

# Gilchrist County Benefits



2016-2017



## 2016-2017 Health, Dental, & Vision Rates

### Health Insurance: Florida Blue Base Plan 0727

Coverage	Total Premium	County Pays	Employee Monthly	Employee Per Pay Period
Employee	\$559.40	\$559.40	\$ 0.00	\$ 0.00
Employee/Spouse	\$1,249.00	\$559.40	\$689.60	\$344.80
Employee/Children	\$972.74	\$559.40	\$413.34	\$206.67
Family	\$1,621.30	\$559.40	\$1,061.90	\$530.95

### Health Insurance: Florida Blue Buy-Up Plan 03748

Coverage	Total Premium	County Pays	Employee Monthly	Employee Per Pay Period
Employee	\$608.04	\$559.40	\$48.64	\$24.32
Employee/Spouse	\$1,357.58	\$559.40	\$798.18	\$399.09
Employee/Children	\$1,057.30	\$559.40	\$497.90	\$248.95
Family	\$1,762.26	\$559.40	\$1,202.86	\$601.43

### Standard Dental

Coverage	Monthly	Bi-Weekly
Employee	\$32.48	\$16.24
Employee/Spouse	\$63.40	\$31.70
Employee/Children	\$82.44	\$41.22
Family	\$113.36	\$56.68

### Standard Vision

Coverage	Monthly	Bi-Weekly
Employee	\$6.88	\$3.44
Employee/Spouse	\$14.24	\$7.12
Employee/Children	\$12.04	\$6.02
Family	\$19.36	\$9.68

*These are the payroll rates beginning September 2016 through August 2017*

## Dependent Eligibility Medical

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this Booklet:

1. The Covered Plan Participant's spouse under a legally valid existing marriage.
2. The Covered Plan Participant's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Plan Participant has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Plan Participant, whether the dependent child resides with the Covered Plan Participant, or whether the dependent child is eligible for or enrolled in any other group health plan.
3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

*Note: It is the Covered Plan Participant's sole responsibility to establish that a child meets the applicable requirements for eligibility.*

### Handicapped Children

In the case of a handicapped dependent child, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 30 if the child is:

1. Otherwise eligible for coverage under the Group Health Plan;
2. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
3. Chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 30th birthday.

This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a handicapped child.

### Dependents to age 26 Requirement

Under Healthcare Reform, group medical plans are required to cover dependent children, through the end of the calendar year, in which the child reaches the age of 26. PRM has extended this to vision and dental coverage. Until the age of 26, a child's financial dependence on the parent, student status, place of residence, etc. is immaterial. The term "child" includes biological children, stepchildren, legally adopted/placed for adoption, and eligible foster children. Disabled children will retain child status after age 26 if proof of disability is submitted to PRM.

### Florida's State Statute Overage Dependent Coverage

When coverage under Healthcare Reform ends for the dependent (the end of the year in which the dependent turns 26) then Florida State Statute 627.6562 becomes effective. The Statute allows dependents to stay on the plan until the end of the calendar year in which they attain age 30. In order to continue coverage until the end of the year they turn age 30, the dependent must meet ALL of the following requirements.

- (a) Is unmarried and does not have a dependent of his or her own;
- (b) Is a resident of this state or a full-time or part-time student; and
- (c) Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any Other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

To receive the reduced premium rate a retiree must meet the following requirements.

## Dental

- Through the end of the calendar year in which they turn 25

## Vision

- Through the end of the calendar year in which they turn 25

## Life

- Through the end of the calendar year in which they turn 25

## Qualifying Events

The premiums you pay toward yours and your dependents' coverage will be deducted from your pay check pre-tax through an IRS Section 125 Plan. **Coverage elections made at Open Enrollment or during New Hire enrollment cannot be changed until the next annual Open Enrollment period.** The only exception to this IRS Section 125 Rule is if you experience a "Qualifying Event." A Qualifying Event allows you to make a change to your benefit elections within 30 days of the Event.

Examples of Qualifying Events include:

- Marriage
- Birth, adoption, or legal custody of a dependent child
- Divorce or legal separation
- Involuntary loss of other group coverage
- Death

**Please contact Human Resources within 30 days of any qualifying event.**

## Open Enrollment

Gilchrist County's Open Enrollment period is usually held in August each year for a September payroll deduction start date. The effective date for any insurance changes during Open Enrollment will be October 1st.

## FRS Retirement Information

You should be sent an information package concerning FRS information and options. You will be given a option to choose the Investment Plan or Pension Plan. More information may be found at

[www.frsplan.com](http://www.frsplan.com)

You have 5 months from your date of hire to make a selection.

## Health Insurance

Gilchrist County offers 2 Health Insurance Plans. We have a Base Plan (0727) and a Buy-Up Plan (03748). Below you will find a chart of some common charges.

<b>Florida Blue</b>		
Plan Choice	<b>0727</b>	<b>3748</b>
<u>Cost Sharing Options</u>	Base	Buy-Up
<b>Calendar Year Deductible</b>		
In Network per person/per family	500/1500	0
Out of Network per person/per family	Combined	500/1500
<b>Coinsurance</b>		
In network	20%	0%
Out of network	40%	40%
<b>Office visits</b>		
Family Physician	\$15	\$10
Specialist	\$15	\$20
<b>Allergy injection</b>		
In- network family phy	\$10	\$10
In- network specialist	\$10	\$10
<b>Prescription drugs</b>		
Deductible	none	none
Copay	5/35/35	10/25/60
Independent Diagnostic (AIS)	\$15	\$50
Emergency Room Facility Charge	80% after ded	\$50
Physician Services	80% after ded	\$0
Urgent Care	\$15	\$20
Hospital Facility Charge	80% after ded	250/500
Physician Services	80% after ded	\$0
<b>Out of pocket maximum</b>		
Ind/Family	<b>Add Ded to OOP</b>	
In network per person/per family	1500/4500	1500/3000
Out of network per person/per family	combined	3000/6000

In the next few pages of this Benefit Guide, you will find more detailed information regarding those plans. For specific questions, please ask Tammy Moore.

You are able to change plans during Open Enrollment each year, based on plan options that are available to Gilchrist County.

The information contained in this proposal includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency. In addition, the rates quoted within this proposal are based on the plan benefits at the time the proposal is issued and may change before the plan effective date if additional plan changes become necessary.

Additionally, Interim rules released by the Federal Government February 2, 2010 require BCBSF to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE). Benefits and rates reflected in the proposal are subject to change based on the outcomes of the test.

BlueChoice 0727	
<b>COST SHARING</b>	
Maximums shown are Per Benefit Period (BPM) unless noted	
<b>Deductible (DED) (Per Person/Family Agg)</b>	
In-Network	\$500 / \$1,500
Out-of-Network	Combined w/In-Ntwk
<b>Coinsurance (Member Responsibility)</b>	
In-Network	20%
Out-of-Network	40%
<b>Out of Pocket Maximum (Per Person/Family Agg)</b>	
In-Network	Includes only Coins \$1,500 / \$4,500
Out-of-Network	Combined w/In-Ntwk
<b>Lifetime Maximum</b>	
No Maximum	
<b>PROFESSIONAL PROVIDER SERVICES</b>	
<b>Allergy Injections</b>	
In-Network Family Physician	\$5
In-Network Specialist	\$5
Out-of-Network	DED + 40%
<b>E-Office Visit Services</b>	
In-Network Family Physician	\$15 FP
In-Network Specialist	\$15 SP
Out-of-Network	DED + 40%
<b>Office Services</b>	
In-Network Family Physician	\$15 FP
In-Network Specialist	\$15 SP
Out-of-Network	DED + 40%
<b>Provider Services at Hospital and ER</b>	
In-Network Family Physician	DED + 20%
In-Network Specialist	DED + 20%
Out-of-Network	DED + 20%
<b>Provider Services at Other Locations</b>	
In-Network Family Physician	DED + 20%
In-Network Specialist	DED + 20%
Out-of-Network	DED + 40%
<b>Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center</b>	
In-Network Specialist	DED + 20%
Out-of-Network	DED + 40%
<b>PREVENTIVE CARE</b>	
<b>Adult Wellness Office Services</b>	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	30% (No DED)
<b>Colonoscopies (Routine)</b>	
Age 50+ then Frequency Schedule Applies	
In-Network	\$0
Out-of-Network	40% (No DED)
<b>Mammograms (Routine and Dx)</b>	
In-Network	\$0
Out-of-Network	\$0
<b>Well Child Office Visits (No BPM)</b>	
In-Network Family Physician	\$0
In-Network Specialist	\$0

<b>BlueChoice</b> 0727	
<b>COST SHARING</b> Maximums shown are Per Benefit Period (BPM) unless noted	
Out-of-Network	40% (No DED)
<b>EMERGENCY/URGENT/CONVENIENT CARE</b>	
<b>Ambulance Maximum (per Day)</b>	
In-Network	No Maximum
Out-of-Network	DED + 20%
	In-Ntwk DED + 20%
<b>Convenient Care Centers (CCC)</b>	
In-Network	\$15 FP
Out-of-Network	DED + 40%
<b>Emergency Room Facility Services</b> (also see Professional Provider Services)	
In-Network	DED + 20%
Out-of-Network	DED + 20%
<b>Urgent Care Centers (UCC)</b>	
In-Network	\$15 FP
Out-of-Network	DED + 40%
<b>FACILITY SERVICES - HOSP/SURG/ICL/IDTF</b> Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.	
<b>Ambulatory Surgical Center</b>	
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>Independent Clinical Lab</b>	
In-Network	20% (No DED)
Out-of-Network	40% (No DED)
<b>Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)</b>	
In-Network - Advanced Imaging Services (AIS)	\$15 SP
In-Network - Other Diagnostic Services	\$15 SP
Out-of-Network	DED + 40%
<b>Inpatient Hospital (per admit)</b>	
In-Network	DED + 20%
Out-of-Network	\$300 PAD + DED + 40%
Out-of-Network (Emergency Admission)	DED+20%
<b>Inpatient Rehab Maximum</b>	
	No Maximum
<b>Outpatient Hospital (per visit)</b>	
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>Therapy at Outpatient Hospital</b>	
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b>	
<b>Inpatient Hospitalization (30 day max)</b>	
In-Network	DED + 20%
Out-of-Network	\$300 PAD + DED + 40%
Out-of-Network (Emergency Admission)	DED + 20%
<b>Outpatient Hospitalization (per visit)</b>	
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>Provider Services at Hospital and ER</b>	
In-Network Family Physician or Specialist	DED + 20%
Out-of-Network Provider	DED + 20%
<b>Physician Office Visit</b>	
In-Network Family Physician or Specialist	\$15
Out-of-Network Provider	DED + 40%
<b>Emergency Room Facility Services (per visit)</b>	
In-Network	DED + 20%
Out-of-Network	DED + 20%
<b>Provider Services at Locations other than Hospital and ER</b>	
In-Network Family Physician	DED + 20%
In-Network Specialist	DED + 20%
Out-of-Network Provider	DED + 40%
<b>OTHER SPECIAL SERVICES AND LOCATIONS</b>	
<b>Advanced Imaging Services in Physician's Office</b>	
In-Network Family Physician	\$15 FP
In-Network Specialist	\$15 SP
Out-of-Network	DED + 40%
<b>Birth Center</b>	
In-Network	DED + 20%
Out-of-Network	DED + 40%

<b>BlueChoice</b> 0727	
<b>COST SHARING</b> Maximums shown are Per Benefit Period (BPM) unless noted	
<b>Diabetic Equipment and Supplies*</b>	
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>Durable Medical Equipment, Prosthetics, Orthotics BPM</b>	No Maximum
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>Home Health Care BPM</b>	20 Visits
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>Hospice LTM</b>	No Maximum
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>Outpatient Therapy and Spinal Manipulations BPM</b>	54 Visits (Includes up to 26 Spinal Manipulations)
<b>Skilled Nursing Facility BPM</b>	60 Days
In-Network	DED + 20%
Out-of-Network	DED + 40%
<b>PRESCRIPTION DRUGS</b>	
<b>Deductible</b>	
<b>In-Network</b>	
<b>Retail (30 Days)</b>	
Generic/Preferred Brand/Non-Preferred	\$5/ \$35/\$35
<b>Mail Order (90 Days)</b>	\$10/ \$70/ \$70
Generic/Preferred Brand/Non-Preferred	
<b>Out-of-Network</b>	
<b>Retail (30 Days)</b>	
Generic/Preferred Brand/Non-Preferred	50% of allowance
<b>Mail Order (90 Days)</b>	50% of allowance
Generic/Preferred Brand/Non-Preferred	
<b>Medical Pharmacy (Provider-Administered Rx)**</b>	
In-Network	See Location of Service
Out-of-Network	See Location of Service

\* Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit except when the group carves out pharmacy. When pharmacy is carved out, they are available through DME. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

\*\* (1) Medical Pharmacy Monthly OOP Max includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations; only office cost share applies.

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<b>BlueOptions</b> Predictable Cost 03748	
<b>COST SHARING</b> Maximums shown are Per Benefit Period (BPM) unless noted	
<b>Deductible (DED) (Per Person/Family Agg)</b>	
In-Network	\$0 / \$0
Out-of-Network	\$500 / \$1,500
<b>Coinsurance (Member Responsibility)</b>	
In-Network	0%
Out-of-Network	40%
<b>Out of Pocket Maximum (Per Person/Family Agg)</b>	Includes DED, Coins, Copays
In-Network	\$1,500 / \$3,000
Out-of-Network	\$3,000 / \$6,000
<b>Lifetime Maximum</b>	No Maximum
<b>PROFESSIONAL PROVIDER SERVICES</b>	
<b>Allergy Injections</b>	
In-Network Family Physician	\$10
In-Network Specialist	\$10
Out-of-Network	DED + 40%
<b>E-Office Visit Services</b>	
In-Network Family Physician	\$10
In-Network Specialist	\$10
Out-of-Network	DED + 40%
<b>Office Services</b>	
In-Network Family Physician	\$10 FP
In-Network Specialist	\$20SP
Out-of-Network	DED + 40%
<b>Provider Services at Hospital and ER</b>	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	\$0
<b>Provider Services at Other Locations</b>	
In-Network Family Physician	\$10 FP
In-Network Specialist	\$20 SP
Out-of-Network	DED + 40%
<b>Radiology, Pathology and Anesthesiology</b>	
<b>Provider Services at Hospital or Ambulatory Surgical Center</b>	
In-Network Specialist	\$25 SP
Out-of-Network	DED + 40%
<b>PREVENTIVE CARE</b>	
<b>Adult Wellness Office Services</b>	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	40% (No DED)
<b>Colonoscopies (Routine)</b>	Age 50+ then Frequency Schedule Applies
In-Network	\$0
Out-of-Network	\$0
<b>Independent Clinical Lab</b>	
In-Network	\$0
Out-of-Network	40% (No DED)
<b>Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)</b>	
In-Network - Advanced Imaging Services (AIS)	\$0

<b>BlueOptions</b> Predictable Cost 03748	
<b>COST SHARING</b> Maximums shown are Per Benefit Period (BPM) unless noted	
In-Network - Other Diagnostic Services	\$0
Out-of-Network	40% (No DED)
<b>Mammograms (Routine and Dx)</b>	
In-Network	\$0
Out-of-Network	\$0
<b>Outpatient Hospital (per visit)</b>	
In-Network	\$0
Out-of-Network	\$300
<b>Provider Services at Outpatient Facility</b>	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	\$0
<b>Well Child Office Visits (No BPM)</b>	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	40% (No DED)
<b>EMERGENCY/URGENT/CONVENIENT CARE</b>	
<b>Ambulance Maximum (per Day)</b>	
In-Network	\$5,500
Out-of-Network	\$0
<b>Convenient Care Centers (CCC)</b>	
In-Network	\$10 FP
Out-of-Network	DED + 40%
<b>Emergency Room Facility Services</b> (also see Professional Provider Services)	
In-Network	\$50
Out-of-Network	\$50
<b>Urgent Care Centers (UCC)</b>	
In-Network	\$20
Out-of-Network	DED + 40%
<b>FACILITY SERVICES - HOSP/SURG/ICL/IDTF</b> Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.	
<b>Ambulatory Surgical Center</b>	
In-Network	\$50
Out-of-Network	DED + 40%
<b>Independent Clinical Lab</b>	
In-Network	\$0
Out-of-Network	DED + 40%
<b>Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)</b>	
In-Network - Advanced Imaging Services (AIS)	\$50
In-Network - Other Diagnostic Services	\$50
Out-of-Network	DED + 40%
<b>Inpatient Hospital (per admit)</b>	
In-Network	Option 1 - \$250 Option 2 - \$500
Out-of-Network	\$750
Out-of-Network (Emergency Admission)	\$50
<b>Inpatient Rehab Maximum</b>	
	21 Days
<b>Outpatient Hospital (per visit)</b>	
In-Network	Option 1 - \$100 Option 2 - \$200
Out-of-Network	\$300
<b>Therapy at Outpatient Hospital</b>	
In-Network	Option 1 - \$100 Option 2 - \$200
Out-of-Network	\$300
<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b>	
<b>Inpatient Hospitalization</b>	
In-Network	Option 1 - \$250 Option 2 - \$500
Out-of-Network	\$750
Out-of-Network (Emergency Admission)	\$50
<b>Outpatient Hospitalization (per visit)</b>	
In-Network	Option 1 - \$100 Option 2 - \$200
Out-of-Network	\$300
<b>Provider Services at Hospital and ER</b>	
In-Network Family Physician or Specialist	\$0
Out-of-Network Provider	\$0

<b>BlueOptions</b> Predictable Cost 03748	
<b>COST SHARING</b> Maximums shown are Per Benefit Period (BPM) unless noted	
<b>Physician Office Visit</b> In-Network Family Physician or Specialist Out-of-Network Provider	\$10 FP/\$20 SP 40% (No DED)
<b>Emergency Room Facility Services (per visit)</b> In-Network Out-of-Network	\$50 \$50
<b>Provider Services at Locations other than Hospital and ER</b> In-Network Family Physician In-Network Specialist Out-of-Network Provider	\$10 \$20 40% (No DED)
<b>OTHER SPECIAL SERVICES AND LOCATIONS</b>	
<b>Advanced Imaging Services in Physician's Office</b> In-Network Family Physician In-Network Specialist Out-of-Network	\$10 \$20 DED + 40%
<b>Birthing Center</b> In-Network Out-of-Network	\$0 DED + 40%
<b>Diabetic Equipment and Supplies*</b> In-Network Out-of-Network	\$0 DED + 40%
<b>Durable Medical Equipment, Prosthetics, Orthotics BPM</b> In-Network Out-of-Network	No Maximum DED + 40%
<b>Home Health Care BPM</b> In-Network Out-of-Network	20 Visits \$0 DED + 40%
<b>Hospice LTM</b> In-Network Out-of-Network	No Maximum \$0 DED + 40%
<b>Outpatient Therapy and Spinal Manipulations BPM</b>	35 Visits (Includes up to 26 Spinal Manipulations)
<b>Skilled Nursing Facility BPM</b> In-Network Out-of-Network	60 Days \$0 DED + 40%
<b>PRESCRIPTION DRUGS</b>	
<b>Deductible</b>	
<b>In-Network</b>	
<b>Retail (30 Days)</b> Generic/Preferred Brand/Non-Preferred	\$10/ \$25/ \$60
<b>Mail Order (90 Days)</b> Generic/Preferred Brand/Non-Preferred	\$20/ \$50/ \$120
<b>Out-of-Network</b>	
<b>Retail (30 Days)</b> Generic/Preferred Brand/Non-Preferred	50% of allowance
<b>Mail Order (90 Days)</b> Generic/Preferred Brand/Non-Preferred	50% of allowance
<b>Medical Pharmacy (Provider-Administered Rx)**</b> In-Network Out-of-Network	Not Applicable See Location of Service DED + 50%

\* Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit except when the group carves out pharmacy. When pharmacy is carved out, they are available through DME. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

\*\* (1) Medical Pharmacy Monthly OOP Max includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations; only office cost share applies.

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# Dental Insurance



	<b><u>PPO Plan</u></b>	
<b>Deductible</b>	<b><u>In Network</u></b>	<b><u>Out of Network</u></b>
<b>Preventive Services</b>	Waived	Waived
<b>Basic &amp; Major Services</b>	\$50 / \$150 Family	
<b>Plan Year Maximum (Per Person)</b>	\$1,000	
<b>Out of Network Reimbursement</b>	90th U&C	
<b><u>Preventive Services:</u></b> Exams (2 per benefit period) Cleanings (2 per benefit period) Bitewing X-Rays (2 per benefit period) Full Mouth X-Rays (1 in 3 years) Sealants (age 16 & under) Fluoride Treatments (Children 18 and under, 1 per benefit period) Space Maintainers	Covered 100%	
<b><u>Basic Services:</u></b> Fillings Oral Surgery Root Canal Therapy Periodontics Anesthesia	Covered 80% after Deductible	
<b><u>Major Services:</u></b> Crowns (1 in 5 years per tooth) Fixed Bridges & Repairs Full & Partial Dentures (1 in 5 years) & Repairs	Covered 50% after Deductible	
<b><u>Orthodontia</u> (Children up to age 19)</b>	Covered 50% up to \$1,000 Lifetime Max	
<b>Late Entrant Provision</b>	If you choose to sign up for dental after your initial enrollment period, you will become a late entrant. Late entrants are only eligible for cleanings, exams, and fluoride for the first 12 months of coverage.	

# Vision Insurance



Network: <b>VSP</b>	<b>In Network / Non –Network</b>
<b><u>Exams</u></b>	
<b>Frequency</b>	12 Months
<b>Benefit</b>	\$10 Copay / up to \$43
<b><u>Lenses</u></b>	
<b>Frequency</b>	12 Months
<b>Single</b>	\$10 Copay / up to \$26
<b>Bifocal</b>	\$10 Copay / up to \$43
<b>Trifocal</b>	\$10 Copay / up to \$60
<b><u>Frames</u></b>	
<b>Frequency</b>	24 Months
<b>Benefit</b>	Up to \$120 / up to \$40
<b><u>Contact Lenses</u></b>	
<b>Frequency</b>	12 Months
<b>Elective</b>	Up to \$105 / up to \$100
<b>Medically Necessary (Requires Prior Authorization)</b>	Covered 100% / up to \$210
<b>Notes</b>	



**Additional Life Insurance**

Life insurance coverage can help your family meet daily expenses, maintain their standard of living, pay off debt, secure your children's education, and more in the event of your passing. Standard Insurance Company (The Standard) has developed this document to provide you with information about the elective coverage you may select through Gilchrist County Board of County Commissioners.

**Eligibility Requirements**

**Policy # 751525**

- The group policy effective date is February 1, 2014

**Employee**

- You must be insured for Basic Life through The Standard
- You must be an active employee of Gilchrist County Board of County Commissioners working at least 25 hours each week
- Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible
- You cannot be insured as both an employee and a dependent

**Dependent**

- You must elect Additional Life insurance for yourself in order to elect Dependents Life insurance for your spouse and child(ren)
- Spouse means a person to whom you are legally married
- Child means your child from live birth through age 20 (through age 24 if a registered student in full-time attendance at an accredited educational institution)
- Your child cannot be insured by more than one employee
- Your spouse or children must not be full-time member(s) of the armed forces

**Premium**

- You pay 100 percent of the premium for this coverage through easy payroll deduction

**Coverage Amount Guidelines**

Within the coverage amount guidelines shown below, you select the amount of Additional Life and Dependents Life insurance for which you are interested in applying.

	Minimum	Incremental Unit	Guarantee Issue Amount	Maximum
<b>Employee</b>	\$10,000	\$10,000	\$100,000	\$500,000*
<b>Spouse</b>	\$5,000	\$5,000	\$20,000	\$250,000

**Child**      \$1,000, \$2,000, \$4,000, \$5,000 or \$10,000

\*but not to exceed 5 times your Annual Earnings

Note:

- Amounts of coverage elected above the Guarantee Issue amount are subject to medical underwriting approval. To submit a medical history statement online, visit: [www.standard.com/mhs](http://www.standard.com/mhs)
- All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior life insurance plan are also subject to medical underwriting approval.
- The coverage amount for your spouse cannot exceed 100 percent of your Additional Life coverage.
- The coverage amount for your child(ren) cannot exceed 100 percent of your Basic Life coverage.

**Coverage Amount Needed**

Your family has a unique set of circumstances and financial demands. To help you figure out the amount of Additional Life insurance you may need to protect your loved ones, The Standard has created a Life Insurance Needs Calculator found at: <http://www.standard.com/lifeneeds>.

**Employee Coverage Effective Date**

To become insured, you must satisfy the eligibility requirements listed above, serve an eligibility waiting period\*, receive medical underwriting approval (if applicable), agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

\* You become eligible on the first day of the month that follows or coincides with 30 days of membership

If you are not actively at work on the day before the scheduled effective date of insurance, including Dependents Life insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative for more information regarding these requirements that must be satisfied for your insurance to become effective.

**Life Age Reductions**

Under this plan, your coverage amount reduces by your age by 35 percent at age 65 and by 50 percent at age 70.

Your spouse's coverage amount reduces by your age by 35 percent at age 65 and by 50 percent at age 70.

If you are age 65 or over, ask your human resources representative for the amount of coverage available.

**Life Insurance Exclusions**

This plan contains an exclusion for death resulting from suicide or other intentionally self-inflicted injury. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death. This is subject to state variations.

**Life Insurance Features and Benefits**

Please see your human resources representative for additional information about the features and benefits below.

- |                            |  |
|----------------------------|--|
| <b>Waiver of Premium</b>   | If you become totally disabled while insured under this plan and under age 60, and complete a waiting period of 180 days, your Basic and Additional Life insurance may continue without premium payment until age 65 provided you give us satisfactory proof that you remain totally disabled. |
| <b>Accelerated Benefit</b> | If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of \$500,000.  |
| <b>Portability</b>         | If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage.   |
| <b>Conversion</b>          | If your insurance ends or reduces, you may be eligible to convert your life insurance to an individual life insurance policy without submitting proof of good health.  |

**When Insurance Ends**

Coverage ends automatically on the earliest of the following:

- The last date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements (coverage may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy

In addition to the above requirements, your Dependents Life coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent.

For more details on when insurance ends, contact your human resources representative.

**Group Insurance Certificate**

If coverage becomes effective, and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. Neither the information presented in this summary nor the certificate modifies the group policy or the insurance coverage in any way.

**Employee Life Monthly Premiums**

Coverage Amount	Employee's Age as of last October 1									
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69*	70+*
\$10,000	0.62	0.80	0.90	1.33	2.09	3.28	5.06	7.27	8.26	10.30
\$20,000	1.24	1.60	1.80	2.66	4.18	6.56	10.12	14.54	16.51	20.60
\$30,000	1.86	2.40	2.70	3.99	6.27	9.84	15.18	21.81	24.77	30.90
\$40,000	2.48	3.20	3.60	5.32	8.36	13.12	20.24	29.08	33.02	41.20
\$50,000	3.10	4.00	4.50	6.65	10.45	16.40	25.30	36.35	41.28	51.50
\$60,000	3.72	4.80	5.40	7.98	12.54	19.68	30.36	43.62	49.53	61.80
\$70,000	4.34	5.60	6.30	9.31	14.63	22.96	35.42	50.89	57.79	72.10
\$80,000	4.96	6.40	7.20	10.64	16.72	26.24	40.48	58.16	66.04	82.40
\$90,000	5.58	7.20	8.10	11.97	18.81	29.52	45.54	65.43	74.30	92.70
\$100,000	6.20	8.00	9.00	13.30	20.90	32.80	50.60	72.70	82.55	103.00
\$110,000	6.82	8.80	9.90	14.63	22.99	36.08	55.66	79.97	90.81	113.30
\$120,000	7.44	9.60	10.80	15.96	25.08	39.36	60.72	87.24	99.06	123.60
\$130,000	8.06	10.40	11.70	17.29	27.17	42.64	65.78	94.51	107.32	133.90
\$140,000	8.68	11.20	12.60	18.62	29.26	45.92	70.84	101.78	115.57	144.20
\$150,000	9.30	12.00	13.50	19.95	31.35	49.20	75.90	109.05	123.83	154.50
\$160,000	9.92	12.80	14.40	21.28	33.44	52.48	80.96	116.32	132.08	164.80
\$170,000	10.54	13.60	15.30	22.61	35.53	55.76	86.02	123.59	140.34	175.10
\$180,000	11.16	14.40	16.20	23.94	37.62	59.04	91.08	130.86	148.59	185.40
\$190,000	11.78	15.20	17.10	25.27	39.71	62.32	96.14	138.13	156.85	195.70
\$200,000	12.40	16.00	18.00	26.60	41.80	65.60	101.20	145.40	165.10	206.00
\$210,000	13.02	16.80	18.90	27.93	43.89	68.88	106.26	152.67	173.36	216.30
\$220,000	13.64	17.60	19.80	29.26	45.98	72.16	111.32	159.94	181.61	226.60
\$230,000	14.26	18.40	20.70	30.59	48.07	75.44	116.38	167.21	189.87	236.90
\$240,000	14.88	19.20	21.60	31.92	50.16	78.72	121.44	174.48	198.12	247.20
\$250,000	15.50	20.00	22.50	33.25	52.25	82.00	126.50	181.75	206.38	257.50
\$260,000	16.12	20.80	23.40	34.58	54.34	85.28	131.56	189.02	214.63	267.80
\$270,000	16.74	21.60	24.30	35.91	56.43	88.56	136.62	196.29	222.89	278.10
\$280,000	17.36	22.40	25.20	37.24	58.52	91.84	141.68	203.56	231.14	288.40
\$290,000	17.98	23.20	26.10	38.57	60.61	95.12	146.74	210.83	239.40	298.70
\$300,000	18.60	24.00	27.00	39.90	62.70	98.40	151.80	218.10	247.65	309.00
\$310,000	19.22	24.80	27.90	41.23	64.79	101.68	156.86	225.37	255.91	319.30
\$320,000	19.84	25.60	28.80	42.56	66.88	104.96	161.92	232.64	264.16	329.60
\$330,000	20.46	26.40	29.70	43.89	68.97	108.24	166.98	239.91	272.42	339.90
\$340,000	21.08	27.20	30.60	45.22	71.06	111.52	172.04	247.18	280.67	350.20
\$350,000	21.70	28.00	31.50	46.55	73.15	114.80	177.10	254.45	288.93	360.50
\$360,000	22.32	28.80	32.40	47.88	75.24	118.08	182.16	261.72	297.18	370.80
\$370,000	22.94	29.60	33.30	49.21	77.33	121.36	187.22	268.99	305.44	381.10
\$380,000	23.56	30.40	34.20	50.54	79.42	124.64	192.28	276.26	313.69	391.40
\$390,000	24.18	31.20	35.10	51.87	81.51	127.92	197.34	283.53	321.95	401.70
\$400,000	24.80	32.00	36.00	53.20	83.60	131.20	202.40	290.80	330.20	412.00
\$410,000	25.42	32.80	36.90	54.53	85.69	134.48	207.46	298.07	338.46	422.30
\$420,000	26.04	33.60	37.80	55.86	87.78	137.76	212.52	305.34	346.71	432.60
\$430,000	26.66	34.40	38.70	57.19	89.87	141.04	217.58	312.61	354.97	442.90
\$440,000	27.28	35.20	39.60	58.52	91.96	144.32	222.64	319.88	363.22	453.20
\$450,000	27.90	36.00	40.50	59.85	94.05	147.60	227.70	327.15	371.48	463.50
\$460,000	28.52	36.80	41.40	61.18	96.14	150.88	232.76	334.42	379.73	473.80
\$470,000	29.14	37.60	42.30	62.51	98.23	154.16	237.82	341.69	387.99	484.10
\$480,000	29.76	38.40	43.20	63.84	100.32	157.44	242.88	348.96	396.24	494.40
\$490,000	30.38	39.20	44.10	65.17	102.41	160.72	247.94	356.23	404.50	504.70
\$500,000	31.00	40.00	45.00	66.50	104.50	164.00	253.00	363.50	412.75	515.00

\* Coverage amounts for ages 65 and over reduce due to age reduction (see Life Insurance Age Reductions section).

**Spouse Life Monthly Premiums**

Coverage Amount	Employee's Age as of last October 1									
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69*	70+*
\$5,000	0.31	0.40	0.45	0.67	1.05	1.64	2.53	3.64	4.13	5.15
\$10,000	0.62	0.80	0.90	1.33	2.09	3.28	5.06	7.27	8.26	10.30
\$15,000	0.93	1.20	1.35	2.00	3.14	4.92	7.59	10.91	12.38	15.45
\$20,000	1.24	1.60	1.80	2.66	4.18	6.56	10.12	14.54	16.51	20.60
\$25,000	1.55	2.00	2.25	3.33	5.23	8.20	12.65	18.18	20.64	25.75
\$30,000	1.86	2.40	2.70	3.99	6.27	9.84	15.18	21.81	24.77	30.90
\$35,000	2.17	2.80	3.15	4.66	7.32	11.48	17.71	25.45	28.89	36.05
\$40,000	2.48	3.20	3.60	5.32	8.36	13.12	20.24	29.08	33.02	41.20
\$45,000	2.79	3.60	4.05	5.99	9.41	14.76	22.77	32.72	37.15	46.35
\$50,000	3.10	4.00	4.50	6.65	10.45	16.40	25.30	36.35	41.28	51.50
\$55,000	3.41	4.40	4.95	7.32	11.50	18.04	27.83	39.99	45.40	56.65
\$60,000	3.72	4.80	5.40	7.98	12.54	19.68	30.36	43.62	49.53	61.80
\$65,000	4.03	5.20	5.85	8.65	13.59	21.32	32.89	47.26	53.66	66.95
\$70,000	4.34	5.60	6.30	9.31	14.63	22.96	35.42	50.89	57.79	72.10
\$75,000	4.65	6.00	6.75	9.98	15.68	24.60	37.95	54.53	61.91	77.25
\$80,000	4.96	6.40	7.20	10.64	16.72	26.24	40.48	58.16	66.04	82.40
\$85,000	5.27	6.80	7.65	11.31	17.77	27.88	43.01	61.80	70.17	87.55
\$90,000	5.58	7.20	8.10	11.97	18.81	29.52	45.54	65.43	74.30	92.70
\$95,000	5.89	7.60	8.55	12.64	19.86	31.16	48.07	69.07	78.42	97.85
\$100,000	6.20	8.00	9.00	13.30	20.90	32.80	50.60	72.70	82.55	103.00
\$105,000	6.51	8.40	9.45	13.97	21.95	34.44	53.13	76.34	86.68	108.15
\$110,000	6.82	8.80	9.90	14.63	22.99	36.08	55.66	79.97	90.81	113.30
\$115,000	7.13	9.20	10.35	15.30	24.04	37.72	58.19	83.61	94.93	118.45
\$120,000	7.44	9.60	10.80	15.96	25.08	39.36	60.72	87.24	99.06	123.60
\$125,000	7.75	10.00	11.25	16.63	26.13	41.00	63.25	90.88	103.19	128.75
\$130,000	8.06	10.40	11.70	17.29	27.17	42.64	65.78	94.51	107.32	133.90
\$135,000	8.37	10.80	12.15	17.96	28.22	44.28	68.31	98.15	111.44	139.05
\$140,000	8.68	11.20	12.60	18.62	29.26	45.92	70.84	101.78	115.57	144.20
\$145,000	8.99	11.60	13.05	19.29	30.31	47.56	73.37	105.42	119.70	149.35
\$150,000	9.30	12.00	13.50	19.95	31.35	49.20	75.90	109.05	123.83	154.50
\$155,000	9.61	12.40	13.95	20.62	32.40	50.84	78.43	112.69	127.95	159.65
\$160,000	9.92	12.80	14.40	21.28	33.44	52.48	80.96	116.32	132.08	164.80
\$165,000	10.23	13.20	14.85	21.95	34.49	54.12	83.49	119.96	136.21	169.95
\$170,000	10.54	13.60	15.30	22.61	35.53	55.76	86.02	123.59	140.34	175.10
\$175,000	10.85	14.00	15.75	23.28	36.58	57.40	88.55	127.23	144.46	180.25
\$180,000	11.16	14.40	16.20	23.94	37.62	59.04	91.08	130.86	148.59	185.40
\$185,000	11.47	14.80	16.65	24.61	38.67	60.68	93.61	134.50	152.72	190.55
\$190,000	11.78	15.20	17.10	25.27	39.71	62.32	96.14	138.13	156.85	195.70
\$195,000	12.09	15.60	17.55	25.94	40.76	63.96	98.67	141.77	160.97	200.85
\$200,000	12.40	16.00	18.00	26.60	41.80	65.60	101.20	145.40	165.10	206.00
\$205,000	12.71	16.40	18.45	27.27	42.85	67.24	103.73	149.04	169.23	211.15
\$210,000	13.02	16.80	18.90	27.93	43.89	68.88	106.26	152.67	173.36	216.30
\$215,000	13.33	17.20	19.35	28.60	44.94	70.52	108.79	156.31	177.48	221.45
\$220,000	13.64	17.60	19.80	29.26	45.98	72.16	111.32	159.94	181.61	226.60
\$225,000	13.95	18.00	20.25	29.93	47.03	73.80	113.85	163.58	185.74	231.75
\$230,000	14.26	18.40	20.70	30.59	48.07	75.44	116.38	167.21	189.87	236.90
\$235,000	14.57	18.80	21.15	31.26	49.12	77.08	118.91	170.85	193.99	242.05
\$240,000	14.88	19.20	21.60	31.92	50.16	78.72	121.44	174.48	198.12	247.20
\$245,000	15.19	19.60	22.05	32.59	51.21	80.36	123.97	178.12	202.25	252.35
\$250,000	15.50	20.00	22.50	33.25	52.25	82.00	126.50	181.75	206.38	257.50

\* Coverage amounts for ages 65 and over reduce due to age reduction (see Life Insurance Age Reductions section).

**Child Life Monthly Premiums\***

Coverage	
Amount	Premium
\$1,000	0.20
\$2,000	0.40
\$4,000	0.80
\$5,000	1.00
\$10,000	2.00

\* Regardless of the number of eligible children covered.



### **Standard Insurance Company**

For more than 100 years we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. We have earned a national reputation for quality products and superior service by always striving to do what is right for our customers.

Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group Disability, Life, Dental and Vision insurance and Individual Disability insurance. We provide insurance to more than 24,800 groups, covering over 8 million employees nationwide.\* Our first group policy, written in 1951 and still in force today, stands as a testament to our commitment to building long-term relationships.

To learn more about products from The Standard, Contact your human resources department or visit us at **[www.standard.com](http://www.standard.com)**.

\* As of June 30, 2013, based on internal data developed by Standard Insurance Company.

Standard Insurance Company  
1100 SW Sixth Avenue  
Portland OR 97204

GP190-LIFE/S399, GP399-LIFE/TRUST,  
GP899-LIFE, GP190-LIFE/A997/S399

# CHOOSE YOUR **FRS** RETIREMENT PLAN



Florida Retirement System

## Welcome!

Coming to work here was a great choice. Now you have another important choice to make: which retirement plan to join. The Florida Retirement System (FRS) offers you two retirement plans – the Investment Plan and the Pension Plan. As an FRS member, you get to choose the one that's right for you.

## Visit me at [ChooseMyFRSplan.com](http://ChooseMyFRSplan.com)

Visit [ChooseMyFRSplan.com](http://ChooseMyFRSplan.com) and join me for a quick interactive video. I'll ask you a few simple questions and, based on your answers, I'll let you know which FRS retirement plan may make the most sense for you. I'll also share some other great resources that can help you compare the plans yourself and submit your choice online.



Scan this code with your smartphone.



### Don't Miss Your Chance to Choose!

You have until 4:00 p.m. ET on the last business day of the 5th month after your month of hire to submit your choice. That might sound like a long time, but your deadline will be here before you know it. Take out your phone **now** and set yourself a reminder!

### For Help Enrolling or to Enroll by Phone

Call the MyFRS Financial Guidance Line  
1-866-446-9377  
Option 4 (or TRS 711)  
9:00 a.m. to 8:00 p.m. ET  
Learn more at [MyFRS.com](http://MyFRS.com).

*The following holidays will be observed by the Gilchrist County Board of County Commissioners, County Courthouse and all County Department's during the calendar year of...*



New Year's Day (Observed)

**Monday**, January 2, 2017



Martin Luther King Jr. Birthday

**Monday**, January 16, 2017



President's Day

**Monday**, February 20, 2017



Good Friday

**Friday**, April 14, 2017



Memorial Day

**Monday**, May 29, 2017

Day before Independence Day  
Independence Day

**Monday**, July 3, 2017  
**Tuesday**, July 4, 2017



Labor Day

**Monday**, September 4, 2017

Veteran's Day (Observed)

**Friday**, November 10, 2017



Thanksgiving Day  
Friday after Thanksgiving

**Thursday**, November 23, 2017  
**Friday**, November 24, 2017



Christmas Day

**Monday**, December 25, 2017



**2017**

