2022 OKALOOSA COUNTY 2023

EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

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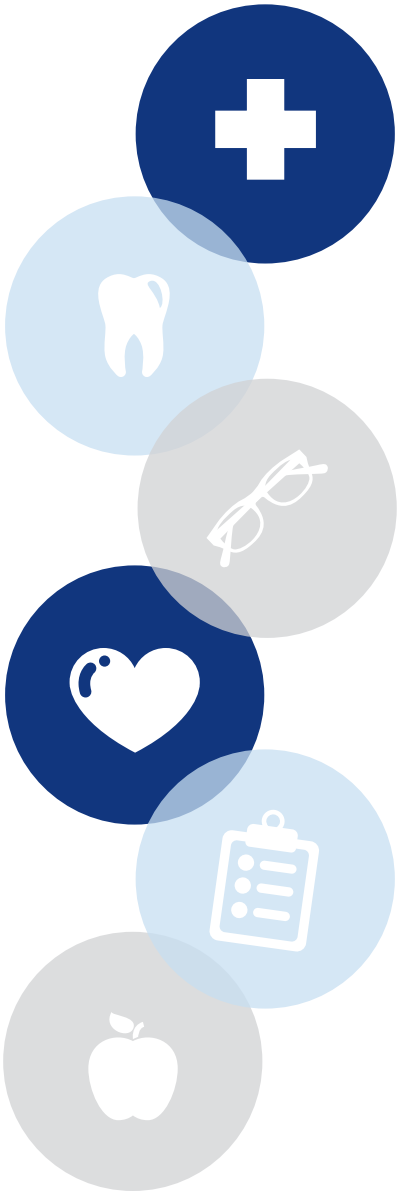
	Risk Manager	Kelly Bird	Phone: (850) 689-5978 Email: kbird@myokaloosa.com
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) Email: support@mybentek.com www.mybentek.com/myokaloosa
	Medical Insurance	Florida Blue	Customer Service: (800) 322-2808 www.floridablue.com
	Prescription Drug Coverage & Mail-Order Program	Express Scripts Pharmacy	Customer Service: (866) 230-7261 www.express-scripts.com
HSA	**Health Savings Account**	HSA Bank	Customer Service: (800) 357-6246 www.HSAbank.com
HRA	**Health Reimbursement Account**	90 Degree Benefits Mississippi	Customer Service: (800) 530-7222 Claims Email: flex.t2@90degreebenefits.com Claims Mailing Address: P.O. Box 1688, Pascagoula, MS 39568 www.90degreebenefits.com/mississippi.php Claims Fax: (228) 769-0401
	Telehealth	Teladoc	Customer Service: (800) 835-2362 www.teladoc.com
	Dental Insurance	MetLife	Customer Service: (800) 942-0854 www.metlife.com
	Vision Insurance	EyeMed	Customer Service: (866) 939-3633 www.eyemed.com
FSA	**Flexible Spending Accounts**	90 Degree Benefits Mississippi	Customer Service: (800) 530-7222 Main Contact: Rachael Burgess | Phone: (228) 762-2500 www.90degreebenefits.com/mississippi.php
	Basic Life and AD&D Insurance	Ochs	Customer Service: (800) 392-7295 www.ochsinc.com
	Voluntary Life and AD&D Insurance	Ochs	Customer Service: (800) 392-7295 www.ochsinc.com
	Long Term Disability Insurance	Ochs	Customer Service: (800) 392-7295 www.ochsinc.com
	Employee Assistance Program	Pattison Professional Counseling & Mediation Center	Locations: Crestview | Phone: (850) 682-1234 Fort Walton | Phone: (850) 863-2873 www.ppccfl.com
	Claims, Billing & Benefit Assistance	Gehring Group	Customer Service: (800) 244-3696 Email: okaloosacounty@gehringgroup.com
	Retirement Plan	Florida Retirement System (FRS)	Customer Service: (866) 466-9377 | www.myfrs.com

Table of Contents



This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The County reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

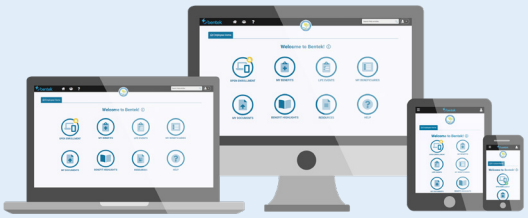
Introduction

The County provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the County Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Risk Management.

Online Benefit Enrollment

The County provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Life Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report qualifying life events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/myokaloosa**

  Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com, Monday through Friday during regular business hours 8:30am - 5:00pm EST.

To access Bentek using a mobile device, scan code.

Group Insurance Eligibility

The County's group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the County's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first of the month following 30 days of employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 1.

Separation of Employment

If employee separates employment from the County, insurance will continue through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child(ren) of the participant or spouse. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to the age of 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 30.

Dental Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

Please see Taxable Dependents if covering eligible over-age dependents.

Disabled Dependents

Coverage for a dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group's insurance plans; and
- The dependent has been continuously insured.

Proof of disability will be required upon request. Please contact Risk Management if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under employee's medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, imputed income must be reported on the employee's W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare taxes. Imputed income is the dollar value of insurance coverage attributable to covering each adult dependent child. Contact Risk Management for further details if covering an adult dependent child who will turn age 27 any time during the upcoming calendar year or for more information.

Please Note: There is no imputed income if adult dependent child is eligible to be claimed as a dependent for Federal income tax purposes on the employee's tax return.

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Flexible Spending Accounts (FSA), and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the open enrollment period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

IMPORTANT NOTES

If employee experiences a Qualifying Event, **Risk Management must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes may be effective the date of the Qualifying Event or the first of the month following the Qualifying Event. Newborns are effective on the date of birth. Qualifying Events will be processed in accordance with employer and carrier eligibility policy. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided as a supplement to this booklet being distributed to new hires and existing employees during the Open Enrollment period. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	Risk Management
Address:	302 N. Wilson St., Suite 301 Crestview, FL 32536
Phone:	Phone: (850) 689-5977
Website URL:	www.mybentek.com/myokaloosa

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting Risk Management.

If there are any questions about the plan offerings or coverage options, please contact Risk Management at (850) 689-5977.

Medical Insurance

The County offers medical insurance through Florida Blue to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following pages. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Florida Blue's customer service.

Medical Insurance – Florida Blue 05192/05193 HSA Base Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$840.15	$840.15	$0.00	$0.00
Employee + Family	$1,282.35	$1,045.59	$366.26	$183.13

Medical Insurance – Florida Blue 05781 Base Buy Up Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$1,124.54	$1,045.59	$78.95	$39.48
Employee + Family	$1,716.43	$1,045.59	$670.84	$335.42

Medical Insurance – Florida Blue 05770 Buy Up Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$1,304.35	$1,045.59	$258.76	$129.38
Employee + Family	$1,990.85	$1,045.59	$945.26	$472.63

Florida Blue | Customer Service: (800) 322-2808 | www.floridablue.com

Medical Plan Opt-Out Benefit

In an effort to ensure equitable contribution to the health care of every employee, the County offers an "opt-out" option to eligible employees who have waived participation in the County's medical plans and who can provide evidence of medical insurance under another medical plan. For more details regarding the opt-out benefit, please contact Risk Management.

Other Available Plan Resources

Florida Blue offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please contact Florida Blue's customer service at (800) 322-2808, or visit www.floridablue.com.

Care Consultation & Advocacy Program

The Care Consultation and Advocacy Program offers personal care services as a part of the medical plan. Care Consultants offer free advice and support to help members manage their health needs and control their total cost. Professionals on the Care Consultant Team includes: Nurse care advocates, Benefit specialists and Community resource experts. The Care Consultant Team can help members save time, save money and make informed health care decisions. The three types of support provided through the Care Consultation and Advocacy Program:

- Benefit Optimization
- Clinical Support
- Social and Community Support

For more information about the program and to find a Care Consultant, please call (888) 476-2227.

24/7 Nurseline

Florida Blue offers a 24/7 nurseline for members who may have health questions to get answers plus helpful resources that can be utilized. The nurseline is always open whether a member has an immediate health concern or a general question about their doctor's plan of treatment. For further information, please contact the nurseline at (877) 789-2583.

Blue365

Blue365 is provided automatically at no additional cost and offers access to discounted products and services at participating providers. Members may log on to www.blue365.com to learn more about these programs or call (800) 345-3885.

- ✓ Fitness Club Memberships, Exercise Footwear and Apparel
- ✓ Vision Care, Glasses and Contact Lenses
- ✓ Hearing Care and Aids
- ✓ Alternative Medicine
- ✓ Elder Care Advisory Services
- ✓ Hotel Rooms and Travel Information
- ✓ Weight Loss Management

The Florida Blue Mobile App

Florida Blue's mobile website can be accessed from any smartphone or download the app from the iPhone® or Android™ with just a tap! Visit the smartphone's app store and search for Florida Blue or visit http://apps.floridablue.com.

Telehealth-Teladoc

Florida Blue provides access to telehealth services as part of the medical plan. Teladoc is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is required and should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Teladoc should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telehealth, such as:

- ✓ Sore Throat
- ✓ Fever
- ✓ Rash
- ✓ Headache
- ✓ Cold And Flu
- ✓ Acne
- ✓ Stomachache
- ✓ Allergies
- ✓ UTIs And More

Teladoc doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact Florida Blue.

Florida Blue
Teladoc | Customer Service: (800) 835-2362 | www.teladoc.com

Wellness Incentive Program

The County offers a wellness incentive program through Better You Strides. Members can earn dollars by completing allowable activities. Earned rewards will be displayed on the gray tool bar at the top of the Dashboard. To get started:

Florida Blue Members

1. Log in to member account: Floridablue.com; click "Health & Wellness," then "Better You Strides."
2. Read and accept the Terms of Service, then choose your communication preferences.

Non-Members

1. Go to https://login.onlifehealth.com/Home/Login and click **Get Started.**
2. Enter name, date of birth, and home zip code. Click **Next**.
3. Enter the employer's group number 41954.
4. Create Username and Password in the Profile section.

For more information contact:
Better You Strides, Florida Blue Members **800-352-2583**
Non-Members call **866-560-9355**.

Florida Blue 05192/05193 HSA Base Plan At-A-Glance

Network	BlueOptions	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network****
Single	$2,500	$5,000
Family*	$5,000	$10,000
Coinsurance		
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Limit		
Single	$5,800	$11,600
Family*	$11,600	$23,200
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	20% After CYD	40% After CYD
Specialist Office Visit	20% After CYD	40% After CYD
Telehealth Services	20% After CYD	Not covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)****	Deductible Only	40% After CYD
X-rays	20% After CYD	40% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD	40% After CYD
Outpatient Surgery in Surgical Center	20% After CYD	40% After CYD
Physician Services at Surgical Center	20% After CYD	40% After CYD
Urgent Care *(Per Visit)*	20% After CYD	20% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After CYD	$500 PAD**** + 40% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD	40% After CYD
Physician Services at Hospital	20% After CYD	20% After INN Deductible
Emergency Room *(Per Visit)*	20% After CYD	20% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	20% After CYD	20% After INN CYD
Outpatient Services *(Per Visit)*	20% After CYD	40% After CYD
Outpatient Office Visit	20% After CYD	40% After CYD
Prescription Drugs *(Rx)*		
Generic	$15 Copay After CYD	50% After INN CYD
Preferred Brand Name	$60 Copay After CYD	50% After INN CYD
Non-Preferred Brand Name	$100 Copay After CYD	50% After INN CYD
Mail Order Drug *(90-Day Supply)*	$40/$150/$250 Copay After CYD	50% After INN CYD

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridablue.com. When completing the necessary search criteria, select BlueOptions network.

Plan References

**For family coverage, the in-network individual deductible amount is $2,800 and the in-network individual Out-of-Pocket Limit is $6,850.*

*****Out-Of-Network Balance Billing:***
For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.

****Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest, please confirm they are contracted with Florida Blue's BlueOptions network prior to receiving services.*

*****Per Admission Deductible*

Health Savings Account

The Florida Blue HSA Base High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollee to open a Health Savings Account (HSA). An HSA is an interest-bearing account where funds may be used to help pay employee and dependent(s) deductible, coinsurance and any qualified health care expenses not covered by the plan.

Plan Year Funding*

- **Employee Only or Employee + Family: $1,500**

Employee may opt to fund an HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free).

- 2022 IRS Contribution Limitations:
  $3,650 (individual coverage) $7,300 (family coverage)
- 2023 IRS Contribution Limitations:
  $3,850 (individual coverage) $7,750 (family coverage)

Guidelines regarding the HSAs are established by the IRS.

**Please contact Risk Management for further information regarding funding variations towards employer HSA contributions.*

What to know about an HSA

- Employee owns the HSA funds from day one and decides how and when to spend the money for eligible medical, dental and vision expenses.
- No use-it or lose-it rules; funds are in the account when needed, now or in the future. Participant cannot fund a traditional Health Care FSA.
- HSA funds may earn interest.
- The HSA will be funded with employer contributions. If employee desires to fund the remaining IRS HSA Combined Contribution Limit balance, they may do so with pre-tax payroll deductions.
- HSA dollars may be used tax-free for all eligible health care expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employee plan for retirement.
- An account holder may write a check or withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.
- Account holder can access HSA statement at any time to track account balance and activity online at www.HSAbank.com.
- To be eligible to open an HSA, employee must be covered by a high deductible health plan. Employee may not be covered under another medical plan that is not a high deductible health plan including a plan the employee's spouse may have selected where he/she has family coverage. Please Note: Eligibility status to qualify for an HSA is specifically driven by employee and NOT dependents.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Over-age dependent is not able to use HSA funds for qualified expenses, even if dependent is covered under the medical plan as Federal law does not recognize them as a qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits the County from contributing HSA funds into the account. If employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts.
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare is eligible to enroll and contribute into the HSA up to the maximum contribution amounts. These funds can be utilized for the active employee and spouse expenses.
- Active employee ON Medicare and with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse may not contribute or receive HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

HSA Bank | Customer Service: (800) 357-6246 | www.HSAbank.com

Health Savings Account: Understanding HSAs *(Continued)*

Question	HSAs Health Savings Accounts
What is an HSA?	Employee who enrolls in the Florida Blue HSA Base High Deductible Health Plan (HDHP) will receive a Health Savings Account (HSA) funded by the County and employee may also additionally fund the account with tax-free dollars. HSA funds can be used for qualified IRS 213 expenses. Go to http://www.irs.gov for a listing of 213 expenses.
How much is funded into the account?	Employee who elects coverage on the Florida Blue HSA Base High Deductible Health Plan (HDHP) will receive an HSA contribution from the County in the amount of $1,500 for single coverage or family coverage. Employee may opt to additionally fund his/her own HSA with tax-free dollars up to $3,650 (individual coverage) or $7,300 (family coverage) during the 2022 plan year or up to $3,850 (individual coverage) or $7,750 (family coverage) during the 2023 plan year. Individuals ages 55 and older can also make additional "catch-up" contributions up to $1,000 annually. ***Please Note:*** *Funding amount will be pro-rated for new hires and for qualifying events.*
How are the funds accessed?	HSA funds can be accessed via: 1) Health Savings Account Debit Card, or 2) Written check
What happens to unused funds at the end of the 2022-2023 Plan Year?	The year-end balance remains in the HSA Account and continues to earn interest. There are no use-it or lose-it rules as the funds are in the account when needed, now or in the future.
What happens to unused funds if employee discontinues participation in an HSA Plan, separates employment, or retires from the County?	Employee owns the HSA funds from day one and decides how and when to spend the money for eligible medical, dental and vision expenses. HSA funds are portable from one employer to another.
What are some examples of qualified expenses that would be eligible for reimbursement?	HSA funds can be used to pay the calendar year deductible ,coinsurance , copays and any qualified health care expenses not covered by the medical plan. Most covered services count toward the deductible, including prescriptions costs, physician visits, dental visits, hospital visits, laboratory work, etc. All expenses must be medically necessary.
Can an employee have an HSA AND a Flexible Spending Account (FSA)?	No, an employee cannot fund a traditional Health Care FSA. For more information on FSAs, please refer to the Flexible Spending Accounts page.

HSA Bank | Customer Service: (800) 357-6246 | www.HSAbank.com

Florida Blue 05781 Base Buy Up Plan At-A-Glance

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridablue.com. When completing the necessary search criteria, select BlueOptions network.

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.

**Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest, please confirm they are contracted with Florida Blue's BlueOptions network prior to receiving services.

***Per Admission Deductible

Network	BlueOptions	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$1,500	$4,500
Family	$4,500	$13,500
Coinsurance		
Member Responsibility	30%	50%
Calendar Year Out-of-Pocket Limit		
Single	$5,500	$11,000
Family	$11,000	$22,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$30 Copay	50% After CYD
Specialist Office Visit	$55 Copay	50% After CYD
Telehealth Services	$10 Copay	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	No Charge	50% After CYD
X-rays	$50 Copay	50% After CYD
Advanced Imaging *(MRI, PET, CT)*	$250 Copay	50% After CYD
Outpatient Surgery in Surgical Center	$200 Copay	50% After CYD
Physician Services at Surgical Center	$55 Copay	50% After CYD
Urgent Care *(Per Visit)*	$60 Copay	$60 Copay After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	30% After CYD	$500 PAD*** + 50% After CYD
Outpatient Hospital *(Per Visit)*	30% After CYD	50% After CYD
Physician Services at Hospital	30% After CYD	30% After INN CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$500 Copay	$500 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	No Charge	50% Coinsurance
Outpatient Services *(Per Visit)*	No Charge	50% Coinsurance
Outpatient Office Visit	No Charge	50% Coinsurance
Prescription Drugs *(Rx)*		
Generic	$15 Copay	50% Coinsurance
Preferred Brand Name	$60 Copay	50% Coinsurance
Non-Preferred Brand Name	$80 Copay	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	$40/$150/$200 Copay	50% Coinsurance

Florida Blue 05770 Buy Up Plan At-A-Glance

Network	BlueOptions	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$750	$1,500
Family	$2,250	$4,500
Coinsurance		
Member Responsibility	20%	50%
Calendar Year Out-of-Pocket Limit		
Single	$5,000	$6,000
Family	$10,000	$12,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$30 Copay	50% After CYD
Specialist Office Visit	$70 Copay	50% After CYD
Telehealth Services	$10 Copay	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	No Charge	50% After CYD
X-rays	$50 Copay	50% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD	50% After CYD
Outpatient Surgery in Surgical Center	$250 Copay	50% After CYD
Physician Services at Surgical Center	$70 Copay	50% After CYD
Urgent Care *(Per Visit)*	$65 Copay	$65 Copay After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After CYD	50% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD	50% After CYD
Physician Services at Hospital	$100 Copay	$100 Copay
Emergency Room *(Per Visit; Waived if Admitted)*	$300 Copay	$300 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	No Charge	50% Coinsurance
Outpatient Services *(Per Visit)*	No Charge	50% Coinsurance
Outpatient Office Visit	No Charge	50% Coinsurance
Prescription Drugs *(Rx)*		
Generic	$15 Copay	50% Coinsurance
Preferred Brand Name	$50 Copay	50% Coinsurance
Non-Preferred Brand Name	$80 Copay	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	$40/$125/$200	50% Coinsurance

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridablue.com. When completing the necessary search criteria, select BlueOptions network.

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.*

***Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest, please confirm they are contracted with Florida Blue's BlueOptions network prior to receiving services.*

Dental Insurance

MetLife Dental PPO Plan

The County offers dental insurance through MetLife to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact MetLife's customer service.

Dental Insurance – MetLife Dental PPO Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$25.49	$25.49	$0.00	$0.00
Employee + Family	$73.95	$25.49	$48.46	$24.23

In-Network Benefits

The MetLife Dental PPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the MetLife PPO. These participating dental providers have contractually agreed to accept MetLife's contracted fee or "allowed amount." This fee is the maximum amount a MetLife dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating MetLife PDP Plus provider. MetLife reimburses out-of-network services based on what it determines as the Reasonable and Customary Charge. The R&C is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between MetLife's R&C and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The MetLife Dental PPO plan requires a $50 individual or a $150 family deductible to be met for in-network and out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the MetLife Dental PPO plan will pay for each covered member is $1,500 for in-network and out-of-network services combined. All services, including preventive, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

MetLife | Customer Service: (800) 942-0854
www.metlife.com

MetLife Dental PPO Plan At-A-Glance

Network	PDP Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,500	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Consecutive 12 Months)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(4 Per Consecutive 12 Months)*		
Complete X-rays *(1 Per Consecutive 36 Months)*		
Bitewing X-rays *(1 Set Per Consecutive 12 Months)*		
Fluoride Treatment *(1 Per 12 Months; Dependent Children Up to Age 16)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam & Composite)*	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Oral Surgery		
Periodontal Services		
Anesthetics		
Endodontics		
Class III Services: Major Restorative Care		
Implants	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Crowns		
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Dependent Children Up To Age 19)*	Plan Pays: 50%	Plan Pays: 50% *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact MetLife's customer service or visit www.metlife.com. When completing the necessary search criteria, select PDP Plus network.

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Out-of-Network Benefits section on the previous page.*

Important Notes

- *Each covered family member may receive up to four (4) routine cleanings in any 12 consecutive months covered under the preventive benefit.*
- *For any dental work expected to cost $300 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

Vision Insurance

EyeMed Insight Vision Plan

The County offers vision insurance through EyeMed to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the carrier's summary plan document or contact EyeMed's customer service.

Vision Insurance – EyeMed Insight Vision Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$5.40	$0.00	$5.40	$2.70
Employee + Spouse	$11.64	$0.00	$11.64	$5.82
Employee + Child(ren)	$9.39	$0.00	$9.39	$4.70
Employee + Family	$15.62	$0.00	$15.62	$7.81

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employee and covered dependent(s) may select any network provider who participates in the EyeMed Insight network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may choose to receive services from vision providers who do not participate in the EyeMed Insight network. When going out of network, the provider will require payment at the time of appointment. EyeMed will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

EyeMed | Customer Service: (866) 939-3633 | www.eyemed.com

EyeMed Insight Vision Plan At-A-Glance

Network		Insight	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$0 copay	Up to $40 Reimbursement
Contact Lens Exam *(Includes Fitting & Follow Up)*	Standard	Up to $40 Allowance	Not Covered
	Premium	10% Off Retail Price	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		$15 Copay	Up to $30 Reimbursement
Bifocal		$15 Copay	Up to $50 Reimbursement
Trifocal		$15 Copay	Up to $70 Reimbursement
Frames			
Allowance		Up to $130 Allowance; 20% Discount over Allowance	Up to $91 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $210 Reimbursement
Elective *(Fitting, Follow-up & Lenses)*	Conventional	Up to $130 Allowance: 15% Discount over Allowance	Up to $130 Reimbursement
	Disposable	Up to $130 Allowance	Up to $130 Reimbursement

Locate a Provider

To search for a participating provider, contact EyeMed's customer service or visit www.eyemed.com. When completing the necessary search criteria, select Insight network.

Plan References

**Contact lenses are in lieu of spectacle lenses.*

Important Notes

Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.

Flexible Spending Accounts

The County offers Flexible Spending Accounts (FSA) administered through 90 Degree Benefits Mississippi. The FSA plan year is from October 1 to September 30.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employees to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year. There are two (2) types of FSAs:

- **Health Care FSA:** Available to eligible employee **not** enrolled in the Florida Blue 05192/05193 HSA Base Plan with an HSA. Covers medical, dental, and vision expenses that are not paid by insurance.
- **Dependent Care FSA:** Covers day care expenses for qualified dependents necessary for employee and legal spouse, if married, to work.

Health Care FSA

This account allows participant to set aside up to an annual maximum of $2,850. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note, if family income is over $20,000, this reimbursement option will likely save participants more money than dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household.

Please Note: Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from participant's paycheck for the Dependent Care FSA.

A sample list of qualified expenses eligible for reimbursement include, but not limited to, the following:

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- The Health Care FSA allows a 2 ½ month grace period at the end of the plan year. The grace period allows additional time to incur claims and use any unused FSA funds on eligible expenses after the plan year ends, September 30, 2023.
- After the grace period ends, the Health Care FSA has a 30-day run out period at the end of the plan year to submit reimbursements on eligible expenses incurred during the period of coverage within the plan year and/or grace period. Once the grace period and run out period ends any unused funds remaining in the Health Care FSA account for the plan year ending September 30, 2023, will be forfeited.
- When a plan year ends and all claims have been filed, all unused funds will be forfeited and not returned.
- Employee can enroll in an FSA only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility period.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. 90 Degree Benefits Mississippi may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the County. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $41.67 based on a 24 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$30,000	$30,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$29,000	$30,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $5,698	- $5,895
After Tax Expenses	- $0	- $1,000
Spendable Income	$23,302	$23,105
Tax Savings	**$197**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year.* ***This rule is known as "use-it or lose-it."***

90 Degree Benefits Mississippi | Phone: (800) 530-7222
Claims Fax: (228) 769-0401 | Claims Email: flex.t2@90degreebenefits.com
Claims Mailing Address: P.O. Box 1688, Pascagoula, MS 39568
www.90degreebenefits.com/mississippi.php
Main Contact: Rachael Burgess | Phone: (228) 762-2500

Employee Assistance Program

The County cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Pattison Professional Counseling and Mediation Center. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes three (3) counseling sessions with a specialist. EAP offers counseling services on issues such as:

- ✓ Child Care Resources
- ✓ Psychological Disorders
- ✓ Grief and Bereavement
- ✓ Stress Management
- ✓ Depression and Anxiety
- ✓ Work Related Issues
- ✓ Adult & Elder Care Assistance
- ✓ Military Personnel Therapy
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral, we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring department. The referring department will not receive specific information regarding the referred employee's case. The department will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Pattison Professional Counseling and Mediation Center
Locations: Crestview: (850) 682-1234 | Fort Walton: (850) 863-2873
www.ppccfl.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The County provides Basic Term Life insurance at no cost to all eligible employees through Ochs. Eligible employees will receive a benefit amount of $25,000.

Accidental Death & Dismemberment Insurance

Also, at no cost to employee, the County provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit, partial benefits may also be payable.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- › Reduces to 65% of the benefit amount at age 65
- › Reduces to 50% of the benefit amount at age 70
- › Reduces to 25% of the benefit amount at age 75
- › Reduces to 15% of the benefit amount at age 80

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek.

Ochs | Customer Service: (800) 392-7295 | www.ochsinc.com

Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

Eligible employee may elect to purchase additional Life and AD&D insurance on a voluntary basis through Ochs. This coverage may be purchased in addition to the Basic Term Life and AD&D coverage. Voluntary Life insurance offers coverage for employee, spouse and/or child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $300,000.**

- Units can be purchased in increments of $5,000 to the maximum of $750,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70
  - Reduces to 25% of the benefit amount at age 75
  - Reduces to 15% of the benefit amount at age 80
- If employee did not initially apply for Voluntary Employee Life insurance during the new hire eligibility period, employee may enroll up to the Guaranteed Issue amount of $40,000 in $5,000 increments without Evidence of Insurability (EOI) application.
- If employee currently has Voluntary Employee Life insurance, the employee will have the option to increase their coverage by up to $40,000 in $5,000 increments, not to exceed the Guaranteed Issue amount of $300,000 each annual open enrollment.

Voluntary Spouse Life Insurance

New Hires may purchase Voluntary Spouse Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $50,000**.

- Employee does not need to participate in the Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $5,000 to a maximum of $250,000 not to exceed 100% of the employee's Basic and Voluntary Life coverage amount combined.

Voluntary Life Insurance Rate Table

Monthly Premium

Age Bracket *(Based on Employee Age)*	Employee *(Rate Per $1,000 of Benefit)*	Spouse *(Rate Per $1,000 of Benefit)*
< 30	0.050	0.050
30-34	0.060	0.060
35-39	0.090	0.090
40-44	0.140	0.140
45-49	0.230	0.230
50-54	0.370	0.370
55-59	0.500	0.500
60-64	0.840	0.840
65-69	0.840	0.850
70-74	0.830	0.840
75*	1.040	1.050
AD&D	0.020	N/A

**Please Note: Rates increase past age 75 and will be provided upon request to Ochs*

Voluntary Dependent Child(ren) Life Insurance

- Employee does not need to participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- Employee may elect coverage in the increments of $1,000 to the maximum of $20,000 not to exceed 100% of the employee's Basic and Voluntary Life coverage amount combined.
- A newborn child is automatically covered for $1,000 for 31 days from the child's live birth. To continue coverage on child, the employee must elect child coverage within those 31 days otherwise the coverage will terminate at the end of the 31-day period.

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek.

Ochs | Customer Service: (800) 392-7295 | www.ochsinc.com

Long Term Disability

The County provides Long Term Disability (LTD) insurance to all eligible employees at no cost through Ochs. The LTD benefit pays a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Long Term Disability (LTD) Benefits Option 1 (Core Plan): Employer Paid

- LTD provides a benefit of 50% of employee's monthly earnings up to a benefit maximum of $3,500 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- Employee disabled prior to age 62, benefits may continue to age 65 or 5 years, whichever is shorter. If Disabled on or after age 62, please contact Risk Management for more information regarding the maximum benefit period.
- Benefits may be reduced by other income.

Ochs | Customer Service: (800) 392-7295 | www.ochsinc.com

Voluntary Long Term Disability

The County offers Voluntary Long Term Disability (LTD) insurance to all eligible employees through Ochs. The LTD benefit pays a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Voluntary Long Term Disability (LTD) Benefits Option 2 (Buy Up Plan): Employee Paid

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of $5,000 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- Employee disabled prior to age 62, benefits may continue to age 65 or the Social Security Normal Retirement Age. If Disabled on or after age 62, please contact Risk Management for more information regarding the maximum benefit period.
- Benefits may be reduced by other income.

Ochs | Customer Service: (800) 392-7295 | www.ochsinc.com

Claims, Billing & Benefit Assistance

If employees have questions on claims, receive bills from providers which they do not understand or would like general information on any of the employee benefits provided, please contact the Gehring Group Service Team.

The Gehring Group Service Team works directly with the County and its employees to provide claims and benefits service and will assist employees with their concerns. Please remember this is in addition to the County's Risk Management and is not replacing assistance employee may need from Risk Management.

Employee may contact a claims specialist by:

1. Email: okaloosacounty@gehringgroup.com

Please include your name, contact information and a brief description of the issue. A Gehring Group Claims Specialist will respond via email or phone call to gather additional information.

OR

2. Call: (800) 244-3696

When calling, please identify yourself as an employee of Okaloosa County and ask to speak to a Claims Specialist or another member of the County's designated team to assist with questions or concerns.

Office hours are Monday through Friday, 8:30am – 5:00pm. If calling after office hours, please leave a message indicating you are a Okaloosa County employee who would like to speak to a Claims Specialist. Please leave full name, contact information and a brief message and a Claims Specialist will be in contact with you the following business day.

At the Gehring Group, our goal is to be your advocate and ensure issues are resolved as quickly as possible.

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctors' names and addresses or prescription medications.

GEHRING GROUP
A RISK STRATEGIES COMPANY

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Last Modified: July 25, 2022 8:47 AM