FBMC®
BENEFITS MANAGEMENT

2024 EMPLOYEE BENEFIT GUIDE

FBMC BENEFITS MANAGEMENT

Table of Contents

Benefit Effective Dates

January 1, 2024 – December 31, 2024

ELIGIBILITY & ENROLLMENT 3

MEDICAL (GROUP NUMBER 607379)..5

FSA...6

DENTAL (GROUP NUMBER)..7

VISION (GROUP NUMBER 607379) 8

LIFE INSURANCE (GROUP NUMBER 138642)..........................9

LIFE INSURANCE VALUE ADDED BENEFITS 10

LONG-TERM DISABILITY BENEFITS 14

AFLAC..15

LEGAL AND IDENTITY PROTECTION 17

DEFFERED COMPENSATION 457(B)..18

IMPORTANT NOTICES 20

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 26 for more details.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.

Eligibility & Enrollment

Who Is Eligible?

If you're a Full-Time employee at Florida Keys Mosquito Control District you're eligible to enroll in the benefits outlined in this guide. Full-Time employees are those who work 37.5 or more hours per week on a regular basis. In addition, your family members could be eligible for coverage as indicated below.

- Eligible dependents generally include:
  - Your legal spouse
  - A dependent child can be covered to the end of their birth month in which they turn 26. A dependent child is: natural, step, adopted, foster, or a case in which you are a legal guardian and they are dependent upon you for support.
  - Dependent children age 26 and older, are allowed to extend medical coverage in the State of Florida to the end of the calendar year they reach age 30.
  - Dependents 26 years or older, who are incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness or physical handicap, see HR for details.
    - This dependent must be primarily dependent upon you for financial support and maintenance on a continuous basis.
    - The adult child's spouse and children are not subject to coverage.
    - Domestic Partner – Must file domestic documents with HR.

How To Enroll

New Hire / Newly Eligible

Your enrollment window to make elections will be within your first 30 days of employment. The benefits you choose during this enrollment period will become effective on the first day of the month following 30 days of employment.

Make your benefit elections online through Employee Navigator (see page 4). Once you have made elections, you will not be able to change them until the next open enrollment period, unless you have a qualifying life event.

Are you ready to enroll? The first step is to ensure you have all your dependents' names, addresses (if different from yours), dates of birth and full social security numbers.

The decisions you make during your new hire /newly eligible enrollment window can have a significant impact on your life and finances, so it is important to weigh your options carefully.

Open Enrollment

Open enrollment begins on November 2nd and ends November 16th for all Benefits. You cannot enroll after November 16th for these products.

The benefits you choose during open enrollment will become effective on January 1, 2024.

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

How To Make Changes

Current IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event. Changes must be reported within 30 days of the actual event.

Some common qualifying events may include:

- Marriage, legal separation, divorce, or death of spouse
- Birth, adoption, or the custody change of an eligible dependent
- Loss of other coverage
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

To determine if any of these apply to you, please check with your benefits representative.

Please note: the IRS does not consider financial hardship a qualifying event to drop coverage.

employee NAVIGATOR

Username

Password

Login

Reset a forgotten password

Register as a new user

1 Log-in

Go to **www.employeenavigator.com** and click “Login.”

- **Returning users:** Log in with the username and password you selected. Click “Reset a forgotten password.”
- **First time users:**
  - Click on your Registration Link in the email sent to you by your admin or;
  - Register as a new user. Create an account, and then create your own username and password.

2 Welcome!

After you login click “Let’s Begin,” to complete your required tasks.

Participation Required

You can't say we didn't tell you, the following items are a MUST HAVE for HR. We require that you complete them. You can log out anytime, but that won't make them go away! You'll be hearing from your HR until these items are completed.

1. Onboarding
2. Benefits Enrollment
3. HR tasks

Lets Begin!

3 Start Enrollment

After clicking “Start Enrollment,” you’ll need to complete some personal & dependent information before moving to your benefit elections.

Note: Make sure you have your dependent’s details handy. To enroll a dependent in coverage, you will need their date of birth and Social Security number.

You've got 2 items to complete.

1. Enroll in your benefits
2. Complete HR tasks.

Start Enrollments

nent.

Medical (Group Number 607379)

Carrier Name – Cigna

Questions? Call 1-800-244-6224 or visit www.mycigna.com

Florida Keys Mosquito Control District is concerned about your financial security and offers the following major medical and pharmacy benefit plan designed to protect our employees. We offer a Cigna Open Access Plan to provide employees flexibility in selecting providers. The following table is a summary of benefits, for a more detailed Summary of Benefits and Coverage, login to Employee Navigator or contact Cigna.

	Cigna Open Access Plus Plan
Bi-Weekly Payroll Deduction	
Employee	$0
Employee Plus One Dependent	$110.00*
Employee Plus Two or more Dependents	$130.00*
Summary of In-Network Benefit Coverage	
Deductible (Ind/Fam)	$500/$1,500
Coinsurance*	20%
Out-of-Pocket Maximum (Ind/Fam)	$2,500/$5,000
Telemedicine/Virtual Visits	$25 Copayment
Primary Care Physician Office Visit	$25 Copayment
Preventive Care Office Visit	$0 Copayment
Specialist Office Visit	$50 Copayment
Diagnostic Testing (X-Ray, Blood Work)	Independent Lab: $0 Copayment Physician's Office: Covered at Physician Office Visit Rate
Advanced Imaging (MRI, MRA, CAT Scan, PET Scan) **(Prior Authorization Required)**	$100 Copayment
Urgent Care Visit	$50 Copayment
Emergency Room Visit	$150 Visit Fee + Deductible +Coinsurance
Outpatient Surgery	Deductible + Coinsurance
Inpatient Treatment	Deductible + Coinsurance
Retail Prescription Drug Coverage – Participating Pharmacy (30-Day Supply)	
Preferred Generic	$15
Preferred Brand	$40
Non-Preferred Brand	$70
Preferred Specialty	$90
* includes DENTAL and VISION	

Express Scripts or CVS are the preferred pharmacies

NOTICE: This guide provides summaries of the benefits offered. Please see policies and certificates of coverage for complete details.

Flexible Spending Account (FSA)

Flexible Spending Accounts (FSAs) are IRS-approved accounts that allow you to pay for eligible medical and dependent care expenses on a tax-free basis. When you enroll in an employer-sponsored Flexible Spending Account, your contributions are not subject to Federal, FICA and most state taxes. This means you bring home more money in your paycheck.

Medical FSA**
(Medical Expense for your family)

What are these funds for?
Funds can be used to pay for eligible medical expenses provided to you, your spouse, or eligible dependents.

When can I start using the funds in my account?
Your full plan year election is available to use on the first day of the plan year.

What is an eligible expense?
You can use these funds to pay for expenses that primarily prevent, treat, diagnose or alleviate a physical or mental defect or illness. Common eligible expenses include:

- *Co-payments, coinsurance, and deductible expenses*
- *Dental care (exams, fillings, crowns)*
- *Vision care, eyeglasses, contact lens*
- *Chiropractic care*
- *Prescription drugs and over-the-counter drugs and medications, bandages.*

What is not allowed?

- *You can't use these funds to pay for expenses that are for personal care, cosmetic or general health purposes*
- *You can't reimburse expenses for any other source. (e.g. insurance)*
- *You can't have a medical FSA if you are enrolled in a Health Savings Account.*

What happens to funds I don't use?

- *You are eligible to roll-over $500.00. All funds over $500.00 are lost.*
- *This is subject to change according to prevailing legislation. (i.e. CARES ACT)*

**Must Re-Enroll Annually.

Dependent Care FSA (Day Care Expenses)**

What are these funds used for?
Funds can be used for a qualified person, who is often one of the following:

- *A dependent child under the age of 13 for who you can claim a tax exemption*
- *A spouse or dependent who is physically or mentally incapable of self-care and for whom you can claim a tax exemption.*

When can I start using the funds in my account?
Dependent Care funds become available as they are deposited from payroll.

What is an eligible expense?
You can pay for the expenses that enable you or your spouse to gainfully employed, look for work, or attend school full-time: Common eligible expenses include:

- *Before and after daycare*
- *Child care*
- *Day care in a facility*
- *In-home dependent care*
- *Nursery School*
- *Adult care*

What isn't allowed?
You can't use these funds to pay for services provided for education, overnight camps, or services provided by the child's parent or other dependent for income tax purposes. You also can't claim a federal tax credit for any expense reimbursed through your Dependent Care FSA or the federal tax credit would be more advantageous.

What happens to funds I don't use?
All fund must be used in accordance with plan rules or prevailing legislation (i.e. CARES Act)

**Must Re-Enroll Annually.

Dental

Carrier Name – Cigna (Group Number 607379)

Questions *Call 1-800-244-6224 or visit www.mycigna.com*

Aside from protecting your smile, dental care ensures good oral and overall health. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Understanding and choosing dental coverage will help protect you and your family from the high cost of dental disease and surgery.

Bi-Weekly Payroll Deduction	
Employee	$0
Employee + Spouse	$15.36/$0 if enrolled in medical
Employee + Child(ren)	$20.79/$0 if enrolled in medical
Family	$40.66/$0 if enrolled in medical

Dental Plan Type	Cigna Dental PPO
Deductible	$50.00 individual, $150.00 family in/out of Network
Annual Maximum Benefit	$2,500
Ortho Annual Benefit/Lifetime	$1,000
In & Out of Network Coinsurance	See Below
UCR Level	90th Percentile
Network	Provider Search https:www.cigna.com

	In-Network	Out-of-Network
Class 1 Expenses Oral Exam Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers Non-Routine X-rays Emergency care	100%, No Deductible	100%, No Deductible
Class II Expenses – Basic Restorative Care Oral Surgery – Simple Extraction Oral Surgery-All Except Simple Extractions Surgical Extraction of Impacted Teeth Anesthetics Minor Perio Major Perio Root Canal Therapy/Endo Relines, Rebases	80%, After Deductible	80%, After Deductible
Class III Expenses-Major Restorative Care Repairs-Bridges, Crowns, and Inlays Repairs-Dentures Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	50%, After Deductible	50%, Deductible

FBMC BENEFITS MANAGEMENT

Vision Group Number 607379

Carrier Name – Cigna

Questions? Call 1-800-244-6224 or visit www.mycigna.com

Driving to work, reading a news article and watching television are likely activities you perform every day. Your ability to do all of these, however, depends on your vision and eye health. Routine eye exams will help maintain your vision as well as detect various eye problems and concerns about your overall health. Obtaining vision insurance is a way to make sure you can continue enjoying good health as well as the sights around you.

	In-Network	Out-of-Network
Annual Eye Exam	Covered in Full after Exam Copayment	Up to $45
Exam Copayment	$10	N/A
Single Vision Lens	Covered in Full after Material Copayment	Up to $32
Lined Bifocal Lens	Covered in Full after Material Copayment	Up to $55
Frame Retail Allowance	Up to $150	Up to $83
Material Copayment	$15	N/A
Frequency *(Exam/Lens/Frames)*	12/12/24 Based on Plan Year	12/12/24 Based on Plan Year
Contact Lenses		
Elective	Up to $150	Up to $135
Medically Necessary	Covered in Full	Up to $210
Bi-Weekly Payroll Deduction		
Employee	$0	
Employee + Spouse	$2.07/$0 if enrolled in medical	
Employee + Child(ren)	$2.12/$0 if enrolled in medical	
Family	$4.62/$0 if enrolled in medical	

NOTICE: This guide provides summaries of the benefits offered. Please see policies and certificates of coverage for complete details.

Life Insurance (Group Number 138642)

Carrier Name – The Standard

Questions? Call 1-888-937-4783 or visit www.standard.com

Basic Life Insurance

If you have people who depend on you for financial support, you might have thought about what happens when you're not there to support them anymore. Life insurance can give you security as you think about the future of your family. Florida Keys Mosquito Control District provides full-time employees with **$50,000** in group life and accidental death and dismemberment (AD&D) insurance.

If you are a retiree, hired before 09/20/2010, the District provides $20,000 of coverage.

The Standard offers all employees covered under the Basic Life Insurance with access to their Life Services Toolkit for assistance with things like wills or powers of attorney documents, as well as Travel Assistance that can assist members when traveling with medical services or transportation support.

Access either of these valuable benefits at the following links:

- Life Services Toolkit: https://www.standard.com/eforms/17526.pdf
- Travel Assistance: https://www.standard.com/eforms/14684.pdf

Voluntary Life Insurance

While Florida Keys Mosquito Control District offers basic life insurance, some employees may want to purchase additional coverage for themselves and their dependents. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage. The following table details available coverage and premiums. **Premiums for employee and spouse are based on the employee's attained age as of January 1, 202**

Your rates will increase on January 1, 2023

	Employee	Spouse	Child
Benefit Amount	$10,000 Increments to maximum of $300,000*	$5,000 Increments to a maximum of $150,000**	$2,000 Increments to a maximum of $10,000**
Guarantee Issue	$250,000	$15,000	Full Benefit
Waiver of Premium	Eligible to Age 60, Waived to Age 65	Not Included	Not Included
Conversion & Portability	Included	Included	Included

*Employee Basic Life benefit plus Voluntary Life benefit cannot exceed 8x annual earnings
** Spouse and Child Life may not exceed 100% of Employee Voluntary Life benefit

	Employee Monthly Premium (based on Employee's Age as of January 1, 2024)	
AGE IN YEARS	Employee Rate	Spouse Rate
Per $1,000 of Employee or Spouse Life Benefit		
0-29	$0.137	$0.137
30-34	$0.148	$0.148
35-39	$0.148	$0.148
40-44	$0.213	$0.213
45-49	$0.315	$0.315
50-54	$0.468	$0.468
55-59	$0.725	$0.725
60-64	$0.928	$0.928
65-69	$1.323	$1.323
70-74	$2.142	$2.142
75+	$6.603	$6.603
Child Life Monthly Premium (One Monthly Premium Covers All Eligible Children)		
$2,000	$0.47	
$4,000	$0.94	
$6,000	$1.41	
$8,000	$1.88	
$10,000	$2.35	

Life Insurance Value Added Benefits

Life Insurance

Online Will Preparation

A simplified way to take care of important life matters

If creating a will has been on your radar, Online Will Preparation can help you get it done. Use this easy tool to help make important decisions for you and your family. Online Will Preparation is included in the Life Services Toolkit, an additional service with your Group Life Insurance from Standard Insurance Company (The Standard).

Why Create a Will?

A will is a legal document that describes how you want to divide up your assets after your death. If you don't have a will, state law will determine how your assets will be divided. A will can also be used to designate a guardian for minor children. Moreover, a will helps your family and friends understand your wishes.

How It Works

Online Will Preparation is an easy-to-follow process. Just answer a series of questions — on your own time — and watch as the document is created. You can save and close the document at any time, then work on it later. After you've created the will, follow instructions to complete the process.

Start Creating Your Will

Go to standard.com/mytoolkit.

In the username field, enter "assurance."

Locate Resource Center & Tools on the home page and click on "Create an Online Will."

Click on the instructions and follow the steps to create a will.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland OR 97204 | standard.com

Life Services Toolkit is provided through an arrangement with Morneau Shepell and is not affiliated with The Standard. Morneau Shepell is solely responsible for providing and administering the included service. Life Services Toolkit is not available to Life insurance beneficiaries who are minors or to non-individual entities such as trusts, estates or charities.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York.

Online Will Preparation SI 18945-D (10/17) EE

NOTICE: This guide provides summaries of the benefits offered. Please see policies and certificates of coverage for complete details.

Life Services Toolkit

Resources and Tools to Help You and Your Beneficiary Meet Life's Challenges

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from Standard Insurance Company (The Standard) does more than help protect your family from financial hardship after a loss. We have partnered with Morneau Shepell to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, beneficiaries can consult experts by phone or in person, and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

Services to Help You Now

Visit the Life Services Toolkit website at standard.com/mytoolkit (enter username "assurance") for information and tools to help you make important life decisions.

Estate Planning Assistance: Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms.

Financial Planning: Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.

Health and Wellness: Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.

Identity Theft Prevention: Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.

Funeral Arrangements: Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

If you are a recipient of an Accelerated Benefit[1], you may access the services for beneficiaries outlined on the next page.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

[1] An Accelerated Benefit allows a covered individual who becomes terminally ill to receive a portion of the Life insurance proceeds while living, if all other eligibility requirements are met.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

standard.com

Life Services Toolkit
SI 17526 - D (10/17) EE

Services for Your Beneficiary

Life insurance beneficiaries[2] can access services for 12 months after the date of death. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

These supportive services can help your beneficiary cope after a loss:

- **Grief Support:** Clinicians with master's degrees are on call to provide confidential grief sessions by phone or in person. Beneficiaries are eligible for up to six face-to-face sessions and unlimited phone contact.
- **Legal Services:** Beneficiaries can obtain legal assistance from experienced attorneys. They can:
  - Schedule an initial 30-minute office and a telephone consultation with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25 percent rate reduction from the attorney's normal hourly or fixed fee rates.
  - Obtain an estate-planning package that consists of a simple will, a living will, a health care agent form and a durable power of attorney.
- **Financial Assistance:** Beneficiaries have unlimited phone access to financial counselors who can help with issues such as budgeting strategies, and credit and debt management, including hour-long sessions on topics requiring more in-depth discussion.
- **Support Services:** During an emotional time, beneficiaries can receive help planning a funeral or memorial service. Work-life advisors can guide them to resources to help manage household repairs and chores; find child care and elder care providers; or organize a move or relocation.
- **Online Resources:** Beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements.

For beneficiary services, visit standard.com/mytoolkit (User name = support) or call the phone assistance line at 800.378.5742.

Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

[2] The Life Services Toolkit is not available to Life insurance beneficiaries who are minors or to non-individual entities such as trusts, estates or charities.

The Life Services Toolkit is provided through an arrangement with Morneau Shepell and is not affiliated with The Standard. Morneau Shepell is solely responsible for providing and administering the included service. This service is not an insurance product.

Travel Assistance

Explore the World with Confidence

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]

You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories

Credit card and passport replacement and missing baggage and emergency cash coordination

Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission

Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]

Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond

Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization

Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded

Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

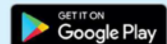
Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

Reference Number:
01-AA-STD-5201



Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

1 Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. Assist America, Inc. is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy.

2 Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

3 Must be arranged by Assist America, Inc.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

SI 14684

Travel Assistance EE
D
(6/20)

Long-Term Disability Benefits

Carrier Name – The Standard

Questions? Call 1-888-937-4783 or visit www.standard.com

When severe illness or injury strikes, the next few weeks and months can seem scary and uncertain, and you may worry about how you will pay your bills and afford your next rent or mortgage payment. Short-term disability insurance can ease your worries and help you with expenses while you're away from work.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, though, that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

What Is Long-term Disability Insurance?

Long-term disability insurance may be offered by your employer as a voluntary benefit to give you financial security in the event that an illness or injury prevents you from being able to work. Most disability insurance plans define a disability as the inability or reduction in ability to perform your job duties; the definition of disability will be specified by your policy. The purpose of long-term disability insurance is to protect your income if you become disabled for a prolonged period prior to your retirement.

What Does Long-term Disability Insurance Provide?

If you are disabled, long-term disability insurance will pay out a set amount or a percentage of your regular income in monthly intervals. Long-term disability provides you income protection for extended periods of time.

	LONG-TERM DISABILITY
Benefit Waiting Period	180 days
Benefits Payable	60% of eligible earnings
Minimum Benefit	$100 per month
Maximum Benefit	$5,000 per month

Additional Features

Your coverage comes with some added features:

Help with Returning to Work	This plan provides incentives to help you get back to work. For instance, you'll get help paying for some of the expenses associated with participating in an approved rehabilitation plan. If a worksite modification would enable you to return to work, the coverage can help your employer make approved modifications. You may also be eligible to receive an additional benefit of 10 percent of your predisability earnings for participating in an approved rehabilitation plan, subject to the plan maximum.
Survivors Benefit	If you die while receiving benefits, your survivor may be eligible to receive a one-time additional payment.
Support When You Need It	You'll have access to an Employee Assistance Program, a valuable confidential counseling resource if you're experiencing personal or work-related issues. This service is provided through an arrangement with a service provider who is not affiliated with The Standard.
Lifetime Security Benefit	Additional benefits may be payable to you if your Long Term Disability benefits end due to the maximum benefit period, you remain disabled and you are unable to perform two or more activities of daily living, or are suffering severe cognitive impairment.

AFLAC is a part of your benefit package, and here is a summary of what is offered.

Key Advantages: **Cash is paid directly to you** – spend it any way you like
Pays in addition to any other medical coverage you may have
Coverage is **affordable** –
Rates do not change
Can cover family members – Spouses and/or children
Fast & accurate claims service
Coverage is payroll deducted
Coverage is portable
Wellness benefit on Accident & Cancer plans

Short-term Disability: In the case of an illness or off-the-job injury, it replaces your income while out of work.
This plan protects your paycheck for the unexpected time off due to an injury or illness. Plan is customized to you based on your salary.

Accident: Policyholders receive cash benefits for any accident that causes bodily injury. It provides benefits if an accident occurs on or off the job. Benefits include payment for the initial ER/Urgent Care visit x-rays, hospitalization, surgical benefits, and a specific sum depending on the type of injury. First night in the Hospital = $1800. Wellness benefit of $60/year.

Hospitalization: Provide cash benefits to help with the our-of-pocket expenses due to a hospital stay. Employees with medical insurance can be responsible for up to $5000 for a hospital stay. The AFLAC Hospital plan offers a benefit of $500, $1000, $1500 or $2000 in their basic plan.

Continued.......

Cancer: The AFLAC Cancer plan offers comprehensive benefits from initial diagnosis, and hospitalization thru hospice. Also included is a travel & lodging benefit which allows policyholders to go to a medical facility for treatment that specializes in the type of cancer that needs to be treated. This plan also includes a Wellness benefit that promotes annual cancer screenings.

Critical Illness: This plan includes generous benefits for the diagnosis & treatment of the following severe illnesses: heart attack, stroke, coronary artery bypass graft surgery, sudden cardiac arrest, third degree burns, major organ transplant, coma, paralysis, end-stage renal failure, persistent vegetative state.

Here is the “Landing Page Link” that includes all product brochures in detail.
https://www.aflacenrollment.com/FloridaKeysMosquitoControl/DZS063736428
Please contact Jean Smith, jean_smith@us.aflac.com, 561-289-1360

American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters – 1932 Wynnton Road – Columbus, GA 31999

1-800-99-AFLAC (1-800-992-3522) Aflac.com

Legal and Identity Protection

Contact, Murray Fischer, Silver Executive Director: 305.343.5127; main@processingcenter.org

Info Video, https://ls-info.com/res/2555/14926

Legal

PLAN TYPE	MONTHLY RATE
LegalShield Family Plan	$21.95
CDLP	$29.95

WHO IS COVERED:
FAMILY PLAN: The employee, their spouse/partner, never-married dependent children under the age of 26 and living at home or full time in college, dependent children under the age of 18 for whom they are legal guardian and/or physically or mentally challenged children living at home.

Info Video, https://ls-info.com/res/2808/14926

Combo Legal & Identity

PLAN TYPE	MONTHLY RATE
Individual Combo 1 Bureau	$37.90
3 Bureau	$41.90
Family Combo 1 Bureau	$44.90
3 Bureau	$53.90

Stand Alone IDShield

PLAN TYPE	MONTHLY RATE (Individual/Family)
IDShield Individual 1 Bureau	$12.45
3 Bureau	$16.95
IDShield Family 1 Bureau	$22.95
3 Bureau	$31.95

WHO IS COVERED:
INDIVIDUAL PLAN: The employee only.
FAMILY PLAN: The employee, their spouse/partner and up to 10 dependent children under the age of 18. Dependent children of the spouse ages 18-26 are eligible for consultation and restoration services only. Monitoring services are not available for dependent children ages 18-26.

Additional Plans/Supplements *Per Month

Home Based Business, $14.95*
Additional Trial Hours, $14.95*
Gun Ownership, $14.95*
Business Legal <25 employees, $49.00* <50 $99.00* <100 $169.00*

Business ID Shield, 1 Bureau $79.95* 3 Bureau $149.95*

All memberships include, Secure website, Mobile app
No rate increases, No claim forms, No enrollment fees, Portable
Corporate discounts in over 500 categories where average Member saves over $2000.00 annually
Quality control measures in place to insure quality services are delivered in a timely manner

Florida Keys Mosquito Control District 457(b) Deferred Compensation Plan

A 457(b) plan for government employees is employer sponsored and allows you to contribute part of your salary toward your retirement savings—while deferring taxes on that income.

Simplicity and convenience

Contributions are made directly from your paycheck—the amount is decided by you, subject to maximum Internal Revenue Service (IRS) limits.

Pre-tax savings

You may be able to reduce your current income taxes because contributions are deducted from your pay before taxes come out. Generally, this means that you can benefit by reducing your taxable income and your income tax withholding now, so you can save more for retirement.

Tax deferral

Accounts have the potential to grow on a tax-deferred basis. That means that taxes won't be due on savings until a distribution is taken or a sum is withdrawn from the account.

The ability to take it with you

If you leave the District, you can transfer your account balance to another 457(b) plan—if the new plan accepts such transfers, roll it over to an IRA, a 403(b) or another eligible retirement plan. You may decide to withdraw your account balance, which may be subject to an income tax penalty. A tax advisor can provide details of these options.

An income when you retire

When you are ready to retire, your employer's plan may allow you to select from several payout options. They may include taking a lump sum, receiving regular periodic payments based on the amount you saved, or receiving regular payments based on your life expectancy. Whatever you choose, remember that they are subject to ordinary income taxation when you receive the money in retirement.

Maximum annual contribution

Generally, the maximum amount you may contribute to a 457(b) plan in 2022 is $20,500. You may also be eligible for "catch-up" contributions. Here's how it works: In each of the last three calendar years before the year you reach the plan's normal retirement age, you may qualify to use a catch-up provision that's calculated based on contributions you made to the plan in previous years.

If you are age 50 or older and participate in a 457(b) plan maintained by a government employer, you may qualify to contribute additional amounts to the plan up to a specified amount that is subject to change each year, based on inflation. You may not make both types of catch-up contributions in the same year.

Withdrawals

Remember, a 457(b) account is for retirement savings. That's why, generally speaking, plan rules do not allow distributions unless a person no longer works for the employer maintaining the plan, retires, reaches age 59½*

457(b) Deferred Compensation Plan continued…………

or has an unforeseeable emergency as defined by IRS regulations. If a plan provides for unforeseeable emergency withdrawals, the emergency that causes the need for withdrawal may occur with respect to the participant, the participant's beneficiary, his or her spouse or dependents. Please check plan guidelines to see rules regarding withdrawals. Keep in mind that limited access to an account can be beneficial because it eliminates the temptation to use the money for purposes other than retirement. Also, if withdrawals are taken, ordinary income taxes will have to be paid on the withdrawn funds.

Even small amounts add up

Over time, even small contributions can add up. The sooner a person starts saving for retirement — or increasing the amount they put toward retirement from each paycheck — the better, even if that amount may seem relatively small. Take a look at this chart of a hypothetical saver. Let's assume that she earns $50,000 a year, is paid bi-weekly and that her savings earn a hypothetical 8% annual rate of return on her contributions to her employer's retirement savings plan. As you can see, her savings begin to add up over time. Even with relatively small contributions from each paycheck.

Years	5	10	20	30
1% Contribution (19.23/Paycheck)	$ 2,163.00	$ 5,313.00	$ 16,743.00	$ 41,417.00
2% Contribution (38.46/Paycheck)	$ 4,326.00	$ 10,626.00	$ 33,485.00	$ 82,835.00
3% Contribution (57.69/Paycheck)	$ 6,490.00	$ 15,940.00	$ 50,288.00	$ 124,252.00

Important Notices

Premium Assistance Under Medicaid And The Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
LOUISIANA – Medicaid	**GEORGIA – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
TEXAS – Medicaid	
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

Read this notice carefully to help understand your COBRA rights. Keep in mind that when you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

Employee

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events occurs:

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

Spouse

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

Dependent Children

Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of **36 months**.
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of **18 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability Extension

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second Qualifying Event Extension

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

Are There Other Coverage Options Besides Cobra?

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed Of Address Changes

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

Women's Health And Cancer Rights Act

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Cigna at (800) 244-6224.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Cigna at (800) 244-6224 for more information.

Newborns' And Mother's Health Protection Act

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

Special Enrollment Notice

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

***Example**: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.*

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

***Example**: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.*

Genetic Information Nondiscrimination Act of 2008 (GINA) Disclosures

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

Michelle's Law Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the Florida Keys Mosquito Control District group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

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

In order to be eligible to continue coverage as a dependent during such leave of absence:

The group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and

HIPAA Privacy Practices Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights Summary

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices Summary

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses And Disclosures Summary

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Instructions for Notice

- Effective January 1, 2024
- Privacy Officer: Michael Behrend 18 Aquamarine Dr, Key West, FL 33040

Important Notice From the Florida Keys Mosquito Control District About Your Prescription Drug Coverage And Medicare Creditable Coverage

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Florida Keys Mosquito Control District has determined that the prescription drug coverage offered by Cigna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Florida Keys Mosquito Control District coverage will only be affected if you cancel coverage. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. If you cancel coverage, under the employer plan, your coverage and any dependent coverage will terminate as well.

If you do decide to join a Medicare drug plan and drop your current Florida Keys Mosquito Control District coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Florida Keys Mosquito Control District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Florida Keys Mosquito Control District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

FBMC
BENEFITS MANAGEMENT

Date:	January 1, 2024
Name of Entity/Sender:	Florida Keys Mosquito Control District
Contact--Position/Office:	Michael Behrend
Address:	18 Aquamarine Drive
	Key West, FL 33040
Phone Number:	305-292-7190, ext. 123

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Tracey Wallace.

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

---

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Florida Keys Mosquito Control District		4. Employer Identification Number (EIN)
5. Employer address 18 Aquamarine Drive		6. Employer phone number 305-292-7190
7. City Key West	8. State FL	9. ZIP code 33040
10. Who can we contact about employee health coverage at this job? Michael Behrend Humana Resources		
11. Phone number (if different from above)	12. Email address mbehrend@keysmosquito.org	

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

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    Employees working 30 or more hours per week.

  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:

    Legal Spouse and Dependents Children to age 26 or age 30 for medical

  - [ ] We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?________________ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $__________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

---

16. What change will the employer make for the new plan year?__________
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $__________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Florida Keys Mosquito Control District 2024

Acknowledgement receipt

I _________________________________, hereby acknowledge the receipt of the

2024 Florida Keys Mosquito Control Employee Benefit Guide.

Signature___________________________ Date___________________