(b) Plan?

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

You can make contributions as part of your paycheck and in 2025, Broward County offers a match for employees contributing to any of the County's 457 plans. Employees who contribute to any of the 457 plans are eligible for a $2,600 match. You can start your 457 plan (s) anytime, and the amount you contribute per paycheck in 2025 will be matched up to $2,600. The maximum contribution to a 457 is regulated by the IRS and includes the County match portion.

Deferred compensation gives you a significant tax break:

- Contributions to your deferred compensation account are taken from your gross salary before federal withholding taxes are calculated.
- Your deferred compensation contributions do not affect your reported earnings for retirement purposes.
- Social Security taxes are not affected by deferred compensation contributions.
- Your contributions are invested in the investment program of your choice offered by the provider you select.

Without a deferred compensation plan:

- You pay taxes on income before you set any aside for savings or investments.

- You have less money to save or invest after taxes are taken out.
- With a deferred compensation plan, your contributions are made on a pre-tax basis.
- You can contribute more money to your savings/investment plan.

You pay no income taxes on your contributions or investment earnings until you withdraw from the plan, allowing earnings to grow on a tax-deferred basis.

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

For more information, contact the account representative for the selected plan.

Roth 457(b) Plan Option Overview

In addition to the pre-tax contributions, Broward County also permits ROTH contributions which are made on an after-tax basis.

- Contributions options available to employer sponsored 457 plans.
- Roth contributions are made on an after-tax basis but can be withdrawn tax-free if IRS requirements are met.

	Pre-Tax	ROTH
Contributions	Made before taxes; in other words, no paid taxes on contribution amount.	Made after taxes; NO current tax benefit.
Withdrawals	Taxed as ordinary income	Qualified distributions are tax-free*

*Distribution of Roth assets are qualified if a period of five(5) years has passed since January 1 of the year of the first Roth contribution, and you are at least 59 ½ years old (or disabled or deceased)

What is a Roth 457(b) plan?

A Roth is a contribution option within a 457(b) plan. In a traditional 457(b) plan, participants can make pre-tax contributions that are then taxed along with the earnings in retirement. Roth 457(b) contributions differ because they are made after-tax and are not taxed when the assets are withdrawn. Earnings may also be withdrawn tax-free if certain criteria are met.

How does a Roth 457(b) plan work?

Roth contributions and associated earnings can be withdrawn tax-free in retirement if the requirements for a "qualified distribution" (also known as withdrawal) are met. If the Roth contribution option is available in your 457(b) plan, you can designate a portion or all your contributions to the plan as Roth.

When can Roth assets be withdrawn from a 457(b) plan?

Distributions of Roth assets (contributions and associated earnings) are qualified if:

- A period of five years has passed since January 1 of the year in which the first contribution (including roll-ins) was made to your Roth account.
- You are at least 59½ years old (or disabled or deceased).

If the requirements for a qualified distribution are not met, and the assets are not rolled into another eligible plan, the earnings portion of any distribution will be taxable.

What are the benefits of Roth contributions?

In addition to potentially tax-free distributions in retirement, making Roth contributions to your 457(b) plan has the following benefits:

- **Higher After-Tax Contribution Limits Than Roth IRAs** — 457(b) plans allow for greater after-tax savings. While Roth IRAs only allow a contribution of up to $7,000 for 2024, Roth contributions in a 457(b) include both employee and employer contributions with a limit of $23,000 in 2024.
- **Eligibility at All Income Levels** — Unlike Roth IRAs, everyone with earned income is eligible to make Roth contributions to their employer's 457(b) plan.
- **Tax Planning and Flexibility —** Having both pre-tax assets and Roth assets available in retirement can be a valuable benefit, allowing you to choose the source of funds most advantageous to your situation at the time of the distribution.

Normal and Catch-Up Contributions

For 2024, the normal deferral amount allowed is $23,000; if over age 50, there is a Catch-Up amount allowed of $7,500.

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

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

Required Minimum Distributions

Required minimum distributions (RMDs) are the minimum amounts you must withdraw from your retirement accounts each year. You generally must start taking withdrawals from your retirement plan accounts when you reach age 72 (73 if you reach age 72 after Dec. 31, 2022).

Account owners in a workplace retirement plan can delay taking their RMDs until the year they retire.

Beginning in 2023, the SECURE 2.0 Act raised the age that you must begin taking RMDs to age 73. If you reach age 72 in 2023, the required beginning date for your first RMD is April 1, 2025, for 2024.

If you reach age 73 in 2023, you were 72 in 2022 and subject to the age 72 RMD rule in effect for 2022. If you reach age 72 in 2022,

- Your first RMD is due by April 1, 2023, based on your account balance on December 31, 2021, and
- Your second RMD is due by December 31, 2023, based on your account balance on December 31, 2022.

If you don't take any distributions, or if the distributions are not large enough, you may have to pay a 50% excise tax on the amount not distributed as required.

For more information visit https://www.irs.gov/retirement-plans/retirement-plan-and-ira-required-minimum-distributions-faqs

❖ Vendors

The County offers Deferred Compensation plans through three vendors:

	BRIGHTHOUSE	Mission Square	NATIONWIDE
Type of Investments	Annuity	Investment	Investment & Annuity
Loans (Borrow from your own acct.)	No	Yes	Yes
Unforeseen Emergency Withdrawal	Yes	Yes	Yes
Managed Accounts	No	Yes	Yes
Self-directed Accounts	No	Yes	Yes
Roth IRA (after-tax)	No	Yes	Yes

Brighthouse

Brighthouse Financial (formerly MetLife) offers a fixed annuity 457 Deferred Compensation plan. Coastal Wealth is the agency assigned by Brighthouse Financial to provide account management services.

For more information contact Delia Veliz, Relationship Manager, at dveliz@financialguide.com. Or call Delia at 954-434-0351.

Mission Square

ICMA-RC is now MissionSquare and has new features to assist in securing the financial future of Broward County employees. New features include Loans, Vantagebroker, Guided Pathways - Advisory Services and ROTH 457 options.

Review the new features below and log in to MissionSquare to learn about all the new plan benefits.

For more information visit https://www.broward.org/WellBeing/Pages/MissionSquare.aspx

Nationwide

This is another Broward County deferred compensation vendor. Here's a list of Nationwide 457 Deferred Compensation Plan Enhancements

- Loans - Borrow from your account.
- Nationwide ProAccount - Personalized management from Wilshire
- Roth 457 contributions
- Schwab Personal Choice Retirement Account

Learn more about your options with the new enhancements to the Nationwide 457 Deferred Compensation plans by attending one of the many webinars available. See the link above.

For more information visit https://www.broward.org/WellBeing/Pages/Nationwide.aspx

FLORIDA RETIREMENT SYSTEM (FRS)

The Florida Retirement System (FRS) is the retirement plan offered to eligible employees in full-time, PT20 and PT19 positions. Employees have an option of two plans to choose from with the first 8-months of eligibility and must meet vesting requirements for either plan. The FRS was created in 1970 and established by the Florida Legislature and is a contributory system that all eligible County employees (members) **must** participate in. Contributions are paid by both members and the County and then transferred to FRS for administration.

Retirement benefits are provided to eligible employees based on the following:

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

❖ Plan Options

Below is a comparison of FRS retirement pension and investment plan:

	INVESTMENT PLAN	PENSION PLAN
VESTING SCHEDULE FOR EMPLOYER CONTRIBUTIONS	One (1) year	• Six years for members first employed by an FRS employer prior to July 1, 2011 • Eight years for members first employed by an FRS employer on or after July 1, 2011
BENEFIT PAYABLE	Your account balance at the time of termination. Multiple payout options are available, including rollovers, lump sum distributions, distributions on demand, guaranteed annuity payments, or any combination of the above distribution options.	• Your lifetime monthly benefit calculation is based on your average final compensation multiplied by the years of creditable service multiplied by the benefit accrual rate. A monthly payment is the only distribution option (except under DROP).
DEATH BENEFITS	You can name anyone as your beneficiary.	• Your beneficiary designation may be limited. Only a beneficiary who qualifies as a joint annuitant (spouse, dependent children, etc.) is eligible for a continuing lifetime benefit. You may name any beneficiary to receive a time

	INVESTMENT PLAN	PENSION PLAN
		certain monthly benefit if you should die within 10 years of retirement.
EARLY RETIREMENT BENEFITS	Your account balance is payable at any age after meeting the vesting requirement (tax penalties may apply). You will not be eligible for County leave payout and benefits as a retiree unless you meet the normal Pension retirement requirement based on your FRS employment date.	• Your benefit is either reduced or not immediately payable if you choose "early retirement" as defined by the FRS.
NORMAL RETIREMENT	Your account balance is payable at any age after meeting the vesting requirement (tax penalties may apply). You will be eligible for County leave payout and benefits as a retiree if you meet the normal retirement requirement for the Pension Plan based on your FRS employment date.	If first employed by an FRS employer prior to July 1, 2011: • Regular Class: Age 62 with six years vesting or 30 years of service, regardless of age. • Special Risk: Age 55 with six years vesting or 25 years of service, regardless of age. If first employed by an FRS employer on or after July 1, 2011: • Regular Class: Age 65 with eight years vesting or 33 years of service, regardless of age. • Special Risk: Age 60 with eight years vesting or 30 years of service, regardless of age.
REEMPLOYMENT AFTER RETIREMENT	You are considered retired by FRS once you terminate FRS-covered employment and request a distribution (including a rollover) from your FRS Investment Plan account. A distribution may not be issued until you have been terminated for three full calendar months (Exception: if you have met the normal retirement requirements of the Investment Plan you may receive a one-time distribution of up to 10 percent of your account balance after one full calendar month). If you are re-employed with an FRS employer prior to receiving a distribution of your benefits, your distribution will be cancelled, and you will not be considered to have terminated/retired.	You become a Pension Plan retiree once you have terminated employment with all FRS-participating employers, established an effective retirement date through the application process, and cashed or deposited a benefit payment. You are considered retired as of your effective retirement date. If you participate in the Deferred Retirement Option Program (DROP), your effective retirement date is your DROP begin date. The termination and reemployment limitations apply to you beginning the calendar month after your termination date. If you return to FRS employment within **6 calendar months** Your retirement will be

	INVESTMENT PLAN	PENSION PLAN
	You must wait six calendar months after taking a distribution before you return to work in any position with an FRS- covered employer. If you return to work within 6 calendar months of any distribution, you will be required to repay the distribution you received. If you return to work during calendar months 7 to 12, no additional Investment Plan distributions are permitted until you terminate employment or complete 12 calendar months of retirement.	voided and you will be required to repay all the Pension Plan benefits you have received, including any DROP payout. If you return to FRS employment during **calendar months 7 to 12,** your Pension Plan benefits will be suspended for each month you are employed during this period (you must notify the Division of Retirement of your employment). If your benefits are not suspended timely, you and your employer will be required to repay benefits you should not have received. If you return to FRS employment **after 12 calendar months,** you will not be required to repay any prior benefits and you will continue receiving benefits from the Pension Plan without interruption.
RENEWED MEMBERSHIP	You are eligible for renewed FRS membership if reemployed on or after July 1, 2017.	You are not eligible for renewed FRS membership.

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

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

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

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

❖ DROP (Deferred Retirement Option)

DROP provides a way for retirees in the Pension Plan to accumulate additional savings while continuing employment for up to 96 months (effective June 2023) beyond their normal retirement date. It is a payout alternative for FRS retirement benefits. Annual leave can also be cashed out upon entering DROP (this income is reported to FRS as earnings and may result in a higher retirement benefit.)

Retirees in the Investment Plan are not eligible to participate in the DROP program.

Note: Enrolling in DROP does not change participants' employment status in any way. Participants may resign and the County may terminate them in the same manner as before DROP participation. Participants my change jobs within the County or even seek employment with other FRS employers during their DROP period.

HOW DOES DROP WORK?

1. You "retire" for FRS purposes at your normal retirement date based on your FRS employment date.
2. You continue to work for a preselected period (up to 96 months).
    a. You may exit DROP at any time, but you may not re-enter if you exit DROP prior to the allowed 96 months.
3. You continue to receive a salary from the County up to the date you preselected to end participation in DROP.
    a. You do not earn additional credit for retirement while participating in DROP.
    b. Your monthly FRS retirement benefit is paid into your DROP account, where it earns interest and is tax deferred while you participate in DROP, instead of being paid directly to you. You do not contribute the mandatory 3% contribution since you are recognized by the FRS as being retired.
4. When your selected DROP period ends you must terminate employment, at which time you will:
    a. Receive your accumulated DROP benefit.
    b. Begin to receive an FRS monthly retirement benefit – in the same amount as determined at retirement – and annual cost-of-living increases (pro-rated and based on years of service prior to 7/11/2011).

Who is eligible for DROP?

All vested members of FRS who have reached normal retirement age based on their FRS employment date or attained 30 years of service in the FRS Pension Plan or 33 years of service for participants entering the FRS on or after 7/01/2011. For the most updated DROP eligibility please visit https://www.dms.myflorida.com/workforce_operations/retirement/publications/retirement_guides and click on DROP.

When can I begin DROP?

A vested FRS Pension Plan member may elect to participate in DROP for a maximum of 96 months following the date on which he/she first reaches normal retirement date (including members who are on a leave of absence or on workers' compensation). A member may apply for DROP up to six months before reaching his/her normal retirement date or DROP deferral date.

A member's normal retirement date is reached:

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

A member who reaches his/her normal retirement date based on years of service before age 57 may defer his/her DROP election.

Eligible members in a regularly established position can elect to participate in DROP for no longer than 96 calendar months beginning any time after their normal retirement date. The provision replaces individual member eligibility windows for electing DROP participation.

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

SECTION VI – RETIREMENT

Who Is a "Retiree"?

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

PENSION PLAN

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

INVESTMENT PLAN

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

Note: If you leave employment under any other circumstances prior to meeting normal retirement requirements, you are NOT considered a "retiree" for County benefit purposes even if you later apply for, and receive, a benefit from FRS.

RETIREE BENEFITS

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

Continuation Coverage for Dependents of Retirees

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

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

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

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

Retiree Health Insurance Premiums

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

Moving Out of Service Area

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

FRS HEALTH INSURANCE SUBSIDY

Retirees enrolled in a health plan (including Medicare) are eligible for a monthly Health Insurance Subsidy (HIS) from FRS of $7.50 (effective June 2023) for each creditable year of FRS service (max 30 years/$225 max monthly benefit and a minimum of $45). FRS will request periodic proof of other coverage. Retirees must apply for the HIS subsidy directly through FRS.

Subsidy application will not be accepted by FRS prior to retirement. FRS will automatically send this form after retirement.

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

NON-RETIREE BENEFITS

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

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

WHAT HAPPENS WHEN I BECOME AGE 65?

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

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

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

MEDICARE D PRESCRIPTION INSURANCE:

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

RETIREE LIFE INSURANCE

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

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

RETIREE CONTINUATION OF OTHER BENEFIT PLANS:

PLAN	CONTINUATION OPTION
HSA-Health Savings Account	Employee owns HSA and takes it with them when they retire or leave County employment. A $5.00 monthly fee will be applied.
HRA-Health Reimbursement Account	After a runout period for pending claims, HRA balance is transferred to a Retirement Health Savings plan at Mission Square (administered by Meritain). Access to this newly established Retirement HSA account will be available late summer of the plan year following year of retirement. Claims for eligible health, prescription, dental, vision and some health premiums can be submitted for reimbursement starting at age 55.
FSA– Medical	May be continued through the end of the calendar year of retirement on an after-tax basis (under COBRA)
FSA– Dependent Day Care	Cannot be continued past termination or retirement date
Personal Income Protection	May be continued through direct bill from carrier.
Legal Insurance	May be continued through direct bill from U.S. Legal Services. Contact U.S. Legal at 1-800-356-5297
Long-Term Disability	Cannot be continued past termination or retirement date

Deferred Compensation Program (457 Plan)	If enrolled in the Deferred Compensation Program (457 plan), contact your provider directly (Mission Square, Brighthouse, or Nationwide) to arrange disbursement of your account. Contact Employee Benefits for assistance at 954-357-6700.

SECTION V – WELLBEING PROGRAMS

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

- Donated Leave Program
- WellBeing Seminars and Health & Benefit Fairs
- Educational Seminars:
    - Deferred Compensation – Group session and one-on-one personal sessions/calls
    - Retirement workshops – FRS, Medicare, Financial Awareness
    - Financial workshops – HSA, Using Health Benefits
    - Health and Mindfulness workshops, etc.
  - Financial Fairs
  - Florida Prepaid College Program
  - Health Fairs with on-site flu shots and additional screenings
  - Higi Health Stations
  - Online wellness program with the ability to earn rewards.
  - On-site Nutritionist
  - On-site Testing -biometric (finger-stick screenings) blood pressure, and more
  - WellBeing Incentive Programs - Disease Management programs, Online Wellness Program, and more
        - Wellness Resource Centers that provide exercise equipment, Yoga sessions
  - County-sponsored / subsidized wellness events within the community (i.e., Corporate Run, Softball League, etc.)

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

•The birth of a child or placement of a child for adoption or foster care;

•To bond with a child (leave must be taken within 1 year of the child's birth or placement);

•To care for the employee's spouse, child, or parent who has a qualifying serious health condition.

•For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job.

•For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Please visit https://www.dol.gov/agencies/whd/fmla/faq to get the answers to frequently asked questions.

IMPORTANT:
To access the Department of Labor's FMLA Poster, go to the BC-Net homepage/HR Corner, click on Employment Policies and Laws, scroll down the list of State and Federal Laws, then click on the link for FMLA.
Please visit https://bc-net/Agencies/humanresources/policies/Pages/policyandforms.aspx to access FMLA forms.

All FMLA questions should be directed to Human Resources/Labor Relations at 954-357-6006 or via email labor_relations@broward.org

DONATED LEAVE PROGRAM

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

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

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

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

Recipients:

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

- accrued sick leave.
- annual leave

- compensatory time
- job basis leave
- personal days

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

DONORS:

- may donate a maximum of 80 hours of sick leave per calendar year.
- may donate a maximum of 80 hours of annual leave per calendar year.
- must have a remaining balance of 160 hours to donate sick leave.
- must have a remaining balance of 80 hours to donate annual leave.
- approved donations are not taxable to the donor.

Application forms are available on the browardemployee.org, or access.browardemployee.org (outside of County) requires log-in and Multifactor Authentication (MFA) under the Forms Tab, Human Resources, Employee Benefit Services Section. Contact the Employee Benefits Services Section for information about donating or receiving donated leave.

Other Provisions:

a. **Sick/Annual Leave Accrual** - Recipients do not accrue Sick or Annual Leave while receiving Donated Leave.
b. **Holiday** - If a designated holiday occurs during the recipient's period of authorized leave, the employee will receive holiday pay which will not be charged against the remaining Donated Leave balance.
c. **Overtime** - Donated Leave will not be counted as time worked for overtime purposes. The maximum amount of Donated Leave that will be approved for any work week is the amount that would bring the hours paid to the recipient's normal work schedule.
d. **Documentation** - Employees applying to receive Donated Leave should provide all required documentation to the agency's Human Resources representative(s) two (2) weeks before exhausting all applicable paid leave when the need is foreseeable, and such prior notice is practicable.
e. **Leave donations** are made on an hour for hour basis. Donations require the approval of the employee's Division Director and the Director of Human Resources or their designee. Donated Leave is not deducted from the donor's leave balance until it is used. Once Leave has been deducted from the donor's account, it cannot be returned to the donor.
f. **Donation of accrued leave** does not affect the donor's earning a Bonus Day were otherwise eligible.
g. **Termination of Eligibility** - Use of Donated Leave may be terminated under any of the following conditions:
    a. The recipient applies for and receives:
        - Retirement benefits from FRS
        - Social Security retirement or disability benefits

- Unemployment compensation
- Accepts other employment during the approved leave.

b. The County determines that the recipient has abused leave, falsified information, or was otherwise not eligible for leave. Employee may be required to repay any previously received leave and be subject to disciplinary action, including termination.

c. A recipient is expected to notify their immediate supervisor immediately when released by their physician and return to work as soon as the medical condition permits. A recipient who fails to advise the County of the physician's release or to return to work in a timely manner will be required to repay any leave received since the effective date of the physician's release and may be subject to disciplinary action, including termination.

h. **Return to work on an intermittent basis** - If a recipient returns to work on a reduced work schedule or an intermittent basis, Donated Leave may be used to supplement pay for time worked, subject to appropriate documentation and approval.

i. **Termination of employment** - Should a recipient's employment terminate for any reason, any remaining unused Donated Leave will not be paid out past the termination/retirement date.

j. **Taxable Earnings** – Donated Leave time is considered regular earnings and taxed as such to the recipient.

FLORIDA PREPAID COLLEGE PROGRAM

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

If you are participating in this program and would like to make your payment through payroll deduction, please contact Payroll Central at PAYROLL@broward.org or 954-357-7190 for a form. The completed form should be submitted to Payroll Central in Room 203 of the Governmental Center.

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

HEALTH AND BENEFIT FAIRS

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

WELLNESS SEMINARS

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

WELLNESS RESOURCE CENTERS

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

❖ Higi Health Stations

Knowing your numbers can save your life. The County, through UnitedHealthcare, has installed several higi health stations at County work sites for employees to check and track their blood pressure, pulse, weight, and body mass index. Higi can connect to your mobile device and allows you to track your activity. Plus, you can share your information with your physician or healthcare provider. Currently, Health Stations can be found at the following locations:

- Governmental Center - 115 S. Andrew Ave, FT Lauderdale
- Government Center WEST - 1 University Dr, Plantation
- Transit Copans - 3201 W. Copans Rd, Pompano
- Water Wastewater - 2555 W. Copans Rd, Pompano
- Traffic Engineering - 2300 W. Commercial Blvd., Ft Lauderdale
- Port Everglades - 1850 Eller DR, Ft Lauderdale
- Transit Ravenswood - 5440 Ravenswood Rd, Dania Beach
- Edgar Mills Center - 900 NW 31st Ave, Ft Lauderdale
- Aviation Admin - 2200 SW 45th Street, Dania Beach
- Aviation Maintenance - 3400 SW 2nd Ave, Dania Beach
- BARC - 325 SW 28th Street, Ft Lauderdale33315

❖ Nutritionist

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

WELLNESS PROGRAMS

The County's health plans are designed to encourage healthy lifestyles and engage employees in actively managing their health care. Managing chronic, long-term diseases by following medical protocols to keep the diseases under control can help the member live a more healthful and productive life.

❖ Disease Management Program

The Disease Management program managed by our health insurance carrier UnitedHealthcare focuses on the following six disease states:

1. Asthma
2. Chronic Obstructive Pulmonary Disease (COPD)
3. Congestive Heart Failure (CHF)

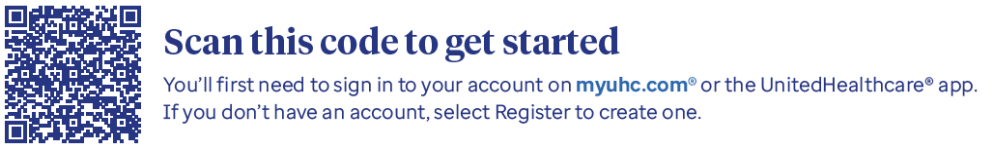
4. Coronary Artery Disease (CAD)
5. Diabetes
6. Hypertension

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

❖ Online WellBeing Program

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

- Health Assessment
- Custom made fitness and nutrition plans.
- Charts to track your progress.
- Wellness and WellBeing webinars and podcasts
- Mental Health and access to Calm Health



- Community Connection through RALLY
- Real Appeal – Online weight and healthy lifestyle program
- Ability to earn rewards by logging on and completing goals and/or downloading workout data from many devices.

Access your wellness tool by logging into your secure account through UnitedHealthcare (myuhc.com) web portal.

❖ Tobacco Cessation Assistance

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

SECTION VII – EMPLOYER NOTICES

Employers who offer group health plans are required to distribute several annual notices to maintain compliance. Here are the notices:

HIPAA Special Enrollment Rights

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. and provide supporting documentation. (Within 60 days of the birth/placement for adoption).

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

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

Broward County
Human Resources Division/Employee Benefit Services Section
115 S. Andrews Avenue, Room 514
Fort Lauderdale, FL 33301

Phone: 954-357-6700

Email: benefits@broward.org

For a complete list of the employer notices please visit
https://www.broward.org/Benefits/Pages/Notices.aspx

there you will find the following:

- ✓ COBRA General Notice
- ✓ Domestic Partners and Over Age Dependents
- ✓ Health Insurance Marketplace
- ✓ Notice of Privacy Practices – Health Plan
- ✓ Medicaid CHIP
- ✓ Medicare Part D Prescription Credible Coverage
- ✓ Privacy Statement (HIPAA)
- ✓ Social Security Number Collection
- ✓ Special Enrollment
- ✓ Termination of Benefits
- ✓ Plan Sponsor
- ✓ Uniformed Services Employment & Re-Employment Rights Act (USERRA)

SECTION VIII – GLOSSARY

INSURANCE TERMS

- **Premium** –The amount an employee pays per pay period for health insurance.
- **Balance Bill** –The difference between the amount charged by an out-of-network provider for a covered health service and the amount a member's health plan (insurance) pays. Out-of-network providers may balance bill members for these costs.
- **Consumer-Driven Health Plan (CDH):** A health plan with a higher premium and some services for a fixed copay and some services subject to an annual deductible and, when met annual coinsurance.
- **Copay** –A fixed dollar amount a member pays for covered health services under a Consumer Driven Health plan, such as a doctor's visit or prescription.
- **Coinsurance** – The sharing of expenses for Covered Services between the Insurance Plan and the Member. Coinsurance is expressed in a percentage rather than a dollar amount.
- **Deductible** – The amount a member must pay before Insurance Plan makes any payment toward Covered Services subject to the annual deductible.
- **Health Reimbursement Account (applies to HDHP Plans if not eligible for an HSA):** A Health Reimbursement Account (HRA) is a County funded pool of money available at the beginning of the year*, or prorated upon benefit eligibility, to pay eligible health, pharmacy, dental and vision care expenses for you and any enrolled dependent(s)** which have not been previously reimbursed by your plans, such as copayments, coinsurance, and deductible.

  * Subject to completion of the 2021 Engagement Incentive. See Health Reimbursement Account (HRA) section for details.

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

- **Health Savings Account (applies only to HDHP Plans):** Health Savings Accounts (HSAs) are like personal savings accounts, but the money in them is used to pay for qualified health, pharmacy, dental, and vision care expenses. You – not your employer or insurance company – own and control the money in your Health Savings Account. The money you deposit into the account is not taxed, and it is not taxed when used to pay for qualified health care expenses (as defined by the IRS) for dependents claimed on your income tax. To be eligible for an HSA, you must be enrolled in a high deductible health plan (HDHP).
- **High Deductible Health Plan (HDHP):** A health insurance plan with lower premiums and higher deductibles than a traditional health plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible).
- **In-Network** –A group of doctors, hospitals, pharmacies, and other providers who contract with the insurance companies and provide services at negotiated rates.
- **Maximum Out of Pocket:** A maximum out-of-pocket expense is the "maximum" amount of money you will be responsible for paying for covered health services that are subject to a deductible and

coinsurance before the plan pays 100%. (100 percent level based on contracted rate In-Network and usual and customary for Out-of-Network.)

- **Out-of-Network** –A group of doctors, hospitals, pharmacies, and other providers who do not contract with the insurance companies and do not provide services at negotiated rates. Members pay more out of pocket due to higher deductible and Out of Pocket limits, and no contracted provider rates. Providers may balance bill even after the out-of-network, out-of-pocket maximum is reached.
- **Out-Of-Pocket Maximum** –The maximum annual out-of-pocket amount a member pays before the health plan (insurance) pays 100% of covered health services. For out-of-network services, providers may balance bill even after the out-of-network, out-of-pocket maximum is reached.
- **Participating Provider:** Individual physicians, hospitals, facilities, and other healthcare providers who have a contract to provide services to its members at a negotiated discounted rate.