Embracing Excellence in Employee Benefits

Hardee County
FLORIDA

Acentria Insurance

2025 BENEFITS GUIDE

Table of Contents

Welcome to Open Enrollment

Hardee County BOCC strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is the period each year when you can make changes to your benefits. This guide will outline all of the different benefits Hardee County BOCC offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on 10/1/2025. If you have any questions about the benefits outlined in this guide, please feel free to contact the Acentria Public Risk Team (page 32).

PLAN CHANGES FOR 2025

This year, the medical carrier will be changing from United Healthcare to PRM/Florida Blue. BlueOptions HDHP (HSA) 05180/05181 will be the plan option for the 2025 year.

WHEN TO ENROLL

Education sessions will take place July 21, 22 and 23 at 9:00, 11:00, 1:30 and 3:00 (each day).

Open enrollment begins July 21st and continues through August 1st.

The benefits you choose during open enrollment will become effective on 10/1/2025.

Welcome to Open Enrollment

We're working hard at Hardee County BOCC to bring you a wide range of benefits that you can take full advantage of. These carefully selected programs are designed to support your well-being and help you become the best version of yourself.

KNOW YOUR BENEFITS!

Making informed decisions about your benefits takes thoughtful planning. By choosing benefits that offer the best care and coverage, you can maximize their value while minimizing their impact on your budget. It's important to approach benefit selection as carefully as you would any major purchase.

All benefits outlined in this guide operate on a calendar year basis. This means your benefits—including deductibles, co-pays, co-insurance, out-of-pocket costs, and carrier payments—reset every January 1st.

The plans you select during Open Enrollment or as a newly eligible employee will remain in effect until 9/30/2026. Changes to your plans can only be made if you experience a qualifying life event.

Pre-Tax Savings - Medical, dental, and vision plans are part of a Section 125 Cafeteria Plan, allowing you to pay premiums on a pre-tax basis, which reduces your taxable income.

BenefitsVIP®
Help starts here.

Welcome to your NEW BenefitsVIP Support Center

BenefitsVIP.com is your one-stop advocacy center, staffed by experienced benefits professionals dedicated to helping you and your family resolve any benefits-related issues.

Your advocacy team offers:

- Direct access to carriers and providers
- Multi-lingual support
- An average of 22 years of industry experience

Here, you will be able to:

Contact BenefitsVIP directly by submitting a form for assistance with:

- Claims inquiries
- Benefits questions
- Pre-authorization needs
- In-network doctor/plan coverage questions
- Prescription issues
- Cost-reduction requests
- Multi-lingual assistance
- Re-ordering ID cards

Additional resources:

- Learn FAQs about employee benefits
- Read the latest research on health, wellness, and effective well-being practices at HealthDiscovery.org
- Get tips on how to better utilize your benefits in a more cost-effective way

866.286.5354

Monday - Friday 8:30am - 8pm (ET)

Fax: 856.996.2755

answers@benefitsvip.com

Scan the QR code to email your BenefitsVIP team now!

Eligibility

If you're a full-time employee at Hardee County BOCC and have satisfied the waiting period, you are eligible to enroll in the benefits outlined in this guide. Full-time employees are defined as those who work 30 or more hours per week.

Eligible dependents for medical, dental, and vision coverage include:

- Legal Spouse
- Legal Dependent Child(ren)
  - Coverage is allowed until the end of the calendar year in which the dependent turns age 26 for medical, dental, and vision. To age 30 if:
    - Unmarried without dependents and a FL resident or a full or part-time student
    - Not covered under any other health plan or policy and
    - Not entitled to coverage under Medicare
- Disabled Dependents: children who become disabled before age 26, and who rely on you for support, are also eligible for medical, dental, and vision coverages.

Changes

You can enroll for coverage during your new hire waiting period or the annual open enrollment period. Outside of these times, you can only change your coverage within 30 days of experiencing a qualifying life event.

Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in a child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

Documents required for a life event: Marriage Certificate, Divorce Decree, Proof of Loss of Coverage, Birth Certificate & Name Change forms

***Please Note**: The Internal Revenue Service (IRS) does not consider financial hardship a qualifying life event to drop or make changes to coverages mid-year.*

How to Access Employee Navigator

First Time Users

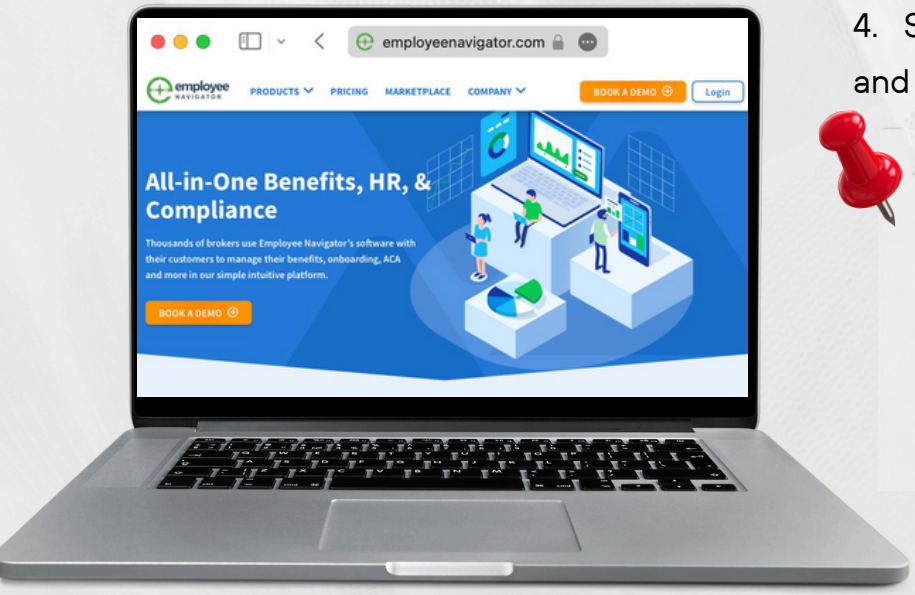
1. Visit the Employee Navigator website at www.employeenavigator.com to register or scan the QR code.
2. Register as a new user by inputting personal details and your company identifier.
3. Fulfill any designated tasks, verify, or revise personal information.
4. Select or decline each coverage option and finalize enrollment by selecting 'Agree.'

QUICK TIP
Gather dependent information beforehand as to add them to your coverage

Returning Users

GO TO WWW.EMPLOYEENAVIGATOR.COM AND CLICK LOGIN

1. Returning users: Sign in using your existing username and password.
2. Forgot your password or username? Click on "Forgot Password?" to reset both.
3. Finish any assigned tasks, verify, or revise personal details.
4. Select or decline each coverage option and finalize enrollment by selecting 'Agree'.



Remember: If you skip a step, you will notice "Enrollment Not Complete" in the progress bar, with the unfinished steps highlighted. Simply click on any incomplete steps to finish them, then proceed to click "Agree".

FLORIDA BLUE MEDICAL PLAN COMPARISON

Plan Name	BlueOptions HDHP (HSA) 05180/05181
In-Network	
Individual Deductible	$2,500
Family Deductible	$5,000
Coinsurance	0%
Individual Out-of-Pocket Maximum	$2,500
Family Out-of-Pocket Maximum	$5,000
Preventive Exams	Covered in Full
Primary Care Physician Office Visit**	0% after Deductible
Specialist Office Visit**	0% after Deductible
Diagnostic Free Standing Lab (X-Ray / Bloodwork)	0% after Deductible
Major Diagnostic Independent Test Center (MRI, CT, PET)	0% after Deductible
Walk-in Urgent Care	0% after Deductible
Emergency Room	0% after Deductible
Inpatient Hospital	0% after Deductible
Outpatient Surgery	0% after Deductible
Prescription Deductible	Subject to Medical Deductible
Prescription Drugs	In-Network: 0% after Deductible Out-of-Network: 50% after In-Network Deductible
Out-Of-Network	
Individual / Family Deductible	$5,000 / $10,000
Coinsurance	20%
Individual / Family Out-of-Pocket Maximum	$10,000 / $20,000
EMPLOYEE'S BI-WEEKLY PAYROLL DEDUCTIONS	
Employee Only	$12.50
Employee & Spouse	$253.16
Employee & Child(ren)	$92.82
Employee & Family	$314.72
Part-Time Employees	$451.17

You are responsible for paying 100% of your medical expenses until you reach your deductible.
***** Value Choice providers provide the highest level of benefits to members. Please contact Florida Blue to confirm participating providers.***

Dependent Age Limit: Age 26

MEDICAL BENEFITS
PRM/FLORIDA BLUE

Public Risk Management offers medical plans with custom benefits administered by Florida Blue.

Register on the Florida Blue member site: www.FloridaBlue.com to sign up and log in. If you haven't done so already, follow the next few steps to sign up for a Member Account.

Step 1: Go to www.FloridaBlue.com and enter your Member Number (shown on your ID card).
Step 2: Complete all the answers and click Next.
Step 3: Choose and type in a User ID.
Step 4: Choose and type in a Password, and re-enter Password second time.
Step 5: Select and answer three different security questions. Then, click Next.
Step 6: Click Continue and be taken to the member website home page.

On the Florida Blue member website, you'll find lots of helpful information including Provider Directories; Cost Comparison tools; your claims activity; educational information on various health topics; various discount programs; ability to print an ID card; and lots more. We offer you medical coverage that utilizes Florida Blue's network of physicians and facilities.

You have the option to choose the benefit plan that best meets the benefit and budgetary needs of you and your family. Before scheduling an appointment with a physician, you should always confirm the provider's current participation status within the Florida Blue provider network.

Your Responsibility

- Before you enroll, make sure you understand the plans and ask questions if you don't.
- After you enroll, you should always check your first paycheck stub to make sure that the correct amount is being deducted and that all the benefits you elected are included.
- Verify that all beneficiary information is up to date.

MEDICAL BENEFITS
PRM/FLORIDA BLUE

Choices for Care
Making smart health care choices helps you – and your wallet – feel healthy, secure, and supported.

Try Telehealth Visits with Teladoc
Do you have a smart phone or tablet? Virtual visits through Teladoc allow you to get fast, convenient care at **no cost with a board-certified physician** — no matter where you are or what time it is — via mobile devices and the internet.

Teladoc doctors are available 24/7 and can diagnose symptoms as well as prescribe medications for minor health concerns. Use it when your primary doctor is not available, if you're sick while traveling, on nights and weekends, or when it's inconvenient to leave home. Use virtual doctor visits for:

- Allergies
- Cold and flu
- Ear infections
- Fever
- Headache
- Nausea
- Rashes
- Sinus infection
- And more!

Visit teladoc.com to get started. Consider creating an account and providing your medical information now so care is available when you need it.

Value Choice Providers
Finding the right doctor can help you get and stay healthy. As a Florida Blue member, you have access to doctors who put a special focus on helping you stay well while saving on out-of-pocket costs. When you see a Value Choice Provider, you:

- Get quality care under one roof for many conditions
- Have the flexibility to schedule evening and weekend appointments
- May have lower costs to see your PCP, visit a specialist, or get urgent care
- Choose an English- or Spanish-speaking doctor

Your path to health can start today. Sanitas Medical Center and GuideWell Emergency Doctors are Value Choice Providers that offer Florida Blue members extra care – and they're in your plan's network. With locations throughout Florida, there's sure to be an office near you. Search for Primary Care and Urgent Care providers by logging in to floridablue.com or clicking Find Care in the Florida Blue mobile app.

MEDICAL BENEFITS
PRM/FLORIDA BLUE

Independent Diagnostic Testing Facility
To save on imaging costs, consider an Independent Diagnostic Testing Facility for x-rays, ultrasounds, MRIs, CT and PET scans. Member cost share is often less at an Independent Diagnostic Testing Facility than through an Outpatient Hospital Facility.

Go Generic and Save
Generic drugs are the non-brand-name, FDA-approved versions of their brand-name counterparts. They're required to have the same active ingredients as the brand-name drug – but at a fraction of the price. Ask your doctor or pharmacist if a generic is a good option for you.

Save the Emergency Room for Emergencies
Unless loss of life or limb is imminent, consider using Urgent Care or Teladoc. Emergency rooms are expensive and crowded, and it can take a long time to be seen depending on your condition. In the event of a true emergency – head injury, severe trauma, chest pain, allergic reaction, etc. – get care from your nearest emergency room. Coverage is the same in- and out-of-network for true emergencies.

Wellness through Florida Blue's Better You Strides
Florida Blue offers a wide range of wellness programs at your local Florida Blue Center and online. Programs include: nutrition, weight management, exercise, cholesterol, diabetes, pre-diabetes, heart health, stress management and more. Look out for monthly wellness newsletters shared by your employer, which includes valuable information and webinars.

Blue365 gives members access to savings across all aspects of your life—including discounts on wearable devices, gym membership access starting at $19/month, discounts on healthy, organic meal delivery services from Sunbasket, and much more! Register now for free to take advantage of Blue365. It's an online destination where participating members can find healthy deals and exclusive discounts, all you need is your Blue Cross Blue Shield member card to get started. Register now for free at Blue365Deals.com.

MEDICAL BENEFITS
PRM/FLORIDA BLUE

Tools and Resources to Help You Make the Best Decisions for Your Health and Your Wallet

Log into your www.FloridaBlue.com member website after you've registered to access great tools and resources, some of which are described below.

Personal Health Information When You Need It

www.FloridaBlue.com provides personal health information when you need it.

- Review your plan benefits and find out where you stand with your deductible and out-of-pocket maximum accumulators.
- Find a doctor or hospital in your plan's network.
- Compare and estimate your costs for medical care and prescription drugs.
- View claim activity, status, and history.
- Create a Personal Health Record so your doctor visits and lab results are all in one secure place.
- Print a paper ID card or request a new member ID card.

Mobile App

Download the Florida Blue Mobile App (free for Android and iPhone) to access health information and tools on the go.

- Get your plan details such as deductibles, Health Equity HSA balance, and claims.
- Get a picture of your member ID card.
- Locate doctors in your plan from wherever you are.
- Compare drug prices on the spot and map the nearest pharmacy.
- Get connected to a person who can help you manage your out-of-pocket costs and find quality care.

Care Consultants (888-476-2227)

Talking to a Care Consultant can save you time and money — and make important decisions easier. Whether it's your first office visit, or a series of ongoing medical treatments or a new medication, call our Care Consultants first. You'll find out how your benefits work, what factors can affect your costs, and which programs are available to assist you. The team can help you plan your next steps and make sure you get the most value from your benefits.

24/7 Nurse Line (877-789-2583)

Whether you have an immediate health concern, or a general question about your doctor's plan of treatment— the nurse line is always open so you don't have to wait for answers. You'll get answers, plus helpful resources that you can use.

MEDICAL BENEFITS
PRM/FLORIDA BLUE

The information in this summary should not be intended to take the place of an official carrier Member Certificate or Summary Plan Description (SPD). This summary contains a general description of the benefits to which you and your eligible dependents may be entitled as a full-time employee. This summary does not change or otherwise interpret the terms of the official plan documents. To the extent that any of the information contained in this guide is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases and the plan documents and carrier certificates will prevail.

This summary highlights recent plan design changes, if any, and is intended to fully comply with the requirements under federal and state laws as appropriate. Public Risk Management (PRM)reserves the right, in its sole and absolute discretion, to amend, modify or terminate, in whole or part, any or all of the provisions of the benefit plans. No party besides Public Risk Management shall receive any right, title or interest in, or any license or right to use, the proprietary information or any patent, copyright, trademark or other intellectual property rights herein, by implication or otherwise. Any unauthorized use, distribution, modification, or duplication of the content herein is strictly prohibited without written consent from the sole proprietor: Public Risk Management.

Florida Blue

Need Care and Don't Know Where to Go?

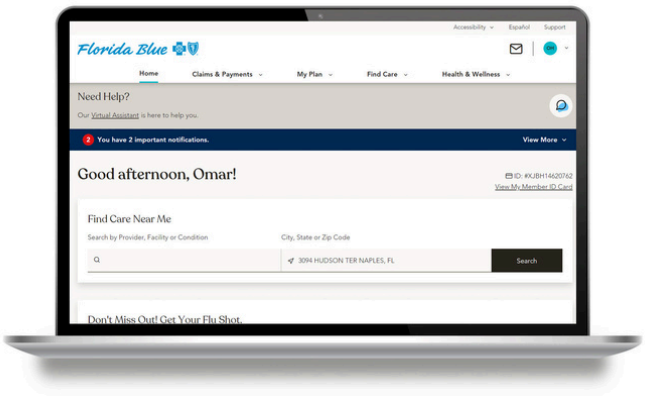
No matter where you are, a doctor, urgent care center, or hospital is right at your fingertips.

Find Care in Florida

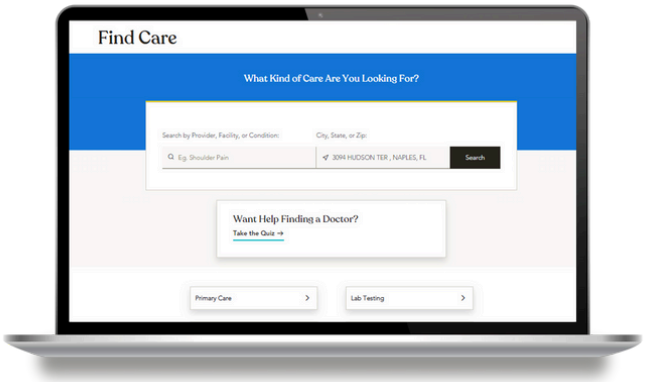
Online

Step 1. **Log in to floridablue.com.**

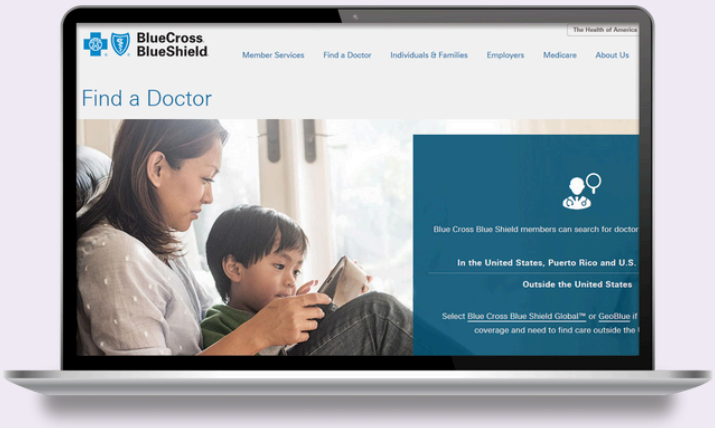
Step 2. **At the top of the screen, click Find Care and select Find A Doctor & More.**



Step 3. **In the search form, simply enter the provider's last name, facility, specialty, condition or NPI. You can also select the Provider Type from one of the options listed below the search bar.**



Step 4. **Click the Search button. For virtual visits covered at $0, look for the Virtual Visit banner and click Get Started.**



Outside Florida?

Many plans have coverage outside of Florida. You are always covered for urgent and emergency care.*

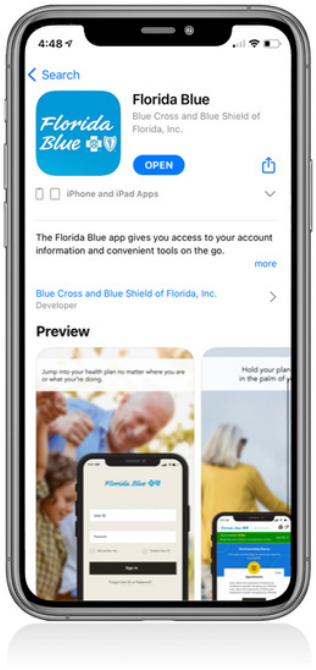
To find a health care provider outside Florida:

1. **Log in to bcbs.com/find-a-doctor or call 800-810-2583.**
2. **Click on In the United States.**
3. **Enter a Location and Plan to find care anywhere in the U.S.**

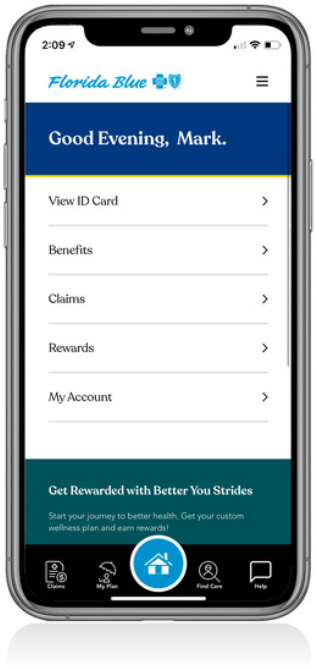
Florida Blue and Florida Blue HMO are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc. Google Play is a trademark of Google Inc. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770).

103723 0121R IU65 | SG

On Your Mobile Device

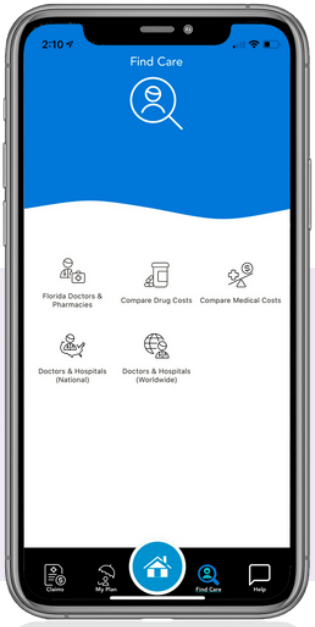


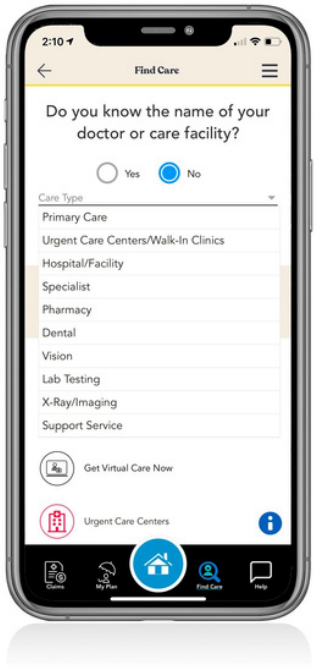
Step 1. **Download the Florida Blue mobile app from the iTunes or Google Play app store.**



Step 2. **Open the app and log in to reach your member dashboard. On the navigation bar at the bottom of the screen, click Find Care.**

Step 3. **At the Find Care screen, click Florida Doctors and Pharmacies.**





Step 4. **Select Yes and search by entering the provider's last name, facility, specialty, condition or NPI.**

Select No, then click the Care Type dropdown button and choose between primary care, urgent care centers, hospitals and more.

Step 5. **Click Get Results.**

For virtual visits, click Get Virtual Care Now and Get Started!

Outside Florida?

Many plans have coverage outside of Florida. You are always covered for urgent and emergency care outside of Florida.*

1. **Open the app and login. Click Find Care on the navigation menu.**
2. **Click on Doctors & Hospitals (National).**
3. **Choose a Location and Plan to find care anywhere in the U.S.**

*Please refer to your policy for information on coverage outside of Florida, or call the telephone number on the back of your member ID card.

Florida Blue
In the pursuit of health®

When You Don't Have Time to Wait, You've Got Teladoc!

Provides 24/7 Access to Care

When you or a family member don't feel well and your primary care doctor or your child's pediatrician can't see you right away, you can now get care within minutes without leaving home with Teladoc.

For a cost that's less than an urgent care or ER visit, Teladoc gives you 24/7/365 access to U.S. board-certified doctors by web, phone or mobile app. It's a more convenient and affordable option for quality medical care. And there's no obligation or extra monthly fee.

Getting Started

Set up your account today—so when you need care, a Teladoc doctor is a just a call or click away.

How Does Teladoc Work?

1. **Register**
   3 easy ways: download the mobile app, visit the Teladoc website or call the number to the right.
2. **Provide Medical History**
   Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.
3. **Request a Visit**
   That's it! The next time you need immediate care for a non-emergency illness, you have another option.

The Teladoc Difference

Teladoc can help with many non-emergency illnesses, including:

- Sinus infection
- Flu
- Cough
- Sore throat
- Rash
- Allergies
- Upset stomach
- Nausea
- Other minor health issues and more

TELADOC®

Talk to a doctor anytime.

Call today 1-800-Teladoc (835-2362) or visit Teladoc.com

Teladoc is an independent company contracted by Florida Blue to provide physician visits via phone or online video to members with non-emergent medical issues. Teladoc is only available in the U.S. Teladoc® is a trademark of Teladoc, Inc.
Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.
We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. For more information, visit floridablue.com/ndnotice. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.
95935B 0519

BetterYou STRIDES

Map Your Personal Path to Health

Welcome to Better You Strides, an online wellness program that uses your needs, goals and interests to build your custom-made plan to better health.

A Personal Plan for You

Better You Strides creates a personal health Journey for you—a custom-made plan with recommended actions to reach your health goals. Activities cover healthy eating, tips to move more and ways to feel happier.

Discover the fun of building healthy habits through activities, videos and quizzes. As you progress, your Journey evolves, offering challenges and activities to help you stay motivated.

Your Mobile Fitness Partner

Tap into your personal health Journey from your smartphone, tablet or computer to track your progress or get support any time, anywhere. Better You Strides can integrate with more than 100 health and wellness wearable devices and mobile app trackers. That makes tracking your progress even easier.

Rewards for Healthy Habits

Earn rewards as you get healthier. Complete your Personal Health Assessment to earn a $25 reward. Complete activities with a dollar amount to earn more rewards. You'll receive a $25 prepaid Mastercard® you can use to help pay for medical services.

Florida Blue

Start Your Journey to Better Health Today!

You can register for Better You Strides online or from the AlwaysOn mobile app.

Registering online

1. **Log into your member account at floridablue.com. Click Health & Wellness, then Better You Strides.**
2. **Read and accept the Terms of Service, then choose your communication preferences.**

From the AlwaysOn mobile app

1. **Download the AlwaysOn Wellness mobile app from the Apple App store or Google Play. Click "New User."**
2. **Complete the authentication step.**
3. **Create your user name, password and PIN.**

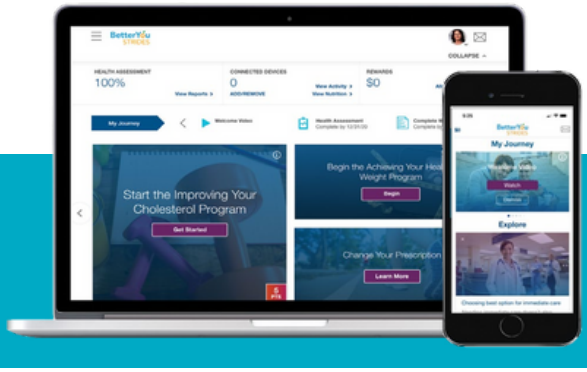
Apple App Store

Google Play Store

If you have questions or need help registering for Better You Strides, call 800-352-2583.

BetterYou STRIDES

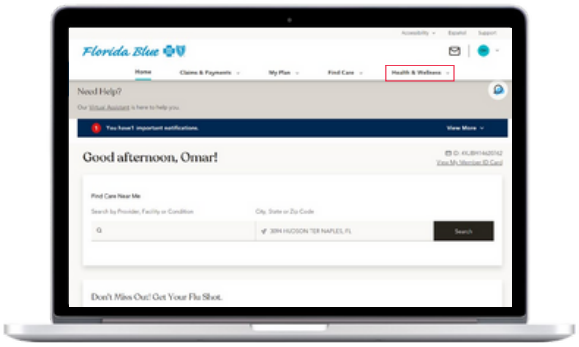
Start Your Journey to Better Health!



Take strides toward better health today.

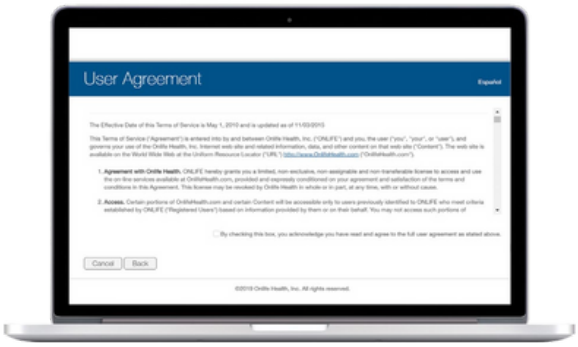
Register now for Better You Strides, a personal wellness program that creates a custom-made plan to help you meet your health and wellness goals. Registering takes just a few steps.

Online



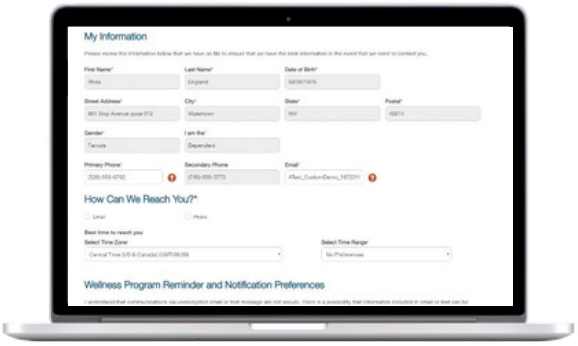
Step 1.

Log in to your member account at floridablue.com. Click **Health & Wellness**, then **Better You Strides**.



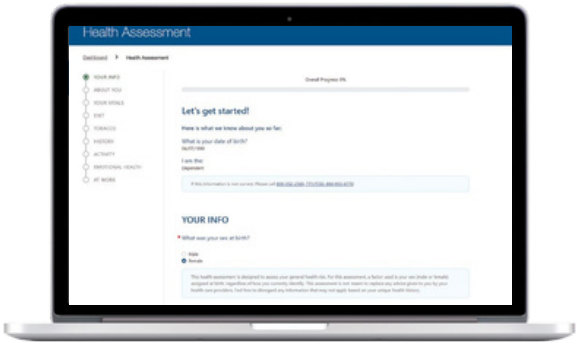
Step 2.

Read and Accept the Terms of Service.



Step 3.

Choose your communications preferences.



Step 4.

Complete your Personal Health Assessment to earn a $25 prepaid Mastercard®.

QUESTIONS?

Give us a call at **800-352-2583.**

HEALTH SAVINGS ACCOUNT (HSA)
ADMINISTERED BY: OPTUM BANK

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in). **Hardee County BOCC HSA Contributions will be made based on the following schedule:**

- Employee Only- $1000 is contributed to their HSA card from October through February ($200 payments each month)
- All other coverage- $2000 is contributed to their HSA card from October through February ($400 payments each month)

Note: Employees who open an Optum Bank HSA will receive a debit card from Optum Bank and funds will then be available as they are contributed. Should an employee leave his/her employment with Hardee County BOCC, the account remains the property of the employee.

WHAT ARE THE BENEFITS OF AN HSA?

There are many benefits of using an HSA, including the following:

- **It saves you money**—HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- **It is portable**—The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- **It is a tax-saver**—HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

The maximum amount that you can contribute to an HSA in 2025 is $4,300 for individual coverage and $8,550 for family coverage.

Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

For a detailed listing of eligible and ineligible medical expenses,
please visit Publication 502 on the IRS website.

HSA CASE STUDY

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. (This example only includes HSA contribution amounts and does not reflect any investment earnings).

Year 1	
HSA - $1,000 Contribution	**$1,000**
Total Expenses:	
Prescription Drugs: $150	-$150
HSA Rollover to Year 2	**$850**
Since Justin did not spend all his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	
Year 2	
HSA Balance: $850 from Year 1, plus $1,000 contribution for Year 2	$1,850
Total Expenses:	
Office Visits: $100 Prescription Drugs: $200 Total: $300	-$300
HSA Rollover to Year 3	**$1,550**
Once again, since Justin did not spend all his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

HEALTH SAVINGS ACCOUNT (HSA)
ADMINISTERED BY: OPTUM BANK

Preventive Care (In-Network)

Covered preventive services and medications are fully paid by the plan—no deductible, no cost to you.

HEALTH SAVINGS ACCOUNT

Contribute pre-tax dollars

Any unused funds roll over year to year

Out-of-Pocket Maximum

After reaching your out-of-pocket limit, the plan covers all eligible expenses for the rest of the year.

Use your HSA to cover deductibles, coinsurance, and qualified medical costs

OR

Save your HSA funds for the future

- **Deductible** — You're responsible for 100% of eligible costs until your deductible is met.
- **Coinsurance** — Once your in-network deductible is met, the plan covers 100% of eligible in-network expenses.
- **Other Qualifying Expenses** — HSA funds can be used for eligible costs not covered by insurance.
- **Balance Rolls Over Each Year** — Your HSA balance rolls over annually and earns tax-free interest—like a retirement fund for healthcare.
- **After Age 65** — At 65+, use HSA funds for any purpose without penalty—non-medical use is taxed like regular income.

Employees enrolled in the High Deductible Health Plan (HDHP) will receive an annual $1,000 contribution and $2,000 for SP-Ch-Family coverage from Hardee County BOCC. Contributions made by Hardee County BOCC are included in the maximum amount employees are allowed to contribute each plan year. Accordingly, employees must ensure that this amount is factored into their election so that they do not exceed the annual contribution limit (employee contributions to a HSA are made semi-monthly).

Anytime support

Resources for Living
To access services:
1-(800) 272-3626, TTY: 711 / resourcesforliving.com
Username: PRM / Access code: 8002723626

Public Risk Management of Florida

Resources for Living is an employer-sponsored program, available at no cost to you and all members of your household. Children living away from home can access services up to age 30.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional wellbeing support

You can access up to 7 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face-to-face, online with televideo, chat therapy or by phone. Services are free and confidential. We're always here to help with a wide range of issues including:

- Anxiety
- Relationship support
- Depression
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Self-esteem and personal development
- Substance misuse and more

Find care

It's easy to find a counselor you'd like to work with. You can:

- View provider options — images, bios, specialties and more
- Compare details — ethnicity, gender, language and more
- See which providers are open to new patients and when they're available
- Find options to schedule your first appointment online
- Get started quickly without any added steps or calls

Resources *for* Living®

3449302-01-01-PRM-ACCPL (7/25)

Daily life assistance

Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Care for older adults
- Caregiver support
- Special needs
- Pet care
- Community resources/basic needs
- Summer programs for kids
- Household services
- and more

Legal services

You can get a free 30-minute consultation with a participating attorney for each new legal topic. Some of the areas of law and issues covered include:

- Family or domestic law
- Civil and criminal law
- Wills and estate planning
- Real estate and more

If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.

* Services must be related to the employee or an eligible household member. Exclusions include work-related and lack of merit issues. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial services

Simply call for a free 30-minute phone consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions

You can get a 25 percent discount on standard tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.

* Services must be for financial matters related to the employee or an eligible household member.

Online resources

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Videos and podcasts
- Articles, blogs and self-assessments
- Mobile app
- Child and adult care provider search tool
- Live and on-demand webinars and more

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

Mind Companion Self-care

You have accessto evidence-based supporttoolstohelp manage depression, anxiety, stress, substance misuse and more.

Additional services

Chat therapy — Send secure text messages to your counselor, who will respond within one working day up to five days a week. A week of texting counts as one session. You can also schedule to meet online for 30-minute televideo sessions. Each televideo session counts as one visit. Work on the same kinds of issues you'd see a counselor face-to-face to talk about.

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

For legal disclaimers, visit **rfl.com/Disclaimers**.
©2025 Resources for Living
3449302-01-01-PRM-ACCPL (7/25)
RFL-COM-Dist

Resources *for* Living®

DENTAL - UNITED HEALTHCARE

PPO DENTAL - OPTIONS PPO 30 NETWORK

Benefit	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$50 / $150	$50 / $150
Benefit Maximum	$1,500	$1,500
Diagnostic & Preventive Services (Type A) : Prophylaxis (Cleanings); Oral Evaluations; Fluoride Treatments; X- rays; Sealants; Space Maintainers; Labs and Other Diagnostic Tests	100% (Deductible Waived)	100% (Deductible Waived)
Basic Services Fillings (Type B): Restorations (Amalgam or Composite); Emergency Treatments/ General Services; Simple Extractions; Periodontics; Endodontics	80% after Deductible	80% after Deductible
Major Services (Type C): Oral Surgery (incl. surgical extractions); Dentures and Removable Prosthetics ; Crowns, Inlays, Onlays, Fixed Partial Dentures (Bridges)	50% after Deductible	50% after Deductible
Orthodontic Services: (Children Only Up to Age 19)	50% after Deductible	50% after Deductible
Orthodontic Max: (Children Only Up to Age 19)	$1,000 (Lifetime Maximum)	$1,000 (Lifetime Maximum)

EMPLOYEE BI-WEEKLY PAYROLL DEDUCTIONS

Employee Only	$17.56
Employee & Spouse	$35.11
Employee & Child(ren)	$37.21
Employee & Family	$57.40

DEPENDENT AGE LIMIT: AGE 30

How to Find a Dentist:

1. Go to myuhc.com
2. Scroll down to Find a Dentist
3. Click Employer and Individual Plans
4. Enter your Zip code or address
5. Select National Options PPO 30
6. Select a General Dentist or Specialist
7. Click Search

Dental insurance pays for preventive care that can protect you and your family from the high cost of dental disease. It also helps pay for more extensive, costly and unexpected expenses such as fillings, crowns and root canals. You can visit any dentist but you benefit from the negotiated discounts on covered services choosing an in-network dentist. For specific plan information please refer to the UnitedHealthcare benefit summary.

VISION - UNITED HEALTHCARE

VISION - V1836

Benefit	In-Network	Out-Of-Network
Eye Exam Copay	$10	$40 Allowance
Materials Copay	$15	N/A
Frames	$130 Allowance; 30% Off Balance Over $130	$45 Allowance
Single Vision Lenses	$15 Copay	$40 Allowance
Bifocal Vision Lenses	$15 Copay	$60 Allowance
Trifocal Vision Lenses	$15 Copay	$80 Allowance
Lenticular Vision Lenses	$15 Copay	$80 Allowance
Medically Necessary Contact Lenses	Covered in Full	$210 Allowance
Elective Contact Lenses	$130 Allowance	$130 Allowance
Frequency (Exam/Frames/Contacts)	12 Months / 24 Months / 12 Months	

EMPLOYEE BI-WEEKLY PAYROLL DEDUCTIONS

Plan Name	Vision
Employee Only	$3.07
Employee & Spouse	$6.11
Employee & Child(ren)	$5.80
Employee & Family	$9.10

DEPENDENT AGE LIMIT: AGE 30

How to Find a Vision Provider:

1. Go to myuhcvision.com
2. Select UnitedHealthcare Vision Plans For the network.
3. Enter your Zip code or address
4. Click Search

Our eyes are constantly changing so it is important to have an annual eye examination. Vision insurance provides benefits for examinations and discounts on frames, lenses, and lens accessories. You can use any provider, but you will benefit from the negotiated discounts using an in-network provider and a higher coinsurance paid by UnitedHealthcare. For specific plan information please refer to the UnitedHealthcare benefit summary.

BASIC LIFE INSURANCE
THE STANDARD

Life insurance provides peace of mind by ensuring your loved ones are financially protected if something happens to you. Hardee County BOCC covers the full cost of your group life insurance, including accidental death and dismemberment (AD&D) coverage.

All benefit eligible employees will receive the $10,000 Basic Life/AD&D benefit ($5,000 age 70+) amount when enrolling in coverage. This benefit is paid in full by Hardee County BOCC. The maximum benefit amount for dependents is $5,000 for spouse and $2,000 child(ren). Rates are based on age.

Please be sure to annually check or update your beneficiary information. Your beneficiary is the person you designate to receive your life insurance benefit in the event of your death. ***It is essential that you update or add your beneficiary information during open enrollment. Your beneficiary(ies) are the individuals you designate to receive your life insurance benefit in the event of your death. Please take action to ensure your information is current and accurate.***

LIFE BENEFIT	
Life Amount	$10,000 Age 70+: $5,000
ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	
AD&D Amount	$10,000
ADDITIONAL BENEFIT FEATURES	

Basic Life Features & Services	• Benefit reduced at age 70 to 50% of total benefit
	• Coverage Terminates at Retirement or End of Employment
	• Your premiums may be waived if you
	  ◦ Become totally disabled while insured under the plan
	  ◦ Are under age 60, and
	  ◦ Complete the waiting period of 180 days.

Basic AD&D Features	• If you are diagnosed with a terminal illness, you can receive up to 75% of your life insurance benefit. The remaining balance will then be paid to your beneficiaries upon your passing.

VOLUNTARY LIFE INSURANCE
THE STANDARD

While Hardee County BOCC provides basic life insurance, some employees may want to purchase additional coverage. This benefit offers financial protection for employees and their families by providing a payment in the event of a death. Employees can choose coverage amounts based on their individual needs, with options to include spouse and dependent coverage.

LIFE & AD&D BENEFIT	
	Employee
Minimum	$10,000
Maximum	$200,000
Benefit Increments	$10,000
Guarantee Issue Amount	$100,000
Benefit Reduction	Benefit reduced at age 70 to 50% of total benefit
Additional Life Features	Your premiums may be waived if you: • Become totally disabled while insured under this plan • Are under age 60, and • Complete a waiting period of 180 days

VOLUNTARY LIFE INSURANCE EMPLOYEE MONTHLY RATES (PER $1,000)	
Age	**Employee**
<25	$0.09
25-29	$0.09
30-34	$0.09
35-39	$0.14
40-44	$0.22
45-49	$0.36
50-54	$0.54
55-59	$0.80
60-64	$1.32
65-69	$2.39
70-74	$3.38
75+	$7.32

New hires can purchase up to the guaranteed issue amount ($100,000) without medical underwriting. After the new hire eligibility period employees will be subject to medical underwriting. You can also purchase $5,000 of coverage on your Spouse and/or $2,000 of coverage on your children for $1.00 per month. For specific plan information, please refer to The Standard benefit summary.

WORKSITE PRODUCTS

AFLAC

Open enrollment planning isn't complete until you have Aflac

Aflac for Hardee County

Who hasn't been blindsided by an unexpected medical bill? That's why there's Aflac. Aflac can help take care of the expenses health insurance doesn't cover, so you can take care of everything else.

Aflac supplemental insurance

Our product portfolio is as broad as your needs, with individual insurance policies that help cover the expected – and unexpected – that's sure to come life's way.

Short-Term Disability: How would you pay your bills if you're disabled and can't work? An Aflac short-term disability insurance policy can help provide you with a source of income while you concentrate on getting better.

Cancer/Specified-Disease: Aflac's cancer/specified-disease insurance policy can help you and your family better cope financially if a positive diagnosis of cancer occurs.

Accident: Accidents happen. When a covered accident happens to you, our accident insurance policy pays you cash benefits, unless assigned otherwise, to help with the unexpected medical and everyday expenses that begin to add up almost immediately.

Critical Illness (Specified Health Event): An Aflac specified health event insurance policy is designed to help with the costs of treatment if you experience a covered health event.

Hospital Confinement Indemnity: Hospital stays are expensive. An Aflac hospital confinement indemnity insurance policy can help ease the financial burden of hospital stays by providing cash benefits.

To learn more, contact your Aflac agent, Diana Casey, at diana_casey@us.aflac.com or 863-382-2076.

Aflac

notes

GLOSSARY *of terms*

Open enrollment is the time of year reserved for you to make changes to your benefit elections, and unfamiliar terms can make this process confusing. Use these definitions of common open enrollment terms to help you navigate your benefits options.

Coinsurance—The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Consumer Driven Health Care (CDHC)—Health insurance programs and plans that are intended to give you more control over your health care expenses. Under CDHC plans, you can use health care services more effectively and have more control over your health care dollars. CDHC plans are designed to be more affordable because they offer reduced premium costs in exchange for higher deductibles. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

Copayment—A flat fee that you pay toward the cost of covered medical services.

Covered Expenses—Health care expenses that are covered under your health plan.

Deductible—A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent—Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Flexible Spending Account (FSA)—An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. Most funds must be used by the end of the year, as there is only a limited carryover amount.

Health Management Organization (HMO)—A type of health insurance plan that usually limits coverage to care from doctors who work for or contract within a specified network. Premiums are paid monthly, and a small copay is due for each office visit and hospital stay. HMOs require that you select a primary care physician who is responsible for managing and coordinating all of your health care.

Health Reimbursement Arrangement (HRA)—An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses.

Health Savings Account (HSA)—An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

High Deductible Health Plan (HDHP)—A qualified health plan that combines very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

In-network—Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

GLOSSARY of terms

Inpatient—A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity)—Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Medicare—An insurance program administered by the federal government to provide health coverage to individuals aged 65 and older, or who have certain disabilities or illnesses.

Member—You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Out-of-network—Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket Expense—Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket Maximum (OOPM)—The highest out-of-pocket amount paid for covered services during a benefit period.

Preferred Provider Organization (PPO)—A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium—The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Primary Care Physician (PCP)—A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance—The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.

Contacts

Benefit Coverage	Carrier	Phone	Website / Email
Medical/Dental/Vision	PRM/Florida Blue	866-414-1959	www.FloridaBlue.com
Life & AD&D	The Standard	888-937-4783	www.standard.com
Employee Assistance Program (EAP)			
Disability, Accident, Cancer, Hospital & Critical Illness Insurance	Aflac	800-992-3522	www.aflac.com
HSA	Optum Bank	800-791-9361	HSAGroup@optumbank.com
Florida Retirement System	FRS	866-446-9377	www.myfrs.com
457(b) Deferred Comp Retirement Plan	Corebridge Financial	800-448-2542	www.corebridgefinancial.com

Benefits VIP

Serves as a powerful, one-stop contact center staffed by seasoned benefits advocates ready to help you and your family resolve benefits issues.

Direct: (866) 286-5354
Email: answers@benefitsvip.com
Monday – Friday 8:30am – 8pm (ET)

For assistance with benefit questions, membership card issues, claims, & billing inquiries, please contact your Acentria service team:

Crystal McMullen
Benefits Account Executive
Direct Line: 850-295-8042
crystal.mcmullen@acentria.com

Laura Marinelarena
Benefits Account Manager
Laura.Marinelarena@acentria.com
Direct Line: 863-262-4994

Michael Watkins
Local Representative
Direct Line: 813-763-3332
michael.watkins@acentria.com

Francis Burroughs
Benefits Account Manager
Francis.Burroughs@acentria.com
Direct Line: 772-247-2609

Beyond Your Benefits

COBRA Q&A

Overview

COBRA is a continuation of Plan coverage when it would otherwise end because of a life event, also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must apply for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Hardee County BOCC.

Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at Healthcare.gov.

More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer.

Keep Address Updated

To protect your family's rights, let your Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Taxable Benefits And The IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pretax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pretax and after-tax dollars, then any payments received under the plan will be taxed on a prorata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages.

Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual Healthcare expenses you incur, if these premiums were paid with pretax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

Life Insurance Premiums and The IRS

According to IRS regulations, you can pay premiums on a pretax basis for the first $50,000 of life insurance coverage under a group term life insurance, a group term life insurance plan, covering your life. However, you must pay tax on such coverage exceeding $50,000.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change.

NOTICE TO EMPLOYEES OF COVERAGE OPTIONS

TO: Employees
FROM: Hardee County Board of County Commissioners
DATE: 10/1/2025
RE: Required Notification Regarding the Patient Protection and Affordable Care Act

The attached notification is being provided to you in compliance with the Patient Protection and Affordable Care Act. This notification is strictly informational regarding the Health Insurance Marketplace.

Hardee County Board of County Commissioners is required to notify all employees about the Health Insurance Marketplace. The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. Open Enrollment for health insurance coverage through the Marketplace begins in October, with coverage starting as early as January 1st. Some employees may be able to get lower costs on private insurance in the Marketplace based on their income. However, because Hardee County Board of County Commissioners offers coverage that meets the required standards, you will not be eligible for a tax credit through the Marketplace and may therefore prefer to remain on Hardee County Board of County Commissioner's group health plan.

If you purchase a health plan through the Marketplace instead of accepting group health coverage offered by Hardee County Board of County Commissioners, then you will lose the employer contribution to the employer-offered coverage. Our employer contribution, as well as your employee contribution to Hardee County Board of County Commissioners group health coverage, is excluded from income for federal income tax purposes under current tax regulations. If you choose coverage through the Marketplace, your payments for coverage are made on an after-tax basis.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Visit www.HealthCare.gov for more information, including an online application. The attached document will provide you with information that you will need while on the Marketplace website.

Hardee County Board of County Commissioners is not able to address questions regarding the Health Insurance Marketplace. If you have questions regarding the Health Insurance Marketplace, you should visit www.HealthCare.gov.

Hardee County
FLORIDA

MARKETPLACE COVERAGE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%11 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. (1.2)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit: https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

MARKETPLACE COVERAGE

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

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

(1) Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
(2) An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name: Hardee County BOCC	2. Employer Identification Number (EIN): 59-6000632	
3. Employer Address: 412 W. Orange St, Suite 204	4. Employer Phone Number: 863-773-2161	
5. City: Wauchula	6. State: FL	7. Zip Code: 33873
8. Who can we contact about employee health coverage at this job: Human Resources		
9. Phone number: 863-773-2161	10. Email address: humanresources@hardeecounty.net	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:
All Full-Time, non-seasonal employees after the applicable waiting period.

With respect to dependents, we do offer coverage. Eligible dependents are:
• Legally married spouses
• Natural, adopted, foster or stepchild(ren)
• Child(ren) for whom the covered employee has been court appointed as legal guardianship or legal custodian

✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from Hardee County Board of County Commissioners About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Hardee County Board of County Commissioners and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Hardee County Board of County Commissioners has determined that the prescription drug coverage offered by the Hardee County Board of County Commissioners is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Hardee County Board of County Commissioners coverage will be affected. While you are still employed, you can keep your current plan if you elect Part D, and this plan will coordinate with Part D coverage. Your Hardee County Board of County Commissioners plan would be your primary coverage, and Part D would be your secondary coverage.
If you do decide to join a Medicare drug plan and drop your current Hardee County Board of County Commissioners coverage, be aware that you and your dependents will be able to get this coverage back as an active employee. This change would be limited to annual open enrollment periods.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Hardee County Board of County Commissioners and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hardee County Board of County Commissioners changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/1/2025
Name of Entity/Sender: Hardee County Board of County Commissioners
Contact--Position/Office: Human Resources
Address: 412 W Orange St suite 103, Wauchula, FL 33873
Phone Number: (863) 773-9430

WELLNESS PROGRAM DISCLOSURE

Wellness Notice – HIPAA

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 800-352-2583 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Wellness Notice – ADA

BetterYou Strides is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $25 for getting healthier. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive a $25 reward.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting BetterYou Strides at 800-352-2583.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

DISCLOSURES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, 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 dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

NO SURPRISES ACT

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

• You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

DISCLOSURES

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
Iowa Medicaid | Health & Human ServicesMedicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

DISCLOSURES

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/ dmahs/Hardee County Board of County Commissionerss/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269
To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:
U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa1-866-444-EBSA (3272)
U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2026)

Plan COMPARISON CHART

MyFRS Florida Retirement System

Comparing the Plans: Investment Plan and Pension Plan

For complete plan details, refer to the Summary Plan Descriptions on MyFRS.com.

	Investment Plan	Pension Plan
This is a …	**401(k)-type investment plan.** It is designed primarily for employees who want greater control over their retirement plan and who want flexibility in how their benefit is paid at retirement.	**Traditional retirement pension plan.** It is designed for employees who are not comfortable with choosing investments and managing their own portfolio, and who want a guaranteed monthly retirement benefit.
You qualify for a benefit after …	**1 year of service.** Once you complete 1 year of service, you own all contributions and earnings in your account. If you leave FRS employment sooner, you own your employee contributions and any earnings on your contributions.	**8 years of service.** Once you complete 8 years of service, you qualify for a benefit which is payable when you reach retirement age as defined by the plan. If you leave FRS employment sooner, you own your employee contributions.
Plan investment choices are made by …	**You.** You are responsible for choosing investments from a diversified set of funds and for managing your account.	**The State.** The State is responsible for managing the Pension Plan Trust Fund.
Your benefit is …	**Based on your account balance.** Your account balance is based on your and your employer's contributions, the performance of your investments, and account fees and expenses.	**Based on a formula.** Your benefit is guaranteed and is based on a formula using your salary, years of service, FRS membership class, and age.
When you retire, your benefit can be paid to you as …	**A lumpsum, a rollover, anannuity, a customized payment schedule,** or any combination of these.	**Monthly payments for your lifetime.** You will have options that provide continuing payments to your qualified beneficiary after your death.
Who contributes to the plan?	Both plans require you to contribute 3% of your salary, beginning with your first paycheck. You cannot change the amount you contribute. Your employer also contributes a fixed percentage of your gross salary to the plan you choose. Contribution rates are set by the Florida Legislature.	

Have Questions?

Get answers from anexperienced, unbiased financial planner. There is no charge to you.

MyFRS Financial Guidance Line • 1-866-446-9377, Option 1 (TRS 711)
8:00 a.m. to 6:00 p.m. ET, Monday through Friday, except holidays.

Plan COMPARISON CHART

Additional Plan Features

	Investment Plan	Pension Plan
What happens if I work long enough to qualify for a benefit, but leave and go to work for …	***…anotherFRS-participating employer?***	
	You remain enrolledand contributions will continue to be made to your account.	You remain enrolled and your benefit will continue to grow.
	… an employer that doesn't participate in the FRS?	
	You willhave the option of leaving your money in the plan or taking a distribution.	Your benefitwill be frozen until you either begin receiving monthly retirement benefits or return to an FRS-participating employer.
Is there a survivor benefit if I die in the line of duty?	Yes.	Yes.
Will my benefit payments be adjusted to reflect increases in the cost of living?	Only if you purchase a fixed annuity that offers it.	No.
Would I be eligible to participate in the Deferred Retirement Option Program (DROP)?	No.	Yes, as of your normal retirement date.
Would I receive the Health Insurance Subsidy (HIS) to help me pay for health insurance in retirement?	Yes, if you satisfy the service requirements.	Yes, if you satisfy the service requirements.
Are there any benefits if I become permanently disabled?	Yes.	Yes.
Once I'm enrolled in one plan, can I switch to the other? While you are actively working for an FRS-participating employer, *regardless of the plan you choose*, you may switch plans once by using your 2nd Election. Reemployed retirees in the Investment Plan as of July 1, 2017 or after are not eligible to use a 2nd Election.	Yes. If you are actively working, earning salary and service credit, you can switch from the Investment Plan to the Pension Plan. You will have to buy into the Pension Plan, using the money in your Investment Plan account. If your balance doesn't cover the cost, you will have to make up the difference out of your own pocket.	Yes. If you are actively working, earning salary and service credit, you can switch from the Pension Plan to the Investment Plan. You may either leave your Pension Plan benefit in place (if you have at least 8 years of service) or transfer it into the Investment Plan. Transferred amount is subject to the Pension Plan's vesting requirements.

This publication is a summary of the retirement options available to new FRS-covered employees and is written in non-technical terms. It is not intended to include every program detail. Complete details can be found in Chapter 121, Florida Statutes, the rules of the State Board of Administration of Florida in Title 19, and the Department of Management Services in Title 60, Florida Administrative Code. In case of a conflict between the information in this publication and the statutes and rules, the provisions of the statutes and rules will control. Before you make an election or select any investment funds, you should review the Fund Profiles, the Investment Fund Summary, and the Annual Fee Disclosure Statement posted in the "Investment Funds" section on MyFRS.com.

© 2020 MyFRS Financial Guidance Program. All rights reserved.

YOUR Guide to FRS RESOURCES

MyFRS Florida Retirement System

The following services are available to you as a Florida Retirement System member. They are completely confidential, unbiased, and *FREE*.

MyFRS Financial Guidance Line

1-866-446-9377 (TRS 711), toll-free
8:00 a.m. to 6:00 p.m. ET, Monday through Friday, except holidays
(Division of Retirement available 8:00 a.m. to 5:00 p.m. ET)

Option1: Speakwithexperienced EY financialplanners aboutmaking an initial or 2nd Election, or get assistance with your MyFRS.com PIN or with other information available on MyFRS.com.

Option 2: Speak with experienced EY financial planners about any issue you think is important to your financial future. These planners work for **you**.

Option 3: Speak with the Division of Retirement about your Pension Plan account.

Option 4: Speak with the Investment Plan Administrator about your Investment Plan account.

MyFRS.com

This is your gateway to tools and information about your FRS retirement plan. Log in with your MyFRS.com PIN to access valuable personal tools and services.

Workshop Webcasts

Attend asmany of these free FRS financial planning workshops as you like. Sessions include “Using the FRS to Plan for Your Retirement,” “Estate Planning,” “Nearing Retirement,” and more. For dates and times, visit www.MyFRS.com/Workshop.htm.

ADVISOR® SERVICE

Thisfree onlineservice can help you estimate your retirement needs, choose investments, and create a personal financial plan that includes FRS and non-FRS retirement accounts. To access the service, log in to MyFRS.com.

Election CHOICE SERVICE

Gethelp choosing between the Investment Plan or the Pension Plan. If you’re already participating in a plan, you can get help using your one-time 2nd Election to see if switching plans makes sense. To access the CHOICE SERVICE, log in to MyFRS.com or call the MyFRS Financial Guidance Line.

The CHOICE SERVICE is not available to you if you’ve already used your 2nd Election or if you are a reemployed retiree who enrolled July 1, 2017 or after.

© 2022 MyFRS Financial Guidance Program. All rights reserved.

corebridge financial

457(b) Deferred Compensation Plan

An opportunity to take advantage of tax-deferred income for your retirement

The tax advantages, plus plan features and benefits, make a 457(b) Deferred Compensation Plan with Corebridge Financial an ideal way to help accumulate funds for your retirement. And Corebridge brings you the knowledge, investment options and personal services to help keep things simple.

Tax-deferred accumulation

Current federal income taxes on all contributions, interest and earnings in your 457(b) DCP are deferred until withdrawal, usually at retirement. Tax-deferred earnings, coupled with the power of compounding, may provide greater growth than might be possible with current taxable savings methods. Remember that income taxes are payable when you withdraw money from your account.

Pretax contributions

You contribute by convenient payroll reduction before federal income tax withholding is calculated. This helps reduce your current taxable income so you can save more for retirement with money that otherwise would have gone toward income taxes. In addition, your salary deferral contributions made to the plan are not subject to the 10% federal early withdrawal tax penalty.

Access to your savings

Generally, depending on your employer's plan, your account contributions can be distributed in any of the following events:

- Reached age 59½*
- Severance from employment
- Your death
- Unforeseeable emergencies

In addition, distributions are not generally subject to the 10% federal early withdrawal tax penalty except on amounts rolled into the 457(b) plan from other non-457(b) eligible retirement plans.

Investment flexibility

We offer an array of innovative investment options from well-known investment managers. This provides the flexibility you might need to design a unique program tailored to your individual needs. Keep in mind that investment values will fluctuate so that your investments, when withdrawn, may be worth more or less than the original cost. Remember investing does involve risk, including the possible loss of principal. Your financial professional can assist you in choosing the options that will match your long-term goals.

Your salary deferral contributions made to the plan are not subject to the 10% federal early withdrawal tax penalty.

- In-service distributions for money purchase pension, defined benefit and governmental 457(b) plans – the Miners Act reduces the minimum age for in-service distribution from pension plans (i.e., money purchase and defined benefit plans) from age 62 to age 59½ and, for governmental 457(b) plans, from age 70½ to age 59½. The provision applies to plan years beginning after December 31, 2019, 401(a) money purchase, and 401(a) defined benefit and governmental 457(b) plans. An employer must make an election to apply this provision.

corebridge financial

2023 contribution limits

- 100% of annual includible income up to $22,500
- Up to $22,500 as a catch-up contribution if you are within the last three taxable years ending in the year before normal retirement age under your plan and undercontributed in prior years
- $7,500 as an age-based catch-up for those age 50 or older [governmental 457(b) plan participants only]

Scan with your mobile phone for up-to-date contribution limits.

Tax-free loans

Tax-free loans, which are available under some governmental 457(b) plans, enable you to borrow against a portion of your accumulated account value, subject to certain limitations, without permanently reducing your account balance. Remember that defaulted loan amounts (not repaid on time) will be taxed as ordinary income.

IMPORTANT NOTE: You cannot benefit from both catch-up contribution amounts, but you may select the option that gives you the higher amount. Nongovernmental 457(b) plan participants are not eligible for the age-based catch-up option.

corebridgefinancial.com/retirementservices 1.800.448.2542

We're here to help you take action

You can reach out directly to your financial professional.

Amy Greth, Financial Advisor, CRPC

425 Commercial Court, Suite B Venice, FL 34292

Cell: 863-399-2779 Email: amy.greth@corebridgefinancial.com

Important considerations before deciding to move funds either into or out of a Corebridge retirement services account

There are many things to consider. For starters, you will want to carefully review and compare your existing account and the new account, including: fees and charges; guarantees and benefits; and, any limitations under either of the accounts. Also, you will want to know whether a surrender of your current account could result in charges. Your financial professional can help you review these and other important considerations.

Investors should carefully consider the investment objectives, risks, fees, charges and expenses before investing. Read the fund prospectuses carefully before investing. The fund prospectuses contain important information, which can be obtained from your financial professional, at corebridgefinancial.com/retirementservices or by calling 1.800.428.2542 and following the prompts.

This material is general in nature, was developed for educational use only, and is not intended to provide financial, legal, fiduciary, accounting or tax advice, nor is it intended to make any recommendations. Applicable laws and regulations are complex and subject to change. Please consult with your financial professional regarding your situation. For legal, accounting or tax advice consult the appropriate professional.

Annuities are issued by **The Variable Annuity Life Insurance Company**, Houston, TX. Variable annuities are distributed by AIG Capital Services, Inc., member FINRA.

Securities and investment advisory services offered through VALIC Financial Advisors, Inc., member FINRA, SIPC and an SEC-registered investment adviser.

VALIC Retirement Services Company provides retirement plan recordkeeping and related services and is the transfer agent for certain affiliated variable investment options.

All companies above are wholly owned subsidiaries of Corebridge Financial, Inc.

Corebridge Retirement Services, Corebridge Financial and Corebridge are marketing names used by these companies.

Hardee County
FLORIDA

10/1/2025 - 9/30/2026

Employee Benefits Guide