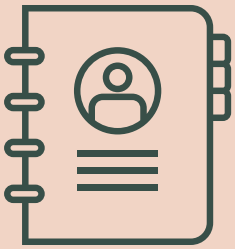
2021

EMPLOYEE BENEFIT HIGHLIGHTS

Property Appraiser

INDIAN RIVER COUNTY PROPERTY APPRAISER



CONTACTS

Office	Contact	Phone	Email
Property Appraiser	Diana Staar	(772) 226-1476	dstaar@ircpa.org

Coverage	Carrier/Policy #	Phone	Website/Email
Medical Insurance	Florida Blue Group #: 90000	Customer Service: (800) 664-5295	www.floridablue.com
Express Scripts administered by RxBenefits, Inc. Retail & Mail Order	Express Scripts RXBIN: 610014 RXGRP: RXBINDI	Pharmacy Member Services: 800-334-8134 Pharmacist Helpdesk: 800-922-1557	www.express-scripts.com
Telemedicine Services	Teladoc	Customer Service: (800) 835-2365	www.teladoc.com
Dental Insurance	Ameritas Group #: 41058	Customer Service: (800) 487-5553	www.ameritas.com
Vision Insurance	EyeMed	Customer Service: (866) 422-4661	www.eyemed.com
Flexible Spending Accounts	TASC	Customer Service: (800) 797-7475	www.tasconline.com
	United Healthcare	Customer Service: (877) 797 - 7475	www.uhcservices.com
Life Insurance	Mutual of Omaha Group #: GLUG-AJFS	Customer Service: (800) 877-5176	www.mutualofomaha.com
Voluntary Long Term Disability Insurance	Mutual of Omaha Group #: GLUG-AJFS	Customer Service: (800) 877-5176	www.mutualofomaha.com
Employee Assistance Program	Health Advocate	Customer Service: (866) 799-2728	www.healthadvocate.com/members
Supplemental Insurance	Aflac	Customer Service: (800) 992-3522	www.aflac.com
Diabetes Management Program	Kannact	Customer Service: (855) 722-5513	www.kannact.com

WELCOME TO ANNUAL ENROLLMENT!

Indian River County Property Appraiser appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefits plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Any time you have questions about benefits or the enrollment process, you can contact your human resources representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD) at ircgov.com.

Here's where to find ...

INTRODUCTION

The Indian River County Property Appraiser provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. If an employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service telephone numbers under each benefit description heading or contact Human Resources.

GROUP INSURANCE ELIGIBILITY

Employee Eligibility

Employees are eligible to participate in the Property Appraiser's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first day of the month following 60 days of full-time employment. For example, if employee is hired on April 11, then effective date of coverage would be July 1.

Termination

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

FYI: The Property Appraiser's group insurance plan year is October 1 through September 30.

Dependent Eligibility

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

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

Dependent Age Requirements

- Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns 26.
- Dental Coverage: Dependent children may be covered through the end of the calendar year in which they turn 26.
- Vision Coverage: Dependent children may be coverage through the end of the calendar year in which they turn 26.

Disabled Dependents

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

- The dependent is physically or mentally disabled and incapable of self-sustaining employment; AND
- The dependent is otherwise eligible for coverage under the group medical plan; AND
- The dependent has been continuously insured.

Proof of disability will be required upon request. Please contact the Human Resources department if further clarification is required.

2020-2021

QUALIFYING EVENTS AND IRS CODE SECTION 125

IRS Code Section 125

Premiums for medical, dental, vision, and/or certain Aflac policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-taxed to the extent permitted. Under Section 125, changes to an employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience a qualifying event and the request to make a change is made within 30 days of the qualifying event, or 60 days for the birth of a child.

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

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Employee, employee's spouse or dependent(s) terminate or start employment
- An increase or decrease in employees work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)
- Enrollment in a qualified health plan offered through an Exchange during a special enrollment period
- Change in cost or need of childcare (Dependent Care FSA ONLY)

Important Notes

An employee who experiences a qualifying event must contact the benefits representative of the Human Resources department within 30 days of the event (60 days for birth of a child) to request the appropriate changes to coverage. Late requests will be denied. As a result of a qualifying event, changes are effective the date of the qualifying event. For newborns the change is effective on the date of birth. Cancellations will be processed at the end of the month except for divorce or death. Divorce or death, coverage will terminate the date following divorce or death. Employee will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Please Note
If an employee knowingly commits fraud by enrolling or continuing coverage for an ineligible person(s) in the Indian River County Property Appraiser's insurance program, the County will take appropriate disciplinary action up to and including termination.

QUALIFYING EVENTS AND COBRA

Please remember the following: In order to enroll dependents on the Property Appraiser's Group Insurance plan, to maintain enrollment for those dependents in the coming year, or to enroll any new dependents in the Group Insurance plan during the open enrollment period, the employee may be required to provide documentation verifying the eligibility of such dependent(s).

Qualifying Event Q&A	
Can I add or delete dependent coverage and make changes to my benefit elections during the year?	A participant is permitted to make changes to his or her elections mid-plan year only for a legitimate Qualifying Event, meaning "on account of and corresponding with a Qualifying Event that affects eligibility for coverage." If an employee experiences a Qualifying Event, the election changes must be requested within 30 days from the Qualifying Event date and the change must be consistent with the type of event. Based on the event, an employee may add or delete dependents to existing coverage.
If I experience a Qualifying Event, how and when must I request the change?	Within 30 days of the Qualifying Event the employee must notify Human Resources and will be asked to furnish supporting documentation. Upon the approval and completion of processing the election change request, the existing benefit elections will be stopped or modified. Requests made later than 30 days from the date of the event will not be approved.
If I add dependents due to a Qualifying Event, when does their coverage become effective?	Coverage for dependents becomes effective on the date of the Qualifying Event OR for all others, on the date of notification, subject to approval by Human Resources. The employee must notify Human Resources of the Qualifying Event within 30 days.
If I delete a dependent due to a Qualifying Event, when does their coverage end?	Coverage for a deleted dependent ends effective the last day of the month in which the Qualifying Event occurred. In the event of a death or divorce, coverage ends effective with the date of death or divorce. The employee must notify Human Resources of the Qualifying Event within 30 days.
If I waive the Property Appraiser's healthcare coverage but then I lose my other group health coverage, can I enroll in a health plan mid-year?	Yes, an employee can enroll in a Property Appraiser plan mid-year if they have lost other group insurance coverage. The employee must notify Human Resources of the Qualifying Event within 30 days and may be asked to provide documentation.

Please Note: If an employee knowingly commits fraud by enrolling or continuing coverage for an ineligible person(s) in the Property Appraiser's insurance program, the Property Appraiser will take appropriate disciplinary action up to and including termination.

COBRA Continuation of Medical Coverage Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees and/or dependents may be able to continue their enrollment in certain health plans such as medical, dental and vision, if such coverage is terminated or changed due to a qualifying event.

HEALTH ADVOCACY

Benefit for Employees Enrolled in the Medical Plan – Health Advocacy Unlimited one-on-one support, 24/7

Resolution of complex claim and benefit issues

- Help members understand their benefits
- Sort out claims and billing issues; correct duplicate or erroneous charges
- Assist with filing an appeal with a health plan

Help locating the right care including second opinions

- Research and arrange second opinions and clinical trials
- Research credentials and availability of in-network physicians, hospitals, dentists and other healthcare providers
- Facilitate the transfer of medical records, X-rays and lab results

Support for medical issues or difficult diagnoses

- Help members understand diagnoses, tests, treatments
- and medications
- Coordinate care between physicians and insurance companies
- Research current literature to identify new treatment opportunities/cutting-edge services
- Provide health information to help members make the right decisions about their care

The whole family can use Health Advocate at no cost to you!

- Employees
- Spouses/Domestic Partners
- Dependents
- Parents and Parents-in-law

Health Advocate

Customer Service: (866) 799 2728
Email:answers@HealthAdvocate.com
www.healthadvocate.com.

HealthAdvocate™
Always at your side

MEDICAL INSURANCE

The Property Appraiser offers medical insurance through Florida Blue to benefit eligible employees. The monthly costs for coverage are listed in the premium table below. For information about the medical plan, please refer to the Summary of Coverage or contact Florida Blue's customer service.

Florida Blue BlueOptions Plan

Monthly Payroll Deductions

Tier of Coverage	Employee Cost
Gold Eligible Employee	$110.00
Gold Employee + Family	$400.00
Silver Eligible Employee	$15.00
Silver Employee + Family	$207.50

Other Available Plan Resources

Florida Blue offers all enrolled members and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please refer to the Summary of Coverage document, or contact Florida Blue's customer service.

Florida Blue

Customer Service:
(800) 664-5295

www.floridablue.com

Locate A Provider

To search for a participating provider, contact customer service or visit www.floridablue.com.

Summary of Benefits and Coverage

A Summary of Benefits & Coverage (SBC) is an important item in understanding the benefit options. The SBC is available online on the employee benefits portal. A free paper copy of the SBC document may be requested or is available as follows:

From: Human Resources Department
Address: 1800 27th Street
Vero Beach, FL 32960
Phone: (772) 226-1476
Email: dstaar@ircpa.org

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the actual group certificate of coverage can be reviewed and obtained by contacting the Human Resources. If employees have any questions about the plan offerings or coverage options, please contact Human Resources.

Florida Blue BlueOptions Plan At-A-Glance

Product	BlueOptions	
Plan Number	Premier Gold Plan-03559	Premier Silver Plan-05302
Cost Sharing - Member's Responsibility		
Calendar Year Deductible (DED)	Single / Family	Single / Family
In-Network (INN)	$600 / $1,200	$1,000 / $2,000
Out-of-Network	$1,200 / $2,400	$2,000 / $4,000
Coinsurance (Member pays after Calendar Year DED)		
In-Network	20%	30%
Out-of-Network	30%	40%
Calendar Year Out of Pocket Maximum	Single / Family	Single / Family
In-Network	$3,000 / $6,000	$6,000 / $12,000
Out-of-Network	$4,000 / $8,000	$8,000 / $16,000
Medical / Surgical Care by a Physician		
Office Services		
In-Network Family Physician	$30 Copayment	$40 Copayment
In-Network Specialist	$50 Copayment	$65 Copayment
Out-of-Network	DED + 30%	DED + 40%
Telemdcine Services		
In-Network General Medical	$10 Copayment	$10 Copayment
In-Network Dermatology	$20 Copayment	$20 Copayment
Out-of-Network	N/A	N/A
Allergy Injections (Office)		
In-Network Family Physician	$5 Copayment	$5 Copayment
In-Network Specialist	$5 Copayment	$5 Copayment
Out-of-Network	DED + 30%	DED + 40%
Convenient Care Center		
In-Network	$30 Copayment	$40 Copayment
Out-of-Network	DED + 30%	DED + 40%
Outpatient Hospital Facility (per visit) (Surgical)		
In-Network	DED + 20%	DED + 30%
Out-of-Network	DED + 30%	DED + 40%
Inpatient Hospital Facility (per admit)		
In-Network	PAID $200 + DED + 20%	PAID $500 + DED + 30%
Out-of-Network	PAID $400 + DED + 30%	PAID $1,000 + DED + 40%
Physician Services at Hospital		
In-Network	DED + 20%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%
Radiology, Pathology and Anesthesiology Provider Services at Hospital		
In-Network	DED + 20%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%
Preventive Services-Adult Wellness Services		
Office Services		
In-Network Family Physician / Specialist	No Charge	No Charge
Out-of-Network	30%	40%

Non-Hospital Services Freestanding Facility		
Clinical Lab (Blood Work): Quest**		
In-Network	No Charge	No Charge
Out-of-Network	DED + 30%	DED + 40%
X-rays (Independent Diagnostic Center)	Premier Gold Plan - 03559	Premier Silver Plan - 05302
In-Network	$15 Copayment	$25 Copayment
Out-of-Network	DED + 30%	DED + 40%
Emergency and Urgent Care		
Emergency Room Facility (per visit)		
In-Network	(Copayment Waived if Admitted) $250 Copayment + DED + 20%	$500 Copayment + DED + 30%
Out-of-Network	$250 Copayment + INN DED + 20%	$500 Copayment + INN DED + 30%
Urgent Care Centers		
In-Network	$30 Copayment	$40 Copayment
Out-of-Network	$30 Copayment	$40 Copayment
Ambulance		
In-Network	DED + 20%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%
Advanced Imaging (MRI, MRA, PET, CT & Nuclear Medicine)		
Physician Office		
In-Network Family Physician or Specialist	$200 Copayment	30%
Out-of-Network	DED + 30%	DED + 40%
Independent Diagnostic Testing Center		
In-Network	$200 Copayment	30%
Out-of-Network	DED + 30%	DED + 40%
Outpatient Hospital Facility		
In-Network	DED + 20%	DED + 30%
Out-of-Network	DED + 30%	DED + 40%
Mental Health / Alcohol & Substance Abuse Services		
Inpatient / Outpatient Hospital Facility	PAD (Per Admission Deductible)	PAD (Per Admission Deductible)
In-Network	PAD $200 + DED + 20%	$500 PAD + DED + 30%
Out-of-Network	PAD $400 + DED + 30%	$1,000 PAD + DED + 40%
Specialist Visits		
In-Network	$45 Copayment	$60 Copayment
Out-of-Network	DED + 30%	DED + 40%
Prescription Drugs (RX Administerd through RX Benefits)		
1X Calendar Year Deductible Per Person	N/A	$100 (must be met before Copayments apply)
Generic	$10 Copay	$5 Copay
Preferred Brand Name	$50 Copay	$65 Copay
Non-Preferred Brand Name	$75 Copay	$95 Copay
Mail Order Drug (90-Day Supply)	Express Script 2x Retail Copay	Express Script 2x Retail Copay
Maintenance Medication	2X Copayment at Covered Pharmacies	2X Copayment at Covered Pharmacies

Plan References:*Out-of-Network Balance Billing: For information regarding Out-of-Network Balance Billing that may be charged by an out-of-network provider, please refer to the Out-of-Network Benefits section on the Summary of Coverage document.
**Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest, please be sure to confirm they are contracted with Florida Blue's BlueOptions Network prior to receiving services.

TELEMEDICINE THROUGH TELADOC

New Benefit Effective 10/01/2020

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

Provides 24/7 Access to Care

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

For a cost that's less than an urgent care or ER visit, Teladoc gives you 24/7/365 access to U.S. board-certified doctors by web, phone or mobile app. It's a more convenient and affordable option for quality general and even dermatological care. This service is included with your medical plan!

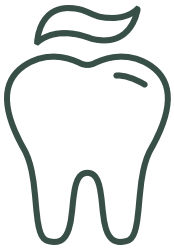
Getting Started

Before you can start using this new service, you must set up your account with Teladoc. Set up your account today—so when you need care, a Teladoc doctor is a just a call or click away. Just call Teladoc at 800-835-2362 or visit www.Teladoc.com to set up your account.

You can even download the mobile app for fast and convenient service. Just visit www.Teladoc.com/mobile or visit your app store.

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

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



DENTAL INSURANCE

Ameritas Plans

The Property Appraiser offers dental insurance through Ameritas to benefit-eligible employees. The monthly costs for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plans, please refer to Ameritas' summary plan document or contact Ameritas' customer service.

Monthly Payroll Deductions

Tier of Coverage	Employee Cost	
	LOW Option	HIGH Option
Employee Only	N/A	$0
Employee + Spouse	$14.76	$33.72
Employee + Child(ren)	$23.16	$47.36
Employee + Family	$46.92	$80.96

Ameritas

Customer Service:
(800) 487-5553

www.ameritas.com

In-Network Benefits

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

Out-of-Network Benefits

Out-of-network benefits are used when members receive services by a non- participating Ameritas Class (PPO) Network provider. Ameritas reimburses out-of-network services based on what it determines is the Maximum Allowable Benefit (MAB). The MAB is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member will pay the out-of-network benefit plus the difference between the amount Ameritas reimburses (MAB) for such services and the amount charged by the dentist. This is known as balance billing. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

LOW Option

The dental LOW Option plan requires a $50 individual or a $150 family in- network deductible, and a $100 individual and $300 family out-of-network deductible to be met before most benefits will begin. The deductible is waived for preventive services. The deductible does not apply to Class I Services.

HIGH Option

The dental HIGH Option plan requires a $25 individual or a $75 family in- network deductible, and a $50 individual and $150 family out-of-network deductible to be met before most benefits will begin. The deductible is waived for preventive services. The deductible does not apply to Class I Services.

Calendar Year Benefit Maximum

LOW Option

The maximum benefit the dental LOW Option plan will pay for each covered member is $1,000 for in-network services.

HIGH Option

The maximum benefit the dental HIGH Option plan will pay for each covered member is $1,500 for in-network.

Dental Rewards Rollover

Dental Rewards (DR) allows an employee to carry over part of the unused annual maximum. An employee earns DR by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. An employee and their covered dependent(s) may accumulate rewards up to the maximum carry over amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member does not submit a dental claim during a benefit year, all accumulated rewards are lost for that year, but member can begin earning rewards again the very next year. In addition, if an employee stays in the PPO network, employee will earn extra DR called the PPO Bonus.

Dental Reward	LOW Option Amount	HIGH Option Amount	Description
Benefit Threshold	$500	$750	Dental benefits received for the year cannot exceed this amount.
Annual Carry Over Amount	$250	$400	Amount added to the following year's benefit maximum.
Annual PPO Bonus	$100	$200	Additional bonus is earned if the covered member sees a PPO provider.
Maximum Carry Over	$1,000	$1,200	Maximum possible accumulation for benefit rollover and PPO bonus combined.

Ameritas Plans At-A-Glance

Network	Classic (PPO) LOW Option		Classic (PPO) HIGH Option	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible (CYD)				
Per Member	$50	$100	$25	$50
Per Family	$150	$300	$75	$150
Waived for Class I Services?	Yes	Yes	Yes	Yes
Calendar Year Benefit Maximum				
Per Member	$1,000	$1,000	$1,500	$1,500
Class I Services: Diagnostic & Preventive				
Routine Oral Exam (1 Per 6 Months)	Plan Pays: 100% Deductible Waived	Plan Pays: 80% Deductible Waived (Subject to Balance Billing)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)
Routine Cleanings (1 Per 6 Months)				
Complete X-rays (1 Per 12 Months)				
Bitewing X-rays (1 Per 5 Years)				
Class II Services: Basic Restorative**				
Fillings (Amalagam and Composite)	Plan Pays: 80% After CYD	Plan Pays: 70% After CYD (Subject to Balance Billing)	Plan Pays: 100% After CYD	Plan Pays: 80% After CYD (Subject to Balance Billing)
Anesthesia				
Simple Extractions				
Root Canal/Endodontics				
Periodontal Services				
Denture Repair				
Class III Services: Major Restorative**				
Crowns	Plan Pays: 50% After CYD	Plan Pays: 40% After CYD (Subject to Balance Billing)	Plan Pays: 60% After CYD	Plan Pays: 50% After CYD (Subject to Balance Billing)
Bridges				
Dentures				
Oral Surgery				
Dental Implants				
Class IV: Major Orthodontia				
Lifetime Maximum	N/A	N/A	$1,000	$1,000
Benefit (Dependent Children to Age 19)	N/A	N/A	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)

Plan References:
*Out-Of-Network Balance Billing: For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the previous page.
**Late entrant limitations apply for 12 months after enrollment if an employee does not elect coverage during their initial eligibility period. Please contact Ameritas for additional information.

Important Notes

- Each covered family member may receive up to two (2) cleanings per calendar year (1 per 6 months) covered under the preventive benefit.
- A pretreatment estimate is recommended for all work that is considered expensive. An employee must request that their dentist submit the request to Ameritas.
- Teeth missing prior to coverage under the Ameritas dental plan will not be covered.
- All services, including Class I, count toward the calendar year maximum.

Locate A Provider

To search for a participating provider, contact customer service or visit www.ameritas.com.

VISION INSURANCE

EyeMed Vision Plan

The Property Appraiser offers vision insurance through EyeMed to benefit eligible employees. The monthly costs for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more information about the vision plan, including exclusions and stipulations, please refer to the carrier's benefit summary or contact EyeMed customer service.

Monthly Payroll Deductions

Tier of Coverage	Employee Cost
Employee Only	$5.24
Employee + Spouse	$9.96
Employee + Child(ren)	$10.50
Employee + Family	$15.42

EyeMed

Customer Service:
(866) 800-5457

www.eyemed.com

In-Network Benefits

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

Out-of-Network Benefits

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

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

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

EyeMed Vision Plan At-A-Glance

Network	Insight	
	In-Network	Out-of-Network*
Services		
Eye Exam	$10 copay	Up to $40 Reimbursement
Frequency of Services		
Examination	12 Months	12 Months
Lenses	12 Months	12 Months
Frames	24 Months	24 Months
Contact Lenses	12 Months	12 Months
Lenses		
Single	$25 Copay	Up to $30 Reimbursement
Bifocal		Up to $50 Reimbursement
Trifocal		Up to $70 Reimbursement
Frames		
Allowance	$0 Copay, $130 Allowance, 20% Off Balance Over $130	Up to $91 Reimbursement
Contact Lenses		
Non-Elective (Medically Necessary; With Prior Authorization)	Covered at 100%	Up to $210 Reimbursement
Elective (Fitting, Follow-up & Lenses)	$0 Copay, $130 Allowance, 15% Off Balance Over $130	Up to $130 Reimbursement
LASIK		
Discount Programs	15% Off Retail Price or 5% Off the Promotional Price	N/A

Important Notes

- As a participant in the Property Appraiser's vision insurance, employee is eligible for exclusive savings from Target Optical and Sears Optical, for any available frames, covered at 100%.

FLEXIBLE SPENDING ACCOUNT (FSA)

The Property Appraiser offers Flexible Spending Accounts (FSA) administered through TASC. The FSA plan year is from October 1 to September 30.

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

Health Care FSA

This account allows participants to set aside up to an annual maximum of $2,750. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

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

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

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

- Ambulance Service
- Chiropractic Care
- Dental Fees/Orthodontic Fees
- Diagnostic Tests/Health Screenings
- Doctor Fees
- Drug Addiction/ Alcoholism Treatment
- Experimental Medical Treatment
- Eyeglasses/Contact Lenses (Corrective)
- Hearing Aids and Exams
- Injections and Vaccinations
- Lasik Surgery
- Mental Healthcare
- Nursing Services
- Optometrist Fees
- Physician Office Visits
- Prescription Drugs
- Sunscreen SPF15 or Greater
- Wheelchairs

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

Dependent Care FSA

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

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

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

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

FSA Guidelines

- The Health Care FSA allows a grace period (December 15) at the end of the plan year. The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends. Once the grace period ends, any unused funds still remaining in the account will be forfeited.
- The Health Care FSA has a deadline of January 31 to file claims for expenses incurred through the end of the grace period (December 15)
- The Dependent Care FSA has a deadline of January 31 to file claims for expenses incurred through the end of the plan year.
- Any unused funds after a plan year ends and all claims have been filed cannot be returned or carried forward to the next plan year.
- When a plan year ends and all claims have been filed, all unused funds will be forfeited and will not be returned.
- Employee can enroll in either or both of the FSAs only during the open enrollment period, a qualifying event, or new hire eligibility.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services they have not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.

Filing a Claim

Claim Form

The TASC Card is the most efficient way to pay for an eligible benefits expense. When you incur an expense simply swipe the TASC Card to pay for and automatically substantiate most eligible expenses at the point of purchase. No need to submit a Request for Reimbursement. If you pay for an eligible expense out of your pocket you may submit a Request for Reimbursement via your online MyTASC account, the MyTASC Mobile App, text, service request, fax or email.

Debit Card

FSA participants can request a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets.

Here's How It Works!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $38.46 based on a 26 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

	With a Health Care FSA	Without a Health Care FSA
Salary	$30,000	$30,000
FSA Contribution	-$1,000	$0
Taxable Pay	$29,000	$30,000
Estimated Tax 22.65% = 15% + 7.65% FICA	-$6,568	$6,795
After Tax Expenses	$0	-$1,000
Spendable Income	$22,432	$22,205
Tax Savings	*$227*	

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

BASIC LIFE AND AD&D INSURANCE

Basic Term Life and Accidental Death & Dismemberment

The Property Appraiser provides Basic Term Life and Accidental Death & Dismemberment (AD&D) insurance through Mutual of Omaha. This insurance is provided to employees at no cost at an amount equal to one times annual earnings (rounded to the next higher multiple of $1,000) to a maximum of $200,000. Coverage will reduce to 50% at age 70. Coverage cancels at termination of employment.

Voluntary Life and AD&D Coverage

Employee Coverage Amount

- An employee may elect Voluntary Life and AD&D coverage in units of $10,000 up to a maximum of ten times an employee's annual salary, not to exceed $500,000.
- Each year at Open Enrollment, employees currently enrolled in coverage may increase coverage by $10,000, up to the Guarantee Issue Amount of $150,000 without going through medical underwriting (age banded Life coverage only)
- Employees who apply for Voluntary Life and AD&D over ten times employee's salary, up to $150,000 (the Guaranteed Issue Amount), will be subject to medical underwriting approval for the excess amount during initial enrollment or subsequent Open Enrollment periods.
- Coverage will reduce to 50% of the benefit amount at age 70. Coverage terminates at termination of employment.
- All late applications are subject to medical underwriting approval.

Spouse Coverage Amount

- An employee may elect coverage for spouse in increments of $5,000 to a maximum of $250,000, not to exceed 100% of the employee's benefit.
- If the Spouse Voluntary Life Insurance amount exceeds $20,000 (the Guarantee Issue Amount), the excess amount will be subject to medical underwriting approval during initial enrollment or subsequent Open Enrollment Periods.
- Coverage will reduce to 50% of the benefit amount at age 70. Coverage terminates when the employee terminates employment (or reaches age 100 if the employee is still actively employed).
- All late applications are subject to medical underwriting approval.
- Please note, the age/rate table is based on the employee's age.

Voluntary Life Rate Table

Rate Per $1,000 of Benefit

Age Bracket	Voluntary Life Rate
Under Age 25	$0.06
25-29	$0.07
30-34	$0.08
35-39	$0.11
40-44	$0.16
45-49	$0.26
50-54	$0.41
55-59	$0.71
60-64	$0.76
65-69	$1.30
70-75	$2.30
75+	$8.73

Mutual of Omaha

Customer Service:
(800) 775-8805

www.mutualofomaha.com

Coverage Amount for Child(ren)

- An employee may elect coverage for child(ren) in the amount of $10,000 (the Guarantee Issue Amount). Child(ren) may be covered from birth to age 21, or 25 if a full time student.

Child(ren) Life with AD&D Rates

The monthly rate per member is $0.64 for $10,000 of Dependents Life insurance for eligible child(ren) regardless of the number of children covered.

Always remember to keep beneficiary forms updated. Employee may update beneficiary information at anytime throughout the year.

EXAMPLE

	÷ 1,000 =		x		=		x 12 =		÷ 24 =	
Benefit Election Premium			Rate by Age (in table)					Pay Periods	Per Pay Period Premium	

VOLUNTARY LONG TERM DISABILITY

The Property Appraiser offers Voluntary Long Term Disability (VLTD) insurance through Mutual of Omaha to all eligible employees. The VLTD benefit pays an employee a percentage of earnings if the employee becomes disabled due to an accident or injury. The premium is calculated based on an employee's annual earnings; examples are illustrated in the VLTD premium rate table. An employee's VLTD rate and benefit will be adjusted annually on the plan anniversary date.

Voluntary Long Term Disability (VLTD) Plan Summary:

- The VLTD benefit pays 60% of monthly pre-disability earnings up to a monthly maximum benefit amount of $5,000.
- The VLTD benefit begins on the 91st or 181st day following the disabling event.
- VLTD benefits are payable to age 65 or are based on a reduced benefit duration if the employee is disabled at or after the age of 62.
- If an employee returns to work part time, a partial VLTD benefit may be payable.

Please Note: An employee who does not elect this coverage when initially eligible, will have to complete an evidence of insurability form if electing coverage now or in the future. This form will ask some basic health history questions and will have to be approved prior to coverage becoming effective.

Voluntary Long Term Disability Elimination Period

	90 Day	180 Day
Age	Rate Per $100 covered Payroll	
< 19	$0.100	$0.081
20 - 24	$0.100	$0.081
25 - 29	$0.100	$0.081
30 - 34	$0.176	$0.143
35 - 39	$0.217	$0.181
40 - 44	$0.315	$0.263
45 - 49	$0.488	$0.407
50 - 54	$0.716	$0.598
55 - 59	$0.865	$0.721
60 - 64	$0.902	$0.751
65 - 69	$0.902	$0.751
70 - 99	$0.902	$0.751

EXAMPLE

$	÷ 12 =	$	÷ 100 =		=	$	x 12 =	$	÷ 24 =	$	
Annual Salary		or $8,333* (whichever is less)		Rate by Age (in table)					Pay Periods	Per Pay Period Premium	

*Benefit is 60% of monthly earnings up to maximum of $5,000 per month.

Mutual of Omaha

Customer Service: (800) 775-8805
Website: www.mutualofomaha.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Property Appraiser provides a comprehensive Employee Assistance Program (EAP) to full-time, part-time and temporary employees and family member(s) through Health Advocate, at no cost to employee. Health Advocate offers access to licensed mental health professionals through a confidential program protected by state and federal laws. The EAP program is available to help employees gain a better understanding of problems, locate the best professional help for their particular problem, and decide upon a plan of action.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employee and family member(s) free and convenient access to a range of confidential and professional services to help address a variety of problems that can negatively affect their well-being such as:

- Anxiety
- Legal and Financial Concerns
- Childcare, Eldercare, Adoption
- Family and/or Marriage Problems
- Stress
- Grief and Bereavement
- Substance Abuse
- Workplace Issues

What is Health Advocate Works?

The Property Appraiser recognizes that employees' personal responsibilities may, at times, spill over into the workplace. To help ensure an employee is able to address these concerns with minimal disruption, the program provides employee and family member(s) assistance for a variety of concerns – including child care, elder care, daily-living issues, and other issues they may encounter. Each employee and family member is allowed one to six in-person counseling sessions per issue per year. There is no limit to the number of issues. Unlimited telephone and web-based sessions are also available.

Are Services Confidential?

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

Health Advocate

Customer Service: (866) 799 2728
Website: www.healthadvocate.com/members
Organization Name: Indian River County Government

SUPPLEMENTAL INSURANCE

Plans may be purchased separately on a voluntary basis and premiums are paid through payroll deduction. The following plans are offered to employees:

Personal Accident Indemnity Plan

Provides an employee with cash if employee or a covered dependent receives treatment for injuries sustained in a covered accident. This policy provides an emergency treatment benefit, specific-sum injuries benefit, initial hospitalization benefit and even accidental death benefit.

Personal Cancer Indemnity Plan

Provides an employee with cash benefits if employee or covered dependent is diagnosed with an internal cancer or skin cancer. This policy gives an employee an initial diagnosis benefit, hospital confinement benefit, radiation and chemotherapy benefit, surgical/anesthesia benefit, as well as ambulance, transportation and lodging benefits.

Personal Disability Policy

Provides an employee with a source of income if unable to work due to an off-the-job injury or a covered sickness. Now with the option of guaranteed-issue. Monthly benefits range from $500-$6,000, subject to income requirements and benefit period restrictions. Available benefit periods are 3, 6, 12, 18, or 24 months. Available elimination periods are (Accident/Sickness): 0/7, 0/14, 7/7, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90 or 180/180.

Critical Care and Recovery Plan

Provides an employee with cash benefits if employee or covered dependent has a hospital stay as a result of a heart attack, stroke, coronary bypass surgery, end-stage renal failure, major third degree burns and continuing care benefit.

Hospital Confinement Plan

Provides an employee with cash benefits, if the employee or covered dependent receive services in the hospital, such as hospital confinement, hospital emergency room or upon hospital exit is in a rehab facility. This plan can also include benefits for physician visits, medical diagnostics and imaging services, ambulance transport and intensive care unit.

Aflac may offer additional products. For more information, please contact the respective Human Resources department.

Aflac

Customer Service: (800) 992-3522

Website: www.aflac.com

- Agent: John Martin
  Phone: (772) 532-1362
  Email: john_martinsr@us.aflac.com
- Agent: Mike Fletcher
  Phone: (772) 778 8858
  Email: michael_fletcher@us.aflac.com

MISCELLANEOUS BENEFITS

Please note that the following benefits may not apply to all constitutional offices. Refer to your policies for specific information.

Paid Holidays

Holiday	Dates
New Year's Day	Friday, January 1, 2021
Martin Luther King Day	Monday, January 18, 2021
Good Friday	Friday, April 2, 2021
Memorial Day	Monday, May 31, 2021
Independence Day (observed)	Monday, July 5, 2021
Labor Day	Monday, September 6, 2021
Veteran's Day	Thursday, November 11, 2021
Thanksgiving Day	Thursday, November 25, 2021
Day after Thanksgiving	Friday, November 26, 2021
Christmas Eve (observed)	Thursday, December 23, 2021
Christmas Day (observed)	Friday, December 24, 2021
New Year's Day (observed)	Friday, December 31, 2021

Pay Schedule and Direct Deposit

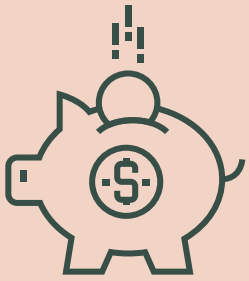
Indian River County Property Appraiser pays on a Semi-Monthly basis and offers the option of direct deposit of paychecks into the financial institution of employee's choice. Paychecks are automatically deposited into an employee's checking or savings account. If an employee is interested in direct deposit, an employee must complete a direct deposit form and return it to the respective Human Resources department.

Employees are entitled to use annual leave only after he or she has completed 90 days of service. Part time/temporary staff are not eligible for annual leave. Full-time employees shall accumulate annual leave days in the following manner:

Years of Service	Amount of Annual Leave Earned Per Year
Up to 5	10 days
6-10	15 days
10-15	20 days
16	21 days
17	22 days
18	23 days
19	24 days
20 and beyond	25 days

Chief deputies, and those staff designated by the Property Appraiser, shall accumulate annual leave days in the following manner:

Years of Service	Amount of Annual Leave Earned Per Year
1	10 days
2-5	20 days
6 and beyond	25 days



RETIREMENT PLANS

Florida Retirement System (FRS)

The Property Appraiser is a member of the Florida Retirement System (FRS) and pays a percentage of employees' salaries to FRS as shown below. Employee has a choice of participating in one of two plans: the pension plan or the investment plan. funded by:

Contribution Rate	Employee Pays	Employer Pays	Total Percentage
Regular Class	3.00%	10.00%	13.00%
Senior Management	3.00%	27.29%	30.29%
DROP	0%	16.98%	16.98%

457 Deferred Compensation and Roth 457 Deferred Compensation

The 457 Deferred Compensation Plan is voluntary retirement plan. Contributions to this plan are made on a tax deferral, so the money is not taxable until the employee takes a distribution.

The Roth 457 Deferred Compensation Plan is voluntary. Contributions to this plan are made post tax, so the money is not taxable when an employee takes a distribution (provided an employee meets the IRS requirements at the time of distribution) to complement FRS and Social Security. For both the 457 Deferred Compensation and Roth 457 Deferred Compensation, the maximum contribution for 2020 is $19,500 ($26,000 for "Age 50 Catch Up Provision" and $39,000 under "Normal Catch Up Provision").

Please Note: Please be advised that the limits apply to all contributions made to the 457 Deferred Compensation Plan and Roth 457 Deferred Compensation Plan. Please consult a financial advisor or check the IRS website (http://www.irs.gov/retirement/article/0,,id=172437,00.html) for more information.

DIABETES MANAGEMENT PROGRAM

If an employee or covered dependent(s) have been diagnosed with diabetes and are covered under the Property Appraiser plan, the Kannact Diabetes Program can provide diabetes management support, including a glucometer, test strips and other supplies at no cost to the employee. If they do not use test strips, but are taking prescription medication, Kannact will work with them and their doctor to help start an effective monitoring plan. Employee also has the option to work with a personal health coach, who will help the employee continue to manage their diabetes.

Kannact's unique system of diabetes management helps patients effectively track and manage key information related to their diabetes treatment. By making this data readily available to patients and health care providers, the Kannact system enables diabetes patients to maintain optimal health and enhance their quality of life, while at the same time minimizing the cost of treatment.

Kannact

Customer Service: (855) 722-5513
Website: www.kannact.com

NOTES

All changes must be made by August 28, 2020!

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.